Spinal Muscular Atrophy Enrollment Form

Please fax completed form to: 855-592-6890 Phone: 866-526-4984

1) PATIENT INFORMATION

First Name:	Last Name:	DOB:	Gender:	CVS Account #:
Address:		City:	State:	ZIP:
Phone:	Height:	Weight:	Date weight recorded:	
☐ Start of treatment	☐ Continuation of therapy	**Requested Start Date:**		

2) PRESCRIBER INFORMATION

Prescriber Name:	Address:	City, State, ZIP:
NPI # DEA #	Phone:	Fax:

3) INSURANCE INFORMATION Please fax copy if prescription and insurance cards with this form, if applicable (front and back)

Is this Patient insured? ☐ Yes ☐ No		Is this patient enrolled or eligible for Medicare/Medicaid? ☐ Yes ☐ No	
Policy Holder's Name:	Policy Holder's DOB:	Relationship to Patient:	
Medical Insurance:	Telephone:	Policy ID:	Group#:
Prescription Insurance:		Prescription Plan Telephone:	
Policy ID:	Group#:	RX BIN#:	RX PCN#:
☐ Check box if patient is enrolled in manufacturer copay assistance,		If yes, please provide ID#	

4) DIAGNOSIS AND CLINICAL INFORMATION

☐ G12.0, Infantile spinal muscular atrophy, type 1 (Werdnig-Hoffman) ☐ G12.1, Other inherited spinal muscular atrophy
☐ G12.8, Other spinal muscular atrophies and related syndromes ☐ G12.9, Spinal muscular atrophy, unspecified
☐ Other Code/Description: _____

Allergies:

☐ Home Infusion ☐ Coram AIS	(Drug, Diluents, Supplies, and Nursing for drug administration or catheter maintenance)
☐ MD Office ☐ Other:_____	Drug-only shipment for facility administration

Address:		Contact:	
City:	State:	ZIP:	Ph#:

If HOME Infusion – all medications, supplies, pump program, and pump to be provided by CVS Specialty to patient, if needed.
If CORAM AIS Infusion – all medications (except AIR protocol), supplies, and pump program will be provided by CVS Specialty to patient if needed. (AIR protocol and pump provided by Coram)
If MDO or Other Infusion Suite – only medication to be provided by CVS Specialty directly to provider's office.

Utilize skilled nursing to establish venous access, administer medication, and assess general status and response to therapy.

5) PRESCRIPTION INFORMATION

Medication	Strength	Directions	Quantity	Refills
Isembyld (apitegromab)	150mg/3mL Vial – 50 mg/ml concentration	☐ Infuse 10mg/kg IV every 4 weeks over approximately 60-120 minutes at no greater than 150 ml/hour. ☐ Other: _____	☐ 28 day supply ☐ _____vials	Refills: ____

***** This medication is add-on. Patient must also be receiving Spinraza or Evrysdi. *****

6) Complete below if Home Infusion or Coram AIS administration

Catheter	**Catheter Care** – flush only on drug admin days – SASH or PRN to maintain IV access & patency
☐ PIV (default if no selection)	**PIV** – NS 5ml (Heparin 10 units/ml 3-5ml if multiple days)
☐ Port	**Port** – NS 10mL & Heparin 100 units/ml 3-5ml
☐ PICC: # Lumens_____	**PICC** – NS 10ml & Heparin 100 units/ml 3-5ml + Maintenance flushes per lumen
☐ Other: _____	
*Give as PIV if Port/PICC failure	**For medications infused by a pump, gravity infusion should be used as backup in event of pump failure.**

PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute **Prescriber's Signature: _____Date: _____**	May Substitute / Product Selection Permitted / Substitution Permissible **Prescriber's Signature: _____Date: _____**

Prescribers are to comply with state-specific prescription regulations, which may include requirements for electronic prescribing, generic substitution, authorized prescription formats, and fax language. Noncompliance with these requirements may prompt follow-up communication with the prescriber. This form is not a valid prescription in Arizona.

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing above, I hereby authorize CVS Specialty Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.

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Please Complete Patient and Prescriber Information

Patient Name: _____ Patient DOB: _____ Patient Phone: _____
Patient Address: _____
Prescriber Name: _____ Prescriber Phone: _____

7) PREMEDICATIONS (Home Infusion or Coram AIS administration)

Diphenhydramine oral 25mg	☐ 25mg PO 30 minutes prior to infusion	Quantity: 1 per infusion	Refills to match prescription(s) above
	☐ 50mg PO 30 minutes prior to infusion	Quantity: 2 per infusion	Refills to match prescription(s) above
Acetaminophen 325mg tablets	☐ 325mg PO 30 minutes prior to infusion	Quantity: 1 per infusion	Refills to match prescription(s) above
	☐ 650mg PO 30 minutes prior to infusion	Quantity: 2 per infusion	Refills to match prescription(s) above
Medication:	☐ Directions:	Quantity: __	Refills to match prescription(s) above
Medication:	☐ Directions:	Quantity: __	Refills to match prescription(s) above
Medication:	☐ Directions:	Quantity: __	Refills to match prescription(s) above

8a) Acute Infusion Reaction Medications – Home Infusion
Please fill out below if going to be infused at HOME and patient requires any other medication besides Epinephrine:

Epinephrine Autoinjector or Ampule (***REQUIRED)***	**Adult** 0.3mg (>30kg / >66lbs)	Administer IM PRN severe allergic reaction. Call 911-may repeat in 5-15 min.	Quantity: 2	RF: 0
	Pediatric 0.15mg (>15-30 kg/ >33-66 lbs)		Quantity: 2	RF: 0
	***Infant** 0.01mg/kg (<15 kg / <16.5 lbs) **not available in auto-injector*		Quantity: 2	RF: 0
Pharmacy to determine dose based on patient weight (above). Leave on file if patient has in-date epinephrine on hand				
Medication:	☐ Directions:	Quantity: ____	Refills to match prescription(s) above	
Medication:	☐ Directions:	Quantity: ____	Refills to match prescription(s) above	

8b) Acute Infusion Reaction Medications – Coram AIS (Coram AIS will provide drug and supplies for the below if MD prescribes)
Please fill out below if going to be infused at CORAM and patient requires any other medication besides Epinephrine:

Epinephrine 1mg/ml amp (1:1000)	Adult (>30kg): 0.3mg IM PRN severe allergic reaction. Call 911. May repeat in 5-15 minutes	Refills to match prescriptions(s) above
Epinephrine 1mg/ml amp (1:1000)	Pediatric (>15-30 kg): 0.15mg IM PRN severe allergic reaction. Call 911. May repeat in 5-15 minutes	Refills to match prescriptions(s) above
Epinephrine 1mg/ml amp (1:1000)	Infant (<15 kg): 0.01mg/kg IM PRN severe allergic reaction. Call 911. May repeat in 5-15 minutes	Refills to match prescriptions(s) above
CORAM AIS to determine dose based on patient weight (above)		

Diphenhydramine 50mg/1ml vial	☐	Directions:	Refills to match prescription(s) above
Diphenhydramine oral Liquid 12.5mg/5ml	☐	Directions:	Refills to match prescription(s) above
Acetaminophen oral	☐	Directions:	Refills to match prescription(s) above
Methylprednisolone univial (adult) 125mg	☐	Directions:	Refills to match prescription(s) above
Methylprednisolone univial (pediatric) 40mg	☐	Directions:	Refills to match prescription(s) above
NaCl 0.9% 10ml PFS	☐	Directions:	Refills to match prescription(s) above
500ml NS with rate flow admin set	☐	Directions:	Refills to match prescription(s) above
Hydrocortisone univial (adult) 250mg	☐	Directions:	Refills to match prescription(s) above
Hydrocortisone univial (pediatric) 100mg	☐	Directions:	Refills to match prescription(s) above

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Patient Address: _____
Prescriber Name: _____ Prescriber Phone: _____

Preparation and Administration

- Prior to administration, verify AIR medications are available at the site of infusion
- Validate patient's weight and review potential adverse reactions with patient
- Do not begin preparation until IV access has been established and or patency confirmed
- Oral Premedication- Validate that medications have been taken prior to mixing medication.
- Injectable Premedication - Validate all injectable premedications are available and ready to administer prior to mixing medication
- Calculate the required dose (mg) of ISEMBYLD to be administered based on the patient's weight.
- Determine the volume (mL) of ISEMBYLD needed and the correct number of vials to supply the calculated dose.
- Remove ISEMBYLD vials from the refrigerator and allow vials to warm to room temperature while remaining in the carton until time of use. Do not use external heat sources to warm ISEMBYLD vials. Do not shake.
- Visually inspect each vial of ISEMBYLD. Do not use if the solution in the vial is discolored or particulate matter is present.
- Withdraw the required volume of ISEMBYLD from each vial using a sterile syringe and transfer to an infusion bag that is DEHP-free.
- Dilute ISEMBYLD to a final concentration of 5 mg/mL by adding the appropriate amount of 0.9% Sodium Chloride Injection to the infusion bag.
- Gently invert the bag to mix the solution. Do not shake. Do not mix or dilute with other drugs.
- Discard any unused ISEMBYLD remaining in the vial(s).
- Visually inspect the diluted ISEMBYLD solution for particles or discoloration prior to administration. Do not use if it is discolored, opaque, or foreign particles are seen.
- Use a dedicated line with an infusion set containing a 0.2 or 0.22 micron low protein binding polyethersulfone (PES) in-line infusion filter. Use infusion sets and lines that are DEHP-free.
- Infuse the diluted solution of ISEMBYLD intravenously over approximately 60 minutes to 120 minutes at an infusion rate no greater than 150 mL/hour.
  After completion of the infusion, flush the infusion line with 0.9% Sodium Chloride Injection to ensure that all the ISEMBYLD has been administered.

Rx includes related diluents, pumps, DME, ancillary supplies (e.g., needles, syringes, dressings) as necessary for drug administration/catheter maintenance and nursing services for drug administration/therapy teach train or catheter maintenance.

Additional Notes:_____

MD Agent/Title Issuing Order_____ **Date & Time _____**

RPh Name Receiving Verbal Order_____ **Verify Read Back – Initials _____**

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