

Inflammatory Bowel Disease Enrollment Form

Fax Referral To: 1-800-323-2445 Phone: 1-800-237-2767

Email Referral To: Customer.ServiceFax@CVSHealth.com
Coram National Call Center Fax: 1-866-843-3221

Six Simple Steps to Submitting a Referral

PATIENT INFORM	ATION (Complete or include de	emographic sheet)	mitting a Referrat	
Patient Name:		DC	DB: Gender:	Female
Address:		City, State, ZIP Code	e:	
Preferred Contact Met	nods: 🗌 Phone (to primary # provi	ded below) 🗌 Text (to	o cell # provided below) 🗌 Email (to email pro	ovided below)
			Pharmacy will attempt to contact by phone.	
		Alte	rnate Phone: Primary Language:	
Email:			ionship to patient:	
2 PRESCRIBER INFO		Relati	ionship to patient:	
Prescriber's Name:		C+o	te License #:	
NIDI #· Name	EA #: Group or Hosp			
Phone:	Fax Cor	Oity, State	e, ZIP Code: Contact's Phone:	
			ce cards with this form, if available (front and b	
			ledicare/Medicaid? Yes No	acity
			B: Relationship to Patient:	
Medical Insurance:	Teler	hone: P	Policy ID: Group #:	
Prescription Insurance	:	Preso	cription Plan Telephone:	
Policy ID:	Group #:	RX	cription Plan Telephone: BIN #: RX PCN #:	
Check box if patient	t is enrolled in manufacturer copay		yes, please provide ID#	
DIAGNOSIS AND	CLINICAL INFORMATION			
Needs by Date:		S	hip to: 🗌 Patient 🗌 Office 🗌 Other:	
Diagnosis (ICD-10):		_	_	
	ease, unspecified, without complica		Date of Diagnosis//	
	olitis, unspecified, without complica		Date of Diagnosis//	
	Description			
Patient Clinical Inform				
Allergies:				
	New to therapy Continuation of			
			received?s status:s	
		•	s status.	
Nursing and Administ		uation		
	coordinate home health Infusion nu	ırse visit as necessarv	2 □Yes □No	
			Prescriber's Office** Other Infusion Clin	nic
	ade Biosimilars: First three doses t			
		-	ug administration/therapy teach train.	
	ther Infusion Clinic: Drug only for fa	•		
PRESCRIPTION		•		
MEDICATION	STRENGTH		DOSE & DIRECTIONS	QUANTITY/REFILLS
Adalimumab-		☐ Inject 40 mg SC		Quantity:
aacf	☐ 40 mg/0.8 mL PEN		C on Day 1 (given in one day or split over two	28 days
(unbranded version	☐ 40 mg/0.8 mL PFS	_ ,	80 mg on Day 15, then 40 mg SC every other	84 days
of Idacio)		week starting Day 2		Refills:
o				
Adalimumab-aaty	☐ 1 x 40 mg/0.4 mL PEN	☐ Inject 40 mg SC		Quantity:
(unbranded version	2 x 40 mg/0.4 mL PEN		C on Day 1 (given in one day or split over two	28 days
of Yuflyma)			80 mg on Day 15, then 40 mg SC every other	84 days
		week starting Day 2	9	Refills:
		☐ Inject 40 ma SC	every other week	Quantity:
Adalimumab-adaz	40 mg/0.4 mL PEN		C on Day 1 (given in one day or split over two	28 days
(unbranded version	40 mg/0.4 mL PFS (with		80 mg on Day 15, then 40 mg every other	84 days
of Hyrimoz)	needle guard)	week starting Day 2		Refills:
Other	Strength:	,		Quantity: Refills:
PRESCRIBER S	SIGNATURE REQUIRED (S	STAMP SIGNAT	URE NOT ALLOWED)	
"Dispense As Written" / E	Brand Medically Necessary / Do Not Substitu	ute / No Substitution /	May Substitute / Product Selection Permitted /	
DAW / May Not Substitute			Substitution Permissible	
Prescriber's Signa	ture:	Date:	Prescriber's Signature:	Date:
CA MA NC & DD: Interch	ange is mandated unless Prescriber writes the	words "No Substitution"	ATTN: New York and Iowa providers, pl	ease submit electronic prosorintion
on, wa, No & PR. merch	ange is manuated unless Plescriber writes the	words IND BUDSUIGUTION	AT IN. New TOIK and IOWA providers, pi	ease submit electronic prescription

			Prescriber Information	
			Patient Phone:	
				
		Pr	rescriber Phone:	
Patient Clinical In				-
Allergies:		NKDA W	/eight:	l cm
	New to therapy Continua			
			tient received?	
			is status:	
PRESCRIPTION		uation		
MEDICATION	STRENGTH		DOSE & DIRECTIONS	QUANTITY/REFILLS
			SC every other week	·
		☐ Inject 40 mg		Quantity:
Adalimumab-	☐ 20 mg/0.4 mL PFS		SC on Day 1, 40mg Day 15, then 20 mg	28 days
fkjp	☐ 40 mg/0.8 mL PFS		k starting Day 29	84 days
(unbranded	40 mg/0.8 mL PEN		SC on Day 1 (given in one day or split over	Refills:
version of Hulio)		-	days), 80 mg on Day 15, then 40 mg every	
voision or mailo,		other week start		
			SC every other week	
			SC every other week	Quantity:
Amjevita	☐ 20 mg/0.4 mL PFS		SC on Day 1, 40 mg on Day 15, then 20 mg	28 days
(adalimumab-	☐ 40 mg/0.8 mL PFS		k starting Day 29	84 days
atto)	☐ 40 mg/0.8 mL PEN		SC on Day 1 (given in one day or split over	Refills:
	3 - 1		days), 80 mg on Day 15, 40 mg every other	
		week starting Da		
			ase (Adult and Pediatric ≥ 6 years old)	
		Induction Dose:	, , , , , , , , , , , , , , , , , , , ,	
			g/kg (Dose =mg) at weeks 0, 2,	
		6 and every 8 we		
			ase (Adult) Maintenance Dose:	
			mg/kg (Dose =mg) every 8 weeks	
			ase (Pediatric ≥6 years old)	
		Maintenance Do		Quantity:
Avsola	100 mg vial		<u>se</u> . g/kg (Dose =mg) every 8 weeks	# of 100 mg vial(s)
			olitis (Adult and Pediatric ≥ 6 years old)	- · · ·
		Induction Dose:	onis (Addit and Fediatric 2 6 years old)	Refills:
			g/kg (Dose =mg) at weeks 0, 2,	
		6 and every 8 we		
			eeks therearter blitis (Adult and Pediatric ≥ 6 years old)	
			· · · · · · · · · · · · · · · · · · ·	
			se: Infuse IV at 5 mg/kg	
			_mg) every 8 weeks	l Occanita in 41.55
□ 0im=:-	Cinamia Chautau Kit (Cinamitili aliania)		Inject SC 400 mg (2 injections) on day 1, and	-
☐ Cimzia	Cimzia Starter Kit (6 prefilled syringes)		I. If response occurs, follow with	(6 prefilled syringes)
	Посо и и и и	400 mg every fo		Refills: 0
Cimzia	200 mg/1 mL prefilled syringe		se: Inject SC 400 mg	Quantity:
=	200 mg vial	(2 injections) eve	ery 4 weeks	Refills:
		Induction Dose:		Quantity:
		☐ Week 0: Infus	sion 300 mg IV	1 Vial
		☐ Week 2: Infus		2 Vials
	300 mg vial	Week 6: Infusion 300 mg IV		3 Vials
☐ Entyvio				Refills: 0
		Maintenance Do		Quantity: 1 Vial
		☐ Inject 300 m	g IV every 8 weeks	Refills:
	108 mg/0.68 mL PEN	☐ Inject 108 mg	SC every 2 weeks	Quantity: 2 pens Refills:
6 PRESCRIBER S	∣ IGNATURE REQUIRED (STAMP SIGN	ATURE NOT AL	LOWED)	Nonus
	" / Brand Medically Necessary / Do Not Substitute /		May Substitute / Product Selection Permitted /	
DAW / May Not Subs		110 OubstitutiOH /	Substitution Permissible	
		ate:	Prescriber's Signature:	Date:
	-			
CA, MA, NC & PR: Inte	erchange is mandated unless Prescriber writes the word	s " No Substitution "	ATTN: New York and Iowa providers,	please submit electronic prescription

		ase Complete Patient and		
			Patient Phone:	
	:			
	e:	Pi	rescriber Phone:	
Patient Clinica	u information:	NKDA W	/eight: kg 🗌 lb Height: 📗	cm \square in
	us: New to therapy	Continuation of therapy: F	Date of last treatment/_/	
			tient received?	
TB Test Date _	_//	Negative Hepatit	is status:	
		(s) for discontinuation:		<u> </u>
	ION INFORMATION			
MEDICATION	STRENGTH		SE & DIRECTIONS	QUANTITY/REFILLS
		Inject 40 mg SC every other		0
	☐ 40 mg/0.4 mL PEN		given in one day or split over two consecutive	Quantity: 28 days
☐ Hadlima	☐ 40 mg/0.8 mL PEN	days), 80 mg on Day 15, then 40 mg every other week s	tarting Day 20	84 days
<u> </u>	☐ 40 mg/0.4 mL PFS		given in one day or split over two consecutive	Refills:
	☐ 40 mg/0.8 mL PFS	days), 80 mg on Day 15, then	given in one day of opiniover two deficed and	rtonac.
		40 mg every other week startin	g Day 29	
		☐ Inject 20 mg SC every other		
		☐ Inject 40 mg SC every other	rweek	Quantity:
	☐ 20 mg/0.4 mL PFS	☐ Inject 80 mg SC on Day 1, 40	0 mg Day 15, then 20 mg every other week	28 days
☐ Hulio	☐ 40 mg/0.8 mL PFS	starting Day 29		84 days
	☐ 40 mg/0.8 mL PEN		given in one day or split over two consecutive	Refills:
		days), 80 mg on Day 15, then	B 00	
		40 mg every other week startin		
		Inject 20 mg SC every week		
		☐ Inject 20 mg SC every other☐ Inject 40 mg SC every week		
		☐ Inject 40 mg SC every other		
		☐ Inject 80 mg SC every other		
		-	O mg on day 15, then 20 mg every other week	
		starting Day 29		
	☐ 20 mg/0.2 mL PFS	☐ Inject 80 mg SC on day 1, 40	0 mg on day 8, 40 mg on day 15, then 20 mg	Quantity:
_	☐ 40 mg/0.4 mL PFS	every week starting day 29		28 days
☐ Humira	☐ 40 mg/0.4 mL Pen		0 mg on day 8, 40 mg on day 15, then 40 mg	84 days
	80 mg/0.8 mL PFS	every other week starting day 2		Refills:
	☐ 80 mg/0.8 mL Pen		single-dose or split over two consecutive	
		days), 80 mg on Day 8, 80 mg o 80 mg every other week startin		
			single-dose or split over two consecutive	
		days), 80 mg on Day 8, 80 mg o		
		40 mg every week starting on I	• •	
			single-dose or split over two consecutive	
		days), 80 mg on Day 15, then 4	0 mg every other week starting on Day 29	
		Inject 40 mg SC every othe		
	40 mg/0.4 mL PEN	-	Omg Day 15, then 20 mg every other week	Quantity:
Hyrimoz	40 mg/0.4 mL PFS	starting Day 29	et a contra a contra de la contra dela contra de la contra del la contra del la contra de la contra del la contra de la contra de la contra del la contra del la contra de la contra de la contra del la contra	28 days
	(with needle guard)		given in one day or split over two consecutive O mg every other week starting Day 29	84 days
				Quantity: Refills:
Other	Strength:	Dose:		Yadinity Neillis
6 PRESCRIB	ER SIGNATURE REQUI	RED (STAMP SIGNATURE N	NOT ALLOWED)	
·		Do Not Substitute / No Substitution /	May Substitute / Product Selection Permitted /	
DAW / May Not S		Doto	Substitution Permissible Procoribor's Signature	Date:
Prescriber's	əigirature:	Date:	Prescriber's Signature:	Date:
CA, MA, NC & PR	t: Interchange is mandated unless Pres	criber writes the words "No Substitution"	ATTN: New York and Iowa providers, ple	ase submit electronic prescription

	Please Co	<u> mplete Patient and I</u>	Prescriber Information	
			Patient Phone:	
Patient Address: _				
		Pr	escriber Phone:	
Patient Clinical I			esta Dic Diction D	🗖 • .
illergies:	∴ Now to thorony Ω	NKDA W	'eight: ☐ kg ☐ lb Height: ☐ late of last treatment/_/	cm 🔛 in
			ient received?	
	// Positive Negative		s status:	
	ION INFORMATION			
MEDICATION	STRENGTH	D	OSE & DIRECTIONS	QUANTITY/REFILL
		_	It and Pediatric ≥ 6 years old) Induction Dose:	
		Infuse IV at 5 mg/kg (Dos	se =mg) at weeks 0, 2, 6 and every 8	
☐ Inflectra		weeks thereafter		
		Crohn's Disease (Adu		
			e IV at 5-10 mg/kg (Dose =mg) every	
☐ Infliximab		8 weeks		Quantity:
	100 mg vial	Crohn's Disease (Pedi		# of 100 mg vial(s)
Remicade		8 weeks	e IV at 5 mg/k (Dose =mg) every	Refills:
Nernicade			ılt and Pediatric ≥ 6 years old) Induction	
			g (Dose =mg) at weeks 0, 2, 6 and	
Renflexis		every 8 weeks thereafter		
		Ulcerative Colitis (Adu	ılt and Pediatric ≥ 6 years old) <u>Maintenance</u>	
		Dose: Infuse IV at 5 mg/k	g (Dose =mg) every 8 weeks	
		Induction Dose		Quantity:
			g via IV infusion over at least 30 minutes	1 Vial
			g via IV infusion over at least 30 minutes	2 Vials 3 Vials
	300 mg/15 mL single dose	Week 8: Infuse 300 mg via IV infusion over at least 30 minutes		Refills: 0
				Quantity:
		Induction Dose Week 0: Infuse 900 mg via IV infusion over at least 30 minutes Week 4: Infuse 900 mg via IV infusion over at least 30 minutes Week 8: Infuse 900 mg via IV infusion over at least 30 minutes		3 Vials
П оh				6 Vials
Omvoh				9 Vials
			g via iv illiusion over at least 30 miliutes	Refills: 0
	☐ 2 x 100 mg/mL PEN	Maintenance Dose		
	2 x 100 mg/mL PFS	Inject 200 mg SC (given as two consecutive injections of 100 mg each) at Week 12 and every 4 weeks thereafter		Oventitus
	1 x 100 mg/mL + 1 x 200 mg/	each) at week 12 and eve	ery 4 weeks thereafter	Quantity: 28 days
	2 mL PEN	Maintenance Dose		84 days
	1 x 100 mg/mL + 1 x 200 mg/		en as two consecutive injections of 100 mg	Refills:
	2 mL PFS	each) at Week 12 and eve	ery 4 weeks thereafter	
	130 mg/26 mL (5 mg/mL) IV			Quantity:
	single-dose vial	Single IV Induction Dose:		2 Vials
☐ Pyzchiva	Date Infusion was completed or	55 kg or less 260 mg a	3 Vials	
	scheduled: (This date is	more than 55 kg to 85	☐ 4 Vials	
	needed to determine shipment of Stelara SC maintenance	more than 85 kg 520 i	mg at Week 0: # of vials to be used 4	Refills: 0
	dosage)			
	90 mg/mL	☐ Inject 90 mg SC 8 wee	eks after the initial IV induction dose, then	Quantity:
Pyzchiva	SC dose in a single-dose	every 8 weeks thereafter		Refills:
	prefilled syringe	☐ Inject 90 mg SC every	8 weeks	
		Induction Dose:		Quantity:
Rinvoq	45 mg	Take 1 tablet once dai		Refills:
		☐ Take 1 tablet once dai	ly for 12 weeks	
PRESCRIR	ER SIGNATURE REQUIRE	D (STAMP SIGNAT	URE NOT ALLOWED)	
"Dispense As Writte DAW / May Not Sub	en" / Brand Medically Necessary / Do Not So estitute	upstitute / No Substitution /	May Substitute / Product Selection Permitted / Substitution Permissible	
•	ignature:	Date:	Prescriber's Signature:	Date:
	nterchange is mandated unless Prescriber write		ATTN: New York and Iowa providers, plea	

Patient Address:				Prescriber Information	
Prescriber Name:				Patient Phone:	
Patient Clinical Information: NKDA Weight: kg to Height: cm in Information of therapy; Date of last treatment // step attent on samples? Mol Yes; Hyes, how many samples has patient neolwod? It she patient on samples? Mol Yes; Hyes, how many samples has patient neolwod? It she patient on samples? Mol Yes; Hyes, how many samples has patient neolwod? It she patient on samples? Mol Yes; Hyes, how many samples has patient neolwod?	Patient Address: _				
Allergies:	Prescriber Name:		P	rescriber Phone:	
Treatment status: New to therapy Continuation of therapy; Date of last treatment	Patient Clinical	Information:	_		
Is the patient on samples? No Yes; If yes, how many samples has patient received? The Test Date _ Positive _ Negative Hepatitis status: Prescription in Formation Strength Maintenance Dose;			∐ NKDA W	/eight: 📙 kg 📙 lb Height: 🗀	cm 🔲 in
TB Test Date/					
Pirot therapy, treatment dates, and reason(s) for discontinuation: PRESCRIBER (DIMATION STRENGTH DOSE & DIRECTIONS Quantity: Quantity: Single-dose yial 130 mg/26 m.l. (5 mg/ml.) IV single-dose yial Date Influsion was completed or scheduled:			· · · · · · · · · · · · · · · · · · ·		
Description in Promisor Description De					
Maintenance Dose: Take 1 tablet once dally Series: Quantity: Quantity: Selarsdi 30 mg /26 mL (5 mg/mL) V Selarsdi Date Infusion was completed or schodulod: (This date is needed to determine shipment of Stelars SC maintenance dossep) 55 kg or less 260 mg at Week 0: # of vials to be used 2 2 vials 3 vials 30 vial		The state of the s	continuation:		
Rinvoq 15 mg Maintenance Dose; Refills: Take 1 tablet once daily Refills: Take 1 tablet once daily Refills: Take 1 tablet once daily Refills: Pake 2 tablet once daily Pake 2 tablet onc				DOSE & DIRECTIONS	QUANTITY/DEFULS
Solarsdi	MEDICATION	_		DOSE & DIRECTIONS	-
Selarsdi Somg/2.2 m. L (5 mg/mL) IV single-dose vial Date Infusion was completed or scheduled: (This date is needed to determine shipment of Stelars SC maintenance dosage) Solarsdi Sola	Rinvoq			doil.	Quantity:
Selarsdi Single-dose vial Date Influsion was completed or scheduled: (This date is needed to determine shipment of Stelara SC comaintenance dosage) Gompat Week 0: # of vials to be used 2 Jalas Jala			Take I tablet once	ually	
Selarsdi Date Infusion was completed or scheduled: (This date is needed to determine shipment of Stelara SC maintenance dosage) more than 58 kg 520 mg at Week 0: # of vials to be used 4 Visils needed to determine shipment of Stelara SC maintenance dosage) more than 58 kg 520 mg at Week 0: # of vials to be used 4 Visils of Stelara SC maintenance dosage) more than 58 kg 520 mg at Week 0: # of vials to be used 4 Visils of Stelara SC maintenance dosage) more than 58 kg 520 mg at Week 0: # of vials to be used 4 Visils of Stelara SC maintenance dosage) more than 58 kg 520 mg at Week 0: # of vials to be used 4 Visils of Visils			Single IV Induction Do	se:	<u> </u>
Selarsdi Scheduled:(This date is needed to determine shipment of Stelara SC maintenance dosage) Gorginal Scalarsdi Gorgina			☐ 55 kg or less 260 m	ng at Week 0: # of vials to be used 2	
needed to determine shipment of Stelara SC maintenance dosage)	☐ Selarsdi	•	more than 55 kg to	85 kg 390 mg at Week 0: # of vials to be	
Stelars SC maintenance dosage) more than 8 kg 520 mg at Week 0: # of vials to be used 4 90 mg/mL Inject 90 mg SC 8 weeks after the initial IV induction dose, then every 8 weeks thereafter. Refills:			used 3		
Selarsdi			more than 85 kg 52	20 mg at Week 0: # of vials to be used 4	Renus. 0
Sclarsdi SC dose in a single-dose prefilled syringe Inject 90 mg SC every 8 weeks Quantity: 28 days Inject 40 mg SC every 9 weeks Inject 160 mg SC on Day 1 (given in one day or split over two consecutive days), 80 mg on Day 15, then 40 mg SC every 9 week starting Day 29 Inject 90 mg sC every 9 weeks Inject 180 mg on Day 15, then 40 mg SC every 9 weeks Inject 180 mg on Day 15, then 40 mg SC every 9 weeks Inject 180 mg every 4 weeks Inject 180 mg every 4 weeks Inject 180 mg Inject 90 mg IV over at least one hour Quantity: 1 Vial Quantity: 2 Vials Inject 90 mg IV over at least two hours Quantity: 2 Vials Qu		+	☐ Inject 90 mg 90 9 1	weeks after the initial IV induction dose then	Quantity:
Syringe	□ Solaredi	9			
Simlandi (adalimumab- 40 mg/0.4 mL PEN Inject 140 mg SC every other week 28 days ngvk) 40 mg/0.4 mL PFS 28 days ngvk) 40 mg/0.8 mL PEN 100 mg/mL in a single-dose prefilled Smart-Ject autoinjector 100 mg/mL in a single-dose prefilled Syringe 100 mg/mL in a single-dose prefilled Syringe 100 mg/mL in a single-dose prefilled Syringe 100 mg at Week 2 and then 100 mg every 4 weeks 100 mg avery 4 weeks 100 mg ave			1 — '		ivenus.
dalimnumabry da mg/0.4 mL PFS do mg/0.4 mL PFS do mg/0.4 mL PFS do mg/0.8 mL PEN do mg/0.4 mL PFS do mg/0.8 mL PEN do mg/0.8 mL PE		syringe			Ouantity:
dadamumab- yvk)	☐ Simlandi	=			<u> </u>
week starting Day 29 100 mg/mL in a single-dose prefilled Smart-Lect autoinjector 100 mg/mL in a single-dose prefilled Smart-Lect autoinjector 100 mg/mL in a single-dose prefilled Smart-Lect autoinjector 100 mg/mL in a single-dose prefilled Syringe Induction Dose: Inject SC 200 mg initially (given as 2 subcutaneous injections of 100 mg each) at Week 0, followed by 100 mg at Week 2 and then 100 mg every 4 weeks Refills: Maintenance Dose; Inject SC 100 mg every 4 weeks Maintenance Dose; Inject SC 100 mg every 4 weeks Maintenance Dose; Inject SC 100 mg every 4 weeks Maintenance Dose; Inject SC 100 mg every 4 weeks Quantity: 1 Vial Quantity: 2 Vials Quantity: 2 Vials Quantity: 2 Vials Quantity:	(adalimumab-			· · · ·	
Simponi	ryvk)	☐ 80 mg/0.8 mL PEN		ing on bay to, then some co every other	
Simponi		100 mg/ml in a single-dose		ect SC 200 mg initially (given as 2	rtonia.
Simponi 100 mg/mL in a single-dose prefilled syringe 100 mg at Week 2 and then 100 mg every 4 weeks Maintenance Dose: Inject SC 100 mg every 4 weeks Maintenance Dose: Inject SC 100 mg every 4 weeks Quantity: 1 Vial Quantity: 2 Vials Quantity:		_			Quantity:
prefilled syringe	∐ Simponi	1 : 1	•	9 ,	Refills:
Skyrizi		_	ū	•	
Week 0: Infuse 600 mg IV over at least one hour Quantity: 1 Vial Week 4: Infuse 600 mg IV over at least one hour Quantity: 1 Vial Quantity: 1 Vial Week 4: Infuse 600 mg IV over at least one hour Quantity: 1 Vial Quantity: 1 Vial Week 8: Infuse 600 mg IV over at least one hour Intravenous UC Induction Dose: Week 0: Infuse 1,200 mg IV over at least two hours Quantity: 2 Vials Week 4: Infuse 1,200 mg IV over at least two hours Quantity: 2 Vials Week 4: Infuse 1,200 mg IV over at least two hours Quantity: 2 Vials Week 8: Infuse 1,200 mg IV over at least two hours Quantity: 2 Vials Week 8: Infuse 1,200 mg IV over at least two hours Quantity: 2 Vials Week 8: Infuse 1,200 mg IV over at least two hours Quantity: 2 Vials Quantity: 2 Vials Week 8: Infuse 1,200 mg IV over at least two hours Quantity: 2 Vials Quantity: 2 Vials Week 8: Infuse 1,200 mg IV over at least two hours Quantity: 2 Vials Quantity: 2 Vials Mintenance UC or CD Dose (Option 1): Inject 180 mg SC week 12 and every 8 weeks thereafter Quantity: 1 devic prefilled cartridge Inject 180 mg SC every 8 weeks Properties of Stelara SC maintenance UC or CD Dose (Option 2): Inject 360 mg SC every 8 weeks Properties of Stelara SC maintenance of Stelara Sc m					Quantity: 1 Vial Refills: 0
Geomy/10 mL (60 mg/mL) single dose vial Week 4: Infuse 600 mg IV over at least one hour Quantity: 1 Vial Week 8: Infuse 600 mg IV over at least one hour Quantity: 2 Vials Week 0: Infuse 1,200 mg IV over at least two hours Quantity: 2 Vials Quantity: 3 Vials Quantity: 3 Vials Quantity: 4 Vials Quantity: 1 devic Quantity:			☐ Week 0: Infuse 600	mg IV over at least one hour	Quantity: 1 Vial Refills: 0
G00 mg/10 mL (60 mg/mL) single dose vial Week 8: Infuse 600 mg IV over at least one hour Intravenous UC induction Dose: Week 0: Infuse 1,200 mg IV over at least two hours Quantity: 2 Vials Week 4: Infuse 1,200 mg IV over at least two hours Quantity: 2 Vials Quantity: 3 Vials Quantity: 4 Vials Quantity: 2 Vials Quantity: 4 Vials Quantity: 5 Vials Quantity: 4			☐ Week 4: Infuse 600	mg IV over at least one hour	Quantity: 1 Vial Refills: 0
Week 0: Infuse 1,200 mg IV over at least two hours Quantity: 2 Vials Week 4: Infuse 1,200 mg IV over at least two hours Quantity: 2 Vials Quantity: 1 devic Quantity: 2 Vials Quantity: 3 devic Quantity: 1 devic Quantity: 1 devic Quantity: 2 Vials Quantity: 3 devic		☐ 600 mg/10 mL	_	=	_
Skyrizi		(60 mg/mL) single dose vial	Intravenous UC Induc	ction Dose:	
Skyrizi			Week 0: Infuse 1,20	00 mg IV over at least two hours	Quantity: 2 Vials Refills: 0
Stelara Stel	□ ot:				Quantity: 2 Vials Refills: 0
single-dose prefilled cartridge with on-body injector	<u> Бкуп</u> гі		☐ Week 8: Infuse 1,20	00 mg IV over at least two hours	Quantity: <u>2 Vials</u> Refills: <u>0</u>
with on-body injector		☐ 180 mg/1.2 mL (150 mg/mL)	Maintenance UC or C	D Dose (Option 1):	
360 mg/2.4 mL (150 mg/mL) single-dose prefilled cartridge with on-body injector Inject 360 mg SC week 12 and every 8 weeks thereafter Inject 360 mg SC every 8 weeks Inject 360 mg SC every 8		single-dose prefilled cartridge	$\perp = \cdot$		Quantity: 1 device with
Stelara Stel					prefilled cartridge
cartridge with on-body injector 130 mg/26 mL (5 mg/mL) IV single-dose vial		_ •			
Stelara Stelara Single -dose vial Date Infusion was completed or scheduled: (This date is needed to determine shipment of Stelara SC maintenance dosage) 90 mg/mL Stelara SC dose in a single-dose prefilled syringe Single IV Induction Dose: Single IV Induction Dose: 2 Vials 2 Vials 3 Vials 4 Vials 4 Vials Refills: 0 4 Vials Refills: 0 Stelara SC maintenance dosage) 90 mg/mL Inject 90 mg SC 8 weeks after the initial IV induction dose, then every 8 weeks thereafter. every 8 weeks thereafter. Inject 90 mg SC every 8 weeks		-			Refills:
single-dose vial Date Infusion was completed or scheduled: (This date is needed to determine shipment of Stelara SC maintenance dosage) 90 mg/mL Stelara Stela			☐ Inject 360 mg SC e	very 8 weeks	
Stelara St			Single IV Induction Do	se:	-
Stelara Date Infusion was completed or scheduled: (This date is needed to determine shipment of Stelara SC maintenance dosage) 90 mg/mL					
scheduled: (I his date is needed to determine shipment of Stelara SC maintenance dosage) 90 mg/mL Scheduled: (I his date is needed to determine shipment of Stelara SC maintenance dosage) 90 mg/mL SC dose in a single-dose prefilled syringe Inject 90 mg SC 8 weeks after the initial IV induction dose, then every 8 weeks thereafter. Inject 90 mg SC every 8 weeks PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED) "Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / May Substitute / Product Selection Permitted /	Stelara			-	
needed to determine shipment of Stelara SC maintenance dosage) more than 85 kg 520 mg at Week 0: # of vials to be used 4 Refills: 0			used 3		_
Stelara SC maintenance dosage) 90 mg/mL SC dose in a single-dose prefilled syringe Inject 90 mg SC 8 weeks after the initial IV induction dose, then every 8 weeks thereafter. Inject 90 mg SC every 8 weeks PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED) "Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / May Substitute / Product Selection Permitted /		·			Refills: 0
Stelara SC dose in a single-dose prefilled syringe every 8 weeks thereafter. Inject 90 mg SC every 8 weeks 6 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED) "Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitute / Product Selection Permitted /					
syringe		9	_ ,		Quantity:
6 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED) "Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / May Substitute / Product Selection Permitted /	∐ Stelara		_ ′		Refills:
"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / May Substitute / Product Selection Permitted /		syringe	☐ Inject 90 mg SC ev	ery & weeks	
"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / May Substitute / Product Selection Permitted /	6 PRESCRIR	ER SIGNATURE RECUIPED	(STAMP SIGNAT	URE NOT ALLOWED)	
Cabolitation of Office States			Stitute / No Substitution /	The state of the s	
Prescriber's Signature:Date:Date:Date:Date:Date:Date:Date:Date:Date:			Date:		Date:
CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "No Substitution"ATTN: New York and Iowa providers, please submit electronic p					

Steqeyma 30 mg/28 mL (5 mg/mL) IV single-dose vial 55 kg or less 280 mg at Week 0: # of vials to be used 2 55 kg or less 280 mg at Week 0: # of vials to be used 2 3 Vials 3 Vials 4 Vials 4 Vials 4 Vials 5 kg or less 280 mg at Week 0: # of vials to be used 2 4 Vials 3 Vials 4 Vials 4 Vials 4 Vials 5 kg or less 280 mg at Week 0: # of vials to be used 4 5 kg or less 280 mg at Week 0: # of vials to be used 4 5 kg or less 280 mg at Week 0: # of vials to be used 4 5 kg or less 280 mg at Week 0: # of vials to be used 4 5 kg or less 280 mg at Week 0: # of vials to be used 4 5 kg or less 280 mg at Week 0: # of vials to be used 4 5 kg or less 280 mg at Week 0: # of vials to be used 4 5 kg or less 280 mg at Week 0: # of vials to be used 4 5 kg or less 280 mg at Week 0: # of vials to be used 4 5 kg or less 280 mg at Week 0: # of vials to be used 4 5 kg or less 280 mg at Week 0: # of vials to be used 4 5 kg or less 280 mg at Week 0: # of vials to be used 4 5 kg or less 280 mg at Week 0: # of vials to be used 4 5 kg or less 280 mg at Week 0: # of vials to be used 4 5 kg or less 280 mg at Week 0: # of vials to be used 4 5 kg or less 280 mg at Week 0: # of vials to be used 2 5 kg or less 280 mg at Week 0: # of vials to be used 2 5 kg or less 280 mg at Week 0: # of vials to be used 2 5 kg or less 280 mg at Week 0: # of vials to be used 2 5 kg or less 280 mg at Week 0: # of vials to be used 2 5 kg or less 280 mg at Week 0: # of vials to be used 2 5 kg or less 280 mg at Week 0: # of vials to be used 2 5 kg or less 280 mg at Week 0: # of vials to be used 2 5 kg or less 280 mg at Week 0: # of vials to be used 2 5 kg or less 280 mg at Week 0: # of vials to be used 2 5 kg or less 280 mg at Week 0: # of vials to be used 2 5 kg or less 280 mg at Week 0: # of vials to be used 2 5 kg or less 280 mg at Week 0: # of vials to be used 2 5 kg or less 280 mg at Week 0: # of vials to be used 2 5 kg or less 280 mg at Week 0: # of vials to be used 2 5 kg o	
Prescriber Name: Prescriber Phone: Patient Clinical Information: NKDA Weight: cm in Incapital Information: cm in in Information: cm in in Information: cm in in in in Information: cm in in in in in in in i	
NKDA Weight:	
Allergies:	_
Is the patient on samples?	
Prior therapy, treatment dates, and reason(s) for discontinuation: PRESCRIPTION INFORMATION	
Steqeyma	
Steqeyma 130 mg/26 mL (5 mg/mL) V single-dose vial Date Infusion was completed or scheduled: (This date is needed to determine shipment of Stelara SC maintenance dosage) Single V Induction Dose: Steqeyma Stepeyma Stepe	
Steqeyma	TITY/REFILL
Steqeyma SC dose in a single-dose prefilled syringe Inject 90 mg SC 8 weeks after the initial IV induction dose, then every 8 weeks thereafter. Inject 90 mg SC every 8 weeks Refills: Re	
Dot mg/r20 mL Intravenous UC or CD Induction Dose: Quantity: 1 Vial R Quantity: 1 Pack Quantity: 2 Pack Quantit	
Quantity: 1 Vial R Quantit	
Induction Pack for Crohn's Disease (2 x 200 mg/2 mL Pens) Week 0: Inject 400 mg SC at Week 0 Quantity: 1 Pack Quantity: 1 Pack Quantity: 1 Pack Week 8: Inject 400 mg SC at Week 4 Quantity: 1 Pack Quantity: 1 Pack Quantity: 1 Pack Week 8: Inject 400 mg SC at Week 8 Quantity: 1 Pack Quantity: 1 Pack Quantity: 1 Pack Week 8: Inject 400 mg SC at Week 8 Quantity: 1 Pack Quantity: 1 Pack Quantity: 1 Pack Week 8: Inject 400 mg SC at Week 8 Quantity: 1 Pack Quant	Refills: 0
	Refills: 0
Press patient-controlled injector	
☐ Tysabri NA Please complete a MS TOUCH/Tysabri enrollment form and indicate CVS/specialty as your preferred pharmacy provider. (For questions, please contact TOUCH Prescribing Program at 1-800-456-2255) 130 mg/26 mL (5 mg/mL) IV singledose vial Date Infusion was completed or Scheduled: (This date is more than 55 kg to 85 kg 390 mg at Week 0: # of vials to be used 2 more than 55 kg to 85 kg 390 mg at Week 0: # of vials to Date Infusion Was completed or Scheduled: (This date is more than 55 kg to 85 kg 390 mg at Week 0: # of vials to Date Infusion Was completed or Scheduled: (This date is more than 55 kg to 85 kg 390 mg at Week 0: # of vials to Date Infusion Was completed or Date Infusion Was complete	OS Refills:
Tysabri NA indicate CVS/specialty as your preferred pharmacy provider. (For questions, please contact TOUCH Prescribing Program at 1-800-456-2255) 130 mg/26 mL (5 mg/mL) IV singledose vial Date Infusion was completed or scheduled: (This date is more than 55 kg to 85 kg 390 mg at Week 0: # of vials to labeled to more than 55 kg to 85 kg 390 mg at Week 0: # of vials to labeled to	OS Refills:
dose vial Date Infusion was completed or Ustekinumab Chis date is Date Infusion was completed or Scheduled: (This date is	
needed to determine shipment of Stelara SC maintenance dosage) be used 3 more than 85 kg 520 mg at Week 0: # of vials to be used 4	
90 mg/mL Ustekinumab 90 mg/mL SC dose in a single-dose prefilled syringe Inject 90 mg SC 8 weeks after the initial IV induction dose, then every 8 weeks thereafter. Inject 90 mg SC every 8 weeks	
☐ Other ☐ Strength: ☐ Dose: Quantity:	Refills:
6 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: D)ate:

			Prescriber Information	
			Patient Phone:	
_			annui hay Dhana.	
rescriber Name:		Pr	rescriber Phone:	
atient Clinical I .llergies:		IKDA W	/eight: 🗌 kg 🗌 lb Height: 🔲 c	m∏ in
		on of therapy. D	eight kg _ to height co	··· 🗀 ···
			ient received?	
			s status:	
rior therapy, tre	atment dates, and reason(s) for discontinua	ation:		
PRESCRIPT	ION INFORMATION			
MEDICATION	STRENGTH		DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Velsipity	2 mg	☐ Take 1 table	t by mouth once daily	Quantity: 30 days 90 days Refills:
☐ Xeljanz	☐ 5 mg ☐ 10 mg	mg twice daily, lowest effective Discontinue Xel	daily for at least 8 weeks; followed by 5 or 10 depending on therapeutic response. Use the e dose to maintain response. Ijanz after 16 weeks of treatment with 10 mg lequate therapeutic benefit is not achieved.	Quantity: Refills:
☐ Yesintek	130 mg/26 mL (5 mg/mL) IV single-dose vial Date Infusion was completed or scheduled: (This date is needed to determine shipment of Stelara SC maintenance dosage)	Single IV Induct 55 kg or less more than 5 be used 3		Quantity: 2 Vials 3 Vials 4 Vials Refills: 0
Yesintek	90 mg/mL SC dose in a single-dose prefilled syringe	then every 8 we	g SC 8 weeks after the initial IV induction dose, eeks thereafter. g SC every 8 weeks	Quantity: Refills:
☐ Yuflyma	☐ 40 mg/0.4 mL PEN ☐ 40 mg/0.4 mL PFS ☐ 40 mg/0.4 mL PFS (with safety guard) ☐ 80 mg/0.8 mL PEN	☐ Inject 40 mg	g SC every other week g SC on Day 1 (given in one day or split over e days), 80 mg on Day 15, then 40 mg every	Quantity: 28 days 84 days Refills:
☐ Zeposia	28-day Starter Kit: (Four 0.23 mg capsules, three 0.46 mg capsules, and one bottle containing twenty-one 0.92 mg capsules)	0.46 mg capsul	ng capsule orally once daily on days 1-4, then le once daily on days 5-7, then 0.92 mg aily starting on day 8 and thereafter.	Quantity: 1 Kit (28-day supply) Refill: 0
Zeposia	7-Day Starter Pack (4 capsules of 0.23 mg and 3 capsules of 0.46 mg)	Take 0.23 mg capsule orally once daily on days 1-4, followed by 0.46 mg capsule once daily on days 5-7.		Quantity: 7-day supply Refill: 0
Zeposia	0.92 mg capsules	☐ Take 0.92 mg capsule orally once daily.		Quantity: Refills:
Zymfentra	☐ 120 mg/ mL PEN☐ 120 mg/ mL PFS (with needle guard)		ose only starting at week 10: once every two weeks	Quantity: 28 days 84 days Refills:
Other	Strength:	Dose:		Quantity:
PRESCRIBI	ER SIGNATURE REQUIRED (STA	MP SIGNAT	URE NOT ALLOWED)	1
"Dispense As Writte DAW / May Not Sub	en" / Brand Medically Necessary / Do Not Substitute / Nostitute		May Substitute / Product Selection Permitted / Substitution Permissible Prescriber's Signature:	Date:

Inflammatory Bowel Disease Enrollment Form Nursing Orders

	Pleas	se Complete Patient and F	Prescriber Information	
			Patient Phone:	
Patient Address:				
Prescriber Name:		Pre	escriber Phone:	
Patient Clinical Informatio				
Allergies: Now	to thorony	NKDA W	eight:	_
s the nationt on samples?	to therapy ☐ No ☐ Vectify	Continuation of therapy; Da	ient received?	
TB Test Date//	Positive N	egative Hepatitis	s status:	
) for discontinuation:		
PRESCRIPTION INFO			ONLY BE SENT FOR INFUSIONS DONE	AT HOME/CORAM AIS**
MEDICATION/SUPPLIES	ROUTE		NGTH/ DIRECTIONS	QUANTITY/REFILLS
		Catheter Care/Flush - Only or	n drug admin days – SASH or PRN to	-
		maintain IV access and paten	cy	
Catheter:		PIV: NS 5 mL (Heparin 10 units	s/mL 3-5 mL if multiple days)	Quantity:
☐ PIV ☐ PORT	IV		eparin 10 units/mL or 🗌 100 units/mL	Refills:
CVC/PICC		3-5 mL.	DODT // /	
		PORT: 10 mL sterile saline to a		
		NS 10 mL & Heparin 10	o units/file 3-5ffle.	Hydration max infusion
		Pre: 500 mL 1000 mL	Other:	rate mL/hr
Hydration:	IV	Concurrent: 500 mL 100		(Adult max rate
☐ NS ☐ D5W		Post: 500 mL 1000 mL		250 mL/hr unless
				otherwise indicated)
		1:1000, 0.3mg/0.3 mL (gre	eater than 30 kg/66 lbs)	
☐ <i>Epinephrine</i>	□ ім	1:1000, 0.15mg/0.3 mL (15	-30 kg/33-66 lbs)	Quantity:
nursing requires	□ sc	1:1000, 0.1 mg/kg, Max 0.3		Refills:
riar sirig requires			ay repeat in 3-5 minutes as needed	Nonus.
		for severe allergic reaction, als	so call 911	
Diphenhydramine		Premedication:		
Oral	PO	12.5 mg/kg (0-30 kg)		Quantity:
		☐ 25 mg ☐ 50 mg (Over 30 kg)		Refills:
		☐ 1 mg/kg (under 15 kg)		
Diphenhydramine		12.5 mg-50 mg (15-30 kg)		
50 mg/mL vial	☐ Slow IV	25 mg-50 mg (Over 30 kg)		Quantity:
nursing required	☐ IM		y repeat in 3-5 minutes as needed	Refills:
a. ag . a qa a a		(Adult max dose: 100 mg/day	•	
		If severe allergic reaction: call		
	Peripheral	□ 40 msl NO m and floorly		C
Flush Orders:	Access	☐ 10 mL NS post flush☐ 50 mL NS post flush		Send quantity sufficient
riusii Orders.	☐ Central	(recommended if no post-hyd	dration)	for medication days
	Venous	Other:		supply
	Access			σαρριγ
Additional				
Medication:				
7 Destinant in interpretability of the	aut pue sur	CTAMP CICHATURE MCT *** CWCT	A101 P	munidad on mandad for the state of
Patient is interested in patient supplement SIGN	. •	STAMP SIGNATURE NOT ALLOWED JIRED (STAMP SIGNATURE)		provided as needed for administration
"Dispense As Written" / Brand M	edically Necessary / D	o Not Substitute / No Substitution /	May Substitute / Product Selection Permitted /	
DAW / May Not Substitute			Substitution Permissible	
Prescriber's Signature:		Date:	Prescriber's Signature:	Date:

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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