



# Asthma Enrollment Form

Fax Referral To: 1-855-297-1270

Phone: 1-888-280-1190

Address: 6020 Ave Roberto Sanchez Vilella Carolina, PR 00982

NCPDP: 4026325

## Six Simple Steps to Submitting a Referral

### 1 PATIENT INFORMATION (Complete or include demographic sheet)

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender:  Male  Female  
 Address: \_\_\_\_\_ City, State, ZIP Code: \_\_\_\_\_  
 Preferred Contact Methods:  Phone (to primary # provided below)  Text (to cell # provided below)  Email (to email provided below)  
*Note: Carrier charges may apply. By providing the phone number(s) and email address above, you are consenting to receive automated calls, emails and/or text messages from CVS Specialty® about your prescription(s), account, and health care. Standard data rates apply. Message frequency varies. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.*  
 Primary Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_  
 Email: \_\_\_\_\_ Last Four of SSN: \_\_\_\_\_ Primary Language: \_\_\_\_\_  
 Parent/Caregiver/Legal Guardian Name (Last, First): \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

### 2 PRESCRIBER INFORMATION

Prescriber's Name: \_\_\_\_\_ State License #: \_\_\_\_\_  
 NPI #: \_\_\_\_\_ DEA #: \_\_\_\_\_ Group or Hospital: \_\_\_\_\_  
 Address: \_\_\_\_\_ City, State, ZIP Code: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Contact Person: \_\_\_\_\_ Contact's Phone: \_\_\_\_\_

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

Is the Patient Insured?  Yes  No Is the 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

Needs by Date: \_\_\_\_\_ Ship to:  Patient  Office  Other: \_\_\_\_\_

#### Diagnosis (ICD-10):

- J45.4 Moderate Persistent Asthma  J45.5 Severe Persistent Asthma
- D72.119 Hypereosinophilic syndrome (HES)  M30.1 Eosinophilic Granulomatosis with Polyangiitis (EGPA)
- J33.0 Polyp of the nasal cavity  J33.1 Polypoid sinus degeneration  J33.8 Other polyp of sinus
- J33.9 Nasal Polyp, unspecified (indication for dupilumab and omalizumab)  J82.83 Eosinophilic asthma
- K20.0 Eosinophilic esophagitis (EoE)
- Other Code: \_\_\_\_\_ Description \_\_\_\_\_

#### Patient Clinical Information:

Allergies: \_\_\_\_\_ Weight: \_\_\_\_\_ lb/kg Height: \_\_\_\_\_ in/cm IgE Level: \_\_\_\_\_  
 Eosinophil count: \_\_\_\_\_ Cells/μL Date of test: \_\_\_/\_\_\_/\_\_\_ Number of exacerbations in the last 12 months: \_\_\_\_\_

### 5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Cinqair (reslizumab)	100 mg/10 mL vial	Inject 3 mg/kg once every 4 weeks by IV infusion over 20 to 50 minutes <input type="checkbox"/> Include sodium chloride and supplies sufficient for medication days supply • IV administration/infusion set (0.2micron filter) • IV Cath Insyte auto guard or PIV insertion kit • Ultrasyte needle-free connector (one per vial shipped) • 30 mL syringe (one per vial shipped) • 50 mL 0.9% NaCl • 2 – 10 mL 0.9% NaCl flush • Alcohol swabs	Quantity: _____ vials <input type="checkbox"/> 28-day supply <input type="checkbox"/> 84-day supply <input type="checkbox"/> _____-day supply Refills: <input type="checkbox"/> 1 year <input type="checkbox"/> Other: _____

Patient is interested in patient support programs **STAMP SIGNATURE NOT ALLOWED** Ancillary supplies and kits provided as needed for administration

### 6 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute <b>Prescriber's Signature:</b> _____ <b>Date:</b> _____	May Substitute / Product Selection Permitted / Substitution Permissible <b>Prescriber's Signature:</b> _____ <b>Date:</b> _____
<b>CA, MA, NC &amp; PR:</b> Interchange is mandated unless Prescriber writes the words "No Substitution" _____ <b>ATTN: New York and Iowa providers,</b> please submit electronic prescription	

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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Patient Name: \_\_\_\_\_ Patient DOB: \_\_\_\_\_ Patient Phone: \_\_\_\_\_

Patient Address: \_\_\_\_\_

Prescriber Name: \_\_\_\_\_ Prescriber Phone: \_\_\_\_\_

## 5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Dupixent (dupilumab)	<p><b>PFS</b></p> <input type="checkbox"/> 100 mg/0.67 mL pre-filled syringe <input type="checkbox"/> 200 mg/1.14 mL pre-filled syringe <input type="checkbox"/> 300 mg/2 mL pre-filled syringe	<p><b>Asthma: Pediatric 15 to &lt;30 kg:</b></p> <input type="checkbox"/> Inject 100 mg SC (one injection) every other week <input type="checkbox"/> Inject 300 mg SC (one injection) every four weeks	<p>Quantity: _____ Refills: _____</p>
<input type="checkbox"/> Fasenna (benralizumab)	<p><b>PEN*</b></p> <input type="checkbox"/> 200 mg/1.14 mL pre-filled pen <input type="checkbox"/> 300 mg/2 mL pre-filled pen *Comes in cartons of 2	<p><b>Asthma: Pediatric ≥30 kg:</b></p> <input type="checkbox"/> Inject 200 mg SC (one injection) every other week	<p>Quantity: _____ Refills: _____</p>
		<p><b>Asthma: Adult Initial Dose:</b></p> <input type="checkbox"/> Inject 400 mg SC (2-200 mg injections in different injection sites) initially then 200 mg SC every other week <input type="checkbox"/> Inject 600 mg SC (2-300 mg injections in different injection sites) initially then 300 mg SC every other week	
		<p><b>Asthma: Adult Maintenance Dose:</b></p> <input type="checkbox"/> Inject 200 mg (one injection) SC every other week <input type="checkbox"/> Inject 300 mg (one injection) SC every other week	
		<p><b>Chronic Sinusitis with Nasal Polyposis in Patients ≥ 12 y/o</b></p> <input type="checkbox"/> Inject 300 mg (one injection) SC every other week	
		<p><b>Eosinophilic Esophagitis (EoE)</b></p> <input type="checkbox"/> Inject 300 mg SC every week	
		<p><b>Severe Asthma</b></p> <input type="checkbox"/> Administer 10 mg/0.5 ml by subcutaneous injection every 4 weeks for the first 3 doses, followed by injection once every 8 weeks thereafter <input type="checkbox"/> Administer 30 mg/mL by subcutaneous injection every 4 weeks for the first 3 doses, followed by injection once every 8 weeks thereafter <input type="checkbox"/> Other: Administer _____	<p>Quantity: _____  <input type="checkbox"/> 1 PFS/Pen  <input type="checkbox"/> 3 PFS/Pen                      Refills: _____  <input type="checkbox"/> 1 year  <input type="checkbox"/> Other: _____</p>
		<p><b>Eosinophilic Granulomatosis with Polyangiitis (EGPA)</b></p> <input type="checkbox"/> Inject 30 mg SC every 4 weeks	
		<p>Note: Pre-filled syringe is administered by healthcare provider. Autoinjector can be caregiver or self-administered if patient is 12 years of age and weighs more than 35kg.</p>	

Patient is interested in patient support programs

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Patient Address: \_\_\_\_\_

Prescriber Name: \_\_\_\_\_ Prescriber Phone: \_\_\_\_\_

### 5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Nucala (mepolizumab)	<p><b>Vial</b></p> <input type="checkbox"/> 100 mg vial	<p><b>Severe Asthma</b></p> <input type="checkbox"/> <b>Adults &amp; Adolescents 12 years and older:</b> Inject 100 mg subcutaneously once every 4 weeks into the upper arm, thigh, or abdomen	<p>Quantity:</p> <input type="checkbox"/> 28-day supply <input type="checkbox"/> 84-day supply <input type="checkbox"/> ___-day supply
	<p><b>PEN</b></p> <input type="checkbox"/> Auto-injector 100 mg/mL auto-injector	<input type="checkbox"/> <b>Pediatric (6-11 years old):</b> Inject 40 mg subcutaneously once every 4 weeks into the upper arm, thigh, or abdomen	<p>Refills:</p> <input type="checkbox"/> 1 year <input type="checkbox"/> Other: _____
	<p><b>PFS</b></p> <input type="checkbox"/> 100 mg/mL pre-filled syringe <input type="checkbox"/> 40 mg/0.4 mL pre-filled syringe	<p><b>Chronic Rhinosinusitis with Nasal Polyps:</b></p> <input type="checkbox"/> Inject 100 mg subcutaneously once every 4 weeks into the upper arm, thigh, or abdomen	
		<p><b>Eosinophilic Granulomatosis with Polyangiitis (EGPA)</b></p> <input type="checkbox"/> Inject 300 mg as 3 separate 100 mg subcutaneous injections once every 4 weeks into the upper arm, thigh, or abdomen	
		<p><b>Hypereosinophilic Syndrome (HES)</b></p> <input type="checkbox"/> Inject 300 mg as 3 separate 100 mg subcutaneous injections once every 4 weeks into the upper arm, thigh, or abdomen	
		<input type="checkbox"/> Include sterile water and supplies sufficient for medication days supply	
		<input type="checkbox"/> No supplies requested (supplies will be sent with shipment unless indicated)	
		<ul style="list-style-type: none"> <li>One 10 mL vial sterile water for injection for every vial of Nucala dispensed</li> <li>Alcohol swabs</li> <li>3 mL Luer Lock injection syringe</li> <li>NDL 21G needle for reconstitution</li> </ul>	
		<p>1 mL polypropylene syringe with 21G to 27G x 1/2" needle for subcutaneous injection</p>	
<input type="checkbox"/> Tezspire (Tezepelumab)	<p><b>PFS</b></p> <input type="checkbox"/> 210 mg/1.91 mL (110 mg/mL) pre-filled syringe	<p>Inject 210mg subcutaneously every 4 weeks</p>	<p>Quantity: 1 Refills: 1 Year</p>
	<p><b>PEN</b></p> <input type="checkbox"/> 210 mg/1.91 mL (110 mg/mL) pre-filled pen		

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**CONFIDENTIALITY NOTICE:** This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by telephone and destroy all copies of this communication and any attachments.

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Patient Address: \_\_\_\_\_

Prescriber Name: \_\_\_\_\_ Prescriber Phone: \_\_\_\_\_

### 5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Xolair (omalizumab)	<b>Vial</b> <input type="checkbox"/> 150 mg vial kit  <b>PFS</b> <input type="checkbox"/> 75 mg/0.5 mL pre-filled syringe <input type="checkbox"/> 150 mg/1 mL pre-filled syringe <input type="checkbox"/> 300 mg/2 mL pre-filled syringe  <b>Auto-injector</b> <input type="checkbox"/> 75 mg/0.5 mL <input type="checkbox"/> 150 mg/mL <input type="checkbox"/> 300 mg/2 mL	<b>Every 4 weeks dosing:</b> <input type="checkbox"/> Administer 75 mg per dose subcutaneously every 4 weeks <input type="checkbox"/> Administer 150 mg per dose subcutaneously every 4 weeks <input type="checkbox"/> Administer 225 mg per dose subcutaneously every 4 weeks <input type="checkbox"/> Administer 300 mg per dose subcutaneously every 4 weeks <input type="checkbox"/> Other: Administer _____ mg per dose subcutaneously every 4 weeks  <b>Every 2 weeks dosing:</b> <input type="checkbox"/> Administer 225 mg per dose subcutaneously every 2 weeks <input type="checkbox"/> Administer 300 mg per dose subcutaneously every 2 weeks <input type="checkbox"/> Administer 375 mg per dose subcutaneously every 2 weeks <input type="checkbox"/> Other: Administer _____ mg per dose subcutaneously every 2 weeks  <b>For Xolair Vials only:</b> <input type="checkbox"/> Include sterile water and supplies sufficient for medication days supply <input type="checkbox"/> No supplies requested (supplies will be sent with shipment unless indicated)	Quantity: <input type="checkbox"/> 28-day supply <input type="checkbox"/> 84-day supply <input type="checkbox"/> ____-day supply Refills: <input type="checkbox"/> 1 year <input type="checkbox"/> Other: _____

I certify that the rationale for Xolair therapy for Allergic Asthma is necessary for this patient and I will be supervising the patient's treatment accordingly.

## Nursing Medications

### 5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Other: _____	Other: _____	Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> EpiPen	Other: _____	Use as directed.	Quantity: 1 Refills: _____
<input type="checkbox"/> EpiPen Jr.	Other: _____	Use as directed.	Quantity: 1 Refills: _____

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