

Fax Referral To: 1-877-232-5455 Address: 500 Ala Moana Blvd., Bldg 1 Honolulu, HI 96813

Phone: 1-808-254-2727
Bldg 1 Honolulu, HI 96813

NCPDP: 1203417

PATIENT INFORMATIO	N (Complete or include de	•			
Patient Name:					_ Gender: 🗌 Male 🔲 Female
Address:			City, State, ZIP Co		
Preferred Contact Methods:	Phone (to primary # prov	ided below)	Text (to cell # pro	vided below	/) Email (to email provided
below)					
Note: Carrier charges may apply	y. By providing the phone i	number(s) an	nd email address abo	ve, you are c	consenting to receive
automated calls, emails and/or	text messages from CVS S	Specialty® ab	out your prescription	(s), account,	, and health care. Standard data
rates apply. Message frequency	varies. If unable to contac	ct via text or e	email, Specialty Phar	macy will att	tempt to contact by phone.
Primary Phone:					
					nguage:
Parent/Caregiver/Legal Guardi	an Name (Last, First):		Relationship to	patient:	
2 PRESCRIBER INFORM	MATION				
Prescriber's Name:			State License #:		
NPI #: DEA #:					
Address:					
Phone:	Fax C	ontact Perso	n:	Contact's F	Phone:
3 INSURANCE INFORMA					
Is the Patient Insured? Yes					
Policy Holder's Name:		Policy Ho	ider's DOB:	Relatio	Onship to Patient:
Medical Insurance:					
Prescription Insurance: Policy ID:	Group #:		Prescription Pta	in retepriorie	*
☐ Check box if patient is enrolle					
<u> </u>	• •		ii yes, piease provide		
4 DIAGNOSIS AND CLINI					
Needs by Date:	Ship to: Patient	Office U Ot	her:		
Diagnosis (ICD-10):	Date of Diagnosis//				
K50.00 Crohn's Disease of S	small Intestine Without Co	mplications			
☐ K51.90 Ulcerative colitis, uns	pecified, without complic	ations			
L40.50 Arthropathic Psorias	is, Unspecified				
L40.54 Juvenile Psoriatic Ar	thritis (JPsA)				
M06.9 Rheumatoid Arthritis,	Unspecified				
M08.00 Juvenile Idiopathic	Arthritis (JIA)				
M08.90 Polyarticular Juveni	le Idiopathic Arthritis (PJI/	A)			
☐ M08.20 Systemic Juvenile Id					
M31.6 Giant Cell Arteritis (GC	CA)				
M32.1 Systemic lupus erythe	matosus (SLE)				
M32.14 Glomerular disease i					
M45.9 Ankylosing Spondylit					
M45.A0 Non-Radiographic A		• •			
Other Code:	Description:	·			_
Patient Clinical Information	<u>1:</u>				
Allergies:	N	KDA '	Weight: 🗌 kg	☐ lb Height	: 🗌 cm 🗌 in
Treatment status: New to the			Date of last treatmen		
TB Test Date//_ De			itis status:		
Prior therapy, treatment dates, ar		ıtion:			
Nursing and Administration					
First dose administration of mor	noclonal antibodies (mABs	s) should be	administered in a co	ntrolled setti	ng (may vary depending upon
medication specific policy).		_			
For Remicade/Remicade Biosi					
Specialty pharmacy to coordina			- <u>-</u>		. 🗆
Site of Care: Home Infusion	=				
*Home Infusion/Coram AIS: Dil		-	-	stration/ther	apy teach train.
**Prescriber's Office/Other Infu	sion Clinic: Drug only for '	tacılıtv admir	nistration		

		Please Complete Patient and I	Prescriber Information	
Patient Name: _			Patient Phone:	
Patient Address	•			
		Pr	rescriber Phone:	
Patient Clinical				
Allergies:			/eight: 🗌 kg 🗌 lb Height: 🗎 c	m ∐ in
		Continuation of therapy; D		
			is status:	
Prior therapy, tre	atment dates, and re	ason(s) for discontinuation.		
PRESCRIPTI	ON INFORMATIO	ON		
MEDICATION	STRENGTH		& DIRECTIONS	QUANTITY/REFILLS
	☐ 80 mg/4 mL			
☐ Actemra	200 mg/10 mL	Induction Dose: Infuse 4 mg/kg eve		Quantity:
	☐ 400 mg/20 mL	Maintenance Dose: Infuse 8 mg/kg	every 4 weeks	Refills:
		Ankylosing Spondylitis Induction Do	ose: Infuse IV at 5 mg/kg	
İ		(Dose =mg) at weeks 0, 2, 6 and e	•	
İ		Ankylosing Spondylitis Maintenance	<u>e Dose</u> : Infuse IV at 5 mg/kg	
		(Dose =mg) every 6 weeks	:-> C	
		Crohn's Disease (Adult and Pediatri 5 mg/kg (Dose =mg) at weeks		
		Crohn's Disease (Adult) Maintenand		
		(Dose =mg) every 8 weeks		
		☐ Crohn's Disease (Pediatric ≥ 6 years	Quantity:	
		Infuse IV at 5 mg/kg (Dose =n		
☐ Avsola	100 mg vial	Plaque Psoriasis & Psoriatic Arthritis		
		(Dose =mg) at weeks 0, 2, 6 at	# of 100 mg vial(s)	
		Plaque Psoriasis & Psoriatic Arthritis Infuse IV at 5 mg/kg (Dose =n	Refills:	
		Rheumatoid Arthritis Induction Dos		
		(Dose =mg) at weeks 0, 2, 6 and		
		Rheumatoid Arthritis Maintenance I		
		(Dose =mg) every 4, 6 or 8 we		
			ric ≥ 6 years old) Induction Dose: Infuse IV at	
		5 mg/kg (Dose =mg) at weeks	s 0, 2, 6 and every 8 weeks thereafter ric ≥ 6 years old) Maintenance Dose: Infuse IV	
		at 5 mg/kg (Dose =mg) every	· · · · · · · · · · · · · · · · · · ·	
	☐ 120 mg 5 mL			
Benlysta	vial		=mg) at 2-week intervals for the first 3	Quantity: vials
bentysta	400 mg 20 mL	doses and at 4-week intervals thereafte	er. Infuse IV over 1 hour.	Refills:
	vial	□ ladustica Dans 200 maintural IV	and Constant	0
☐ Entyvio	300 mg in a	every 8 weeks thereafter	over 30 minutes at 0, 2 and 6 weeks, then	Quantity: Refills:
☐ Entyvio	single dose vial in individual carton	Maintenance Dose: 300 mg infused	1 IV over 30 minutes every 8 weeks	Renus.
	Strength:		arv ever do minutes every e weeks	Quantity:
Other		☐ Dose:		Refills:
6 PRESCRIB	ER SIGNATURE	REQUIRED (STAMP SIGNAT	URE NOT ALLOWED)	
"Dispense As Writte	en" / Brand Medically Nece	essary / Do Not Substitute / No Substitution /	May Substitute / Product Selection Permitted /	
DAW / May Not Sub		Data:	Substitution Permissible	Date
Prescriber's S	ignature:	Date:	Prescriber's Signature:	Date:
CA, MA, NC & PR: I	nterchange is mandated unle	ess Prescriber writes the words "No Substitution"	ATTN: New York and Iowa providers, pleas	e 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.

Patient Address: Prescriber Name: Patient Clinical Information Allergies: Treatment status: Name	rmation: New to therapy Positive on t dates, and reserved.	Patient DOB:	cm
Prescriber Name:Patient Clinical Information Clinical Information Clinical Information Clinical Information Clinical Information Clinical Information Clinical Information Clinical Information Clinical Information Clinical Information Clinical Information Clinical Information Clinical Information Clinical Clinica	rmation: New to therapy Positive nt dates, and ref	Prescriber Phone: NKDA Weight: kg lb Height: Plaque Psoriasis & Psoriatic Arthritis Induction Dose: Infuse IV at 5 mg/kg (Dose = mg) every 8 weeks thereafter Plaque Psoriasis & Psoriatic Arthritis Induction Dose: Infuse IV at 5 mg/kg (Dose = mg) every 8 weeks Plaque Psoriasis & Psoriatic Arthritis Induction Dose: Infuse IV at 5 mg/kg (Dose = mg) every 8 weeks Crohn's Disease (Adult and Pediatric ≥ 6 years old) Induction Dose: Infuse IV at 5 mg/kg (Dose = mg) every 8 weeks Crohn's Disease (Adult) Maintenance Dose: Infuse IV at 5-10 mg/kg (Dose = mg) every 8 weeks Crohn's Disease (Pediatric ≥ 6 years old) Maintenance Dose: Infuse IV at 5 mg/kg (Dose = mg) every 8 weeks Plaque Psoriasis & Psoriatic Arthritis Induction Dose: Infuse IV at 5 mg/kg (Dose = mg) every 8 weeks thereafter Plaque Psoriasis & Psoriatic Arthritis Maintenance Dose: Infuse IV at 5 mg/kg (Dose = mg) every 8 weeks Rheumatoid Arthritis Induction Dose: Infuse IV at 3 mg/kg (Dose = mg) at weeks 0, 2, 6 and every 8 weeks thereafter Rheumatoid Arthritis Maintenance Dose: Infuse IV at 3 mg/kg (Dose = mg) at weeks 0, 2, 6 and every 8 weeks thereafter Rheumatoid Arthritis Maintenance Dose: Infuse IV at 3 mg/kg (Dose = mg) at weeks 0, 2, 6 and every 8 weeks thereafter Rheumatoid Arthritis Maintenance Dose: Infuse IV at 3-10 mg/kg (Dose = mg) every 4, 6 or 8 weeks (circle one)	cm in QUANTITY/REFILLS Quantity: # of 100 mg vial(s)
Patient Clinical Informal Patient Clinical Informal Patient Status: Status: Status Prior therapy, treatment PRESCRIPTION INFORMEDICATION STATUS PRESCRIPTION STATUS PR	rmation: New to therapy Positive Int dates, and res FORMATION STRENGTH	NKDA Weight: kg lb Height: Continuation of therapy; Date of last treatment / _ / _	cm in QUANTITY/REFILLS Quantity: # of 100 mg vial(s)
Allergies: Treatment status:	New to therapy Positive nt dates, and re- FORMATION STRENGTH	Continuation of therapy; Date of last treatment// Be Negative	QUANTITY/REFILLS Quantity: # of 100 mg vial(s)
MEDICATION S Inflectra Infliximab Omvoh S S S S S S S S S S S S S	STRENGTH	Ankylosing Spondylitis Induction Dose: Infuse IV at 5 mg/kg (Dose =mg) at weeks 0, 2, 6 and every 6 weeks thereafter Ankylosing Spondylitis Maintenance Dose: Infuse IV at 5 mg/kg (Dose =mg) every 6 weeks Crohn's Disease (Adult and Pediatric ≥ 6 years old) Induction Dose: Infuse IV at 5 mg/kg (Dose =mg) at weeks 0, 2, 6 and every 8 weeks thereafter Crohn's Disease (Adult) Maintenance Dose: Infuse IV at 5-10 mg/kg (Dose =mg) every 8 weeks Crohn's Disease (Pediatric ≥ 6 years old) Maintenance Dose: Infuse IV at 5 mg/kg (Dose =mg) every 8 weeks Plaque Psoriasis & Psoriatic Arthritis Induction Dose: Infuse IV at 5 mg/kg (Dose =mg) at weeks 0, 2, 6 and every 8 weeks thereafter Plaque Psoriasis & Psoriatic Arthritis Maintenance Dose: Infuse IV at 5 mg/kg (Dose =mg) every 8 weeks Rheumatoid Arthritis Induction Dose: Infuse IV at 3 mg/kg (Dose =mg) at weeks 0, 2, 6 and every 8 weeks thereafter Rheumatoid Arthritis Maintenance Dose: Infuse IV at 3-10 mg/kg (Dose =mg) every 4, 6 or 8 weeks (circle one)	Quantity: # of 100 mg vial(s)
☐ Inflectra ☐ 10☐ Infliximab ☐ Omvoh ☐ 3 single		Ankylosing Spondylitis Induction Dose: Infuse IV at 5 mg/kg (Dose =mg) at weeks 0, 2, 6 and every 6 weeks thereafter Ankylosing Spondylitis Maintenance Dose: Infuse IV at 5 mg/kg (Dose =mg) every 6 weeks Crohn's Disease (Adult and Pediatric ≥ 6 years old) Induction Dose: Infuse IV at 5 mg/kg (Dose =mg) at weeks 0, 2, 6 and every 8 weeks thereafter Crohn's Disease (Adult) Maintenance Dose: Infuse IV at 5-10 mg/kg (Dose =mg) every 8 weeks Crohn's Disease (Pediatric ≥ 6 years old) Maintenance Dose: Infuse IV at 5 mg/kg (Dose =mg) every 8 weeks Plaque Psoriasis & Psoriatic Arthritis Induction Dose: Infuse IV at 5 mg/kg (Dose =mg) at weeks 0, 2, 6 and every 8 weeks thereafter Plaque Psoriasis & Psoriatic Arthritis Maintenance Dose: Infuse IV at 5 mg/kg (Dose =mg) every 8 weeks Rheumatoid Arthritis Induction Dose: Infuse IV at 3 mg/kg (Dose =mg) at weeks 0, 2, 6 and every 8 weeks thereafter Rheumatoid Arthritis Maintenance Dose: Infuse IV at 3-10 mg/kg (Dose =mg) every 4, 6 or 8 weeks (circle one)	Quantity: # of 100 mg vial(s)
☐ Infliximab ☐ 10 ☐ 10 ☐ 10 ☐ 10 ☐ 10 ☐ 10 ☐ 10 ☐ 1	100 mg vial	(Dose =mg) at weeks 0, 2, 6 and every 6 weeks thereafter Ankylosing Spondylitis Maintenance Dose: Infuse IV at 5 mg/kg (Dose =mg) every 6 weeks Crohn's Disease (Adult and Pediatric ≥ 6 years old) Induction Dose: Infuse IV at 5 mg/kg (Dose =mg) at weeks 0, 2, 6 and every 8 weeks thereafter Crohn's Disease (Adult) Maintenance Dose: Infuse IV at 5-10 mg/kg (Dose =mg) every 8 weeks Crohn's Disease (Pediatric ≥ 6 years old) Maintenance Dose: Infuse IV at 5 mg/kg (Dose =mg) every 8 weeks Plaque Psoriasis & Psoriatic Arthritis Induction Dose: Infuse IV at 5 mg/kg (Dose =mg) at weeks 0, 2, 6 and every 8 weeks thereafter Plaque Psoriasis & Psoriatic Arthritis Maintenance Dose: Infuse IV at 5 mg/kg (Dose =mg) every 8 weeks Rheumatoid Arthritis Induction Dose: Infuse IV at 3 mg/kg (Dose =mg) at weeks 0, 2, 6 and every 8 weeks thereafter Rheumatoid Arthritis Maintenance Dose: Infuse IV at 3-10 mg/kg (Dose =mg) every 4, 6 or 8 weeks (circle one)	# of 100 mg vial(s)
single		5 mg/kg (Dose =mg) at weeks 0, 2, 6 and every 8 weeks thereafter Ulcerative Colitis (Adult and Pediatric ≥ 6 years old) Maintenance Dose: Infuse IV at 5 mg/kg (Dose =mg) every 8 weeks	
Orencia 2	300 mg/15 mL le dose vial	Induction Dose Week 0: Infuse 300 mg via IV infusion over at least 30 minutes Week 4: Infuse 300 mg via IV infusion over at least 30 minutes Week 8: Infuse 300 mg via IV infusion over at least 30 minutes	Quantity: Refills: 0 1 Vial 2 Vials 3 Vials
	250 mg vial	Infuse mg at weeks 0, 2 and 4, then every 4 weeks thereafter	Quantity: Refills:
Remicade 10	100 mg vial	Ankylosing Spondylitis Induction Dose: Infuse IV at 5 mg/kg (Dose =mg) at weeks 0, 2, 6 and every 6 weeks thereafter Ankylosing Spondylitis Maintenance Dose: Infuse IV at 5 mg/kg (Dose =mg) every 6 weeks Crohn's Disease (Adult and Pediatric ≥ 6 years old) Induction Dose: Infuse IV at 5 mg/kg (Dose =mg) at weeks 0, 2, 6 and every 8 weeks thereafter Crohn's Disease (Adult) Maintenance Dose: Infuse IV at 5-10 mg/kg (Dose =mg) every 8 weeks Crohn's Disease (Pediatric ≥ 6 years old) Maintenance Dose: Infuse IV at 5 mg/kg (Dose =mg) every 8 weeks Plaque Psoriasis & Psoriatic Arthritis Induction Dose: Infuse IV at 5 mg/kg (Dose =mg) at weeks 0, 2, 6 and every 8 weeks thereafter Plaque Psoriasis & Psoriatic Arthritis Maintenance Dose: Infuse IV at 5 mg/kg (Dose =mg) every 8 weeks Rheumatoid Arthritis Induction Dose: Infuse IV at 3 mg/kg (Dose =mg) at weeks 0, 2, 6 and every 8 weeks thereafter Rheumatoid Arthritis Maintenance Dose: Infuse IV at 3-10 mg/kg (Dose =mg) every 4, 6 or 8 weeks (circle one) Ulcerative Colitis (Adult and Pediatric ≥ 6 years old) Induction Dose: Infuse IV at 5 mg/kg (Dose =mg) at weeks 0, 2, 6 and every 8 weeks thereafter Ulcerative Colitis (Adult and Pediatric ≥ 6 years old) Maintenance Dose: Infuse IV at 5 mg/kg (Dose =mg) at weeks 0, 2, 6 and every 8 weeks thereafter	Quantity: # of 100 mg vial(s) Refills:
☐ Other ☐ St	Strength:	Dose:	Quantity: Refills:
PRESCRIBER SIGNA	ATURE REQUI	RED (STAMP SIGNATURE NOT ALLOWED)	
		ssary / Do Not Substitute / No Substitution / May Substitute / Product Selection Permitted / Substitution Permissible	Date:

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	Pleas	se Complete Patient and F	Prescriber Information	
Patient Name: _			Patient Phone:	
Patient Address:				
Prescriber Name	e:	Pr	rescriber Phone:	
<u>Patient Clinical</u>	<u>Information:</u>	<u></u>	<u> </u>	
Allergies:		NKDA W	'eight: 🗌 kg 🗌 lb Height:	cm in
Treatment status	: ☐ New to therapy	Continuation of therapy; D	ate of last treatment//	
			s status:	
	atment dates, and reason(s)	for discontinuation:		
MEDICATION	STRENGTH	DOSE	& DIRECTIONS	QUANTITY/REFILLS
Riabni		D33E (a birections	QUANTITYKETIEES
Rituxan Ruxience	☐ 100 mg/10 mL vial ☐ 500 mg/50 mL vial	☐ Infuse two doses of 1000) mg separated by 2 weeks	Quantity: Refills:
Saphnelo	☐ 300 mg/2 mL (150 mg/mL)	300 mg IV over a 30-min	nute period, every 4 weeks	Quantity: vials Refills:
		☐ Week 4: Infuse 2 mg/kg	IV (Dose=mg) over 30 minutes IV (Dose=mg) over 30 minutes	Quantity: vials Refills: 0 Quantity: vials Refills: 0
Simponi	Simponi dosovial weeks	Infuse 2 mg/kg IV (Dose: weeks	=mg) over 30 minutes every 8	Quantity: vials Refills:
ARIA		n ² IV (Dose=mg) over 30	Quantity: vials Refills: 0 Quantity: vials Refills: 0	
		8 weeks	old) Maintenance Dose ee=mg) over 30 minutes every	Quantity: vials Refills:
Skyrizi	600 mg/10 mL (60 mg/mL) single dose vial		V over at least one hour V over at least one hour	Quantity: 1 vial Refills: 0 Quantity: 1 vial Refills: 0 Quantity: 1 vial Refills: 0 Quantity: 2 vials Refills: 0 Quantity: 2 vials Refills: 0 Quantity: 2 vials Refills: 0
☐ Stelara	130 mg/26 mL (5 mg/mL) IV single- dose vial	more than 55 kg to 85 kg used 3	week 0: # of vials to be used 2 g 390 mg at week 0: # of vials to be g at week 0: # of vials to be used 4	Quantity: 2 Vials 3 Vials 4 Vials Refills: 0
6 PRESCRIBI	ER SIGNATURE REOL	JIRED (STAMP SIGNAT		
"Dispense As Writte DAW / May Not Sub Prescriber's Si	en" / Brand Medically Necessary / Do stitute gnature:	o Not Substitute / No Substitution / Date:	May Substitute / Product Selection Permitted / Substitution Permissible Prescriber's Signature:	Date:
CA, MA, NC & PR: Ir	nterchange is mandated unless Prescri	ber writes the words "No Substitution"	ATTN: New York and Iowa provider	s, please submit electronic prescription

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	Pleas	se Complete Patient and P	rescriber Information	
Patient Name: _		Patient DOB:	Patient Phone:	
Patient Address	·			
Prescriber Name	e:	Pre	escriber Phone:	
Patient Clinical	<u>Information:</u>	_		
Allergies:		NKDA We	eight: 🗌 kg 🗌 lb Height:	cm in
			ate of last treatment//	
			status:	
) for discontinuation:		
	ION INFORMATION		NOTE OF THE PROPERTY OF THE PR	
MEDICATION	STRENGTH		DIRECTIONS	QUANTITY/REFILLS
	☐ 200 mg/20 mL	Induction Dose:		Overtity 1 Viel Defiller O
☐ Tremfya	(10 mg/mL) single-	Week 0: Infuse 200 mg IV		Quantity: 1 Vial Refills: 0
	dose vial	Week 4: Infuse 200 mg IV		Quantity: 1 Vial Refills: 0
	0.000 1.0.1	Week 8: Infuse 200 mg IV	over at least one hour	Quantity: 1 Vial Refills: 0
	□ 400			
☐ Truxima	100 mg/10 mL vial	Infuse two doses of 1000		Quantity:
	500 mg/50 mL vial	Other:	·····	Refills:
		RA Induction Dose: Infuse	e 4 mg per kg (mg) IV every	
		4 weeks	01 0 ==== 0,	
		RA Maintenance Dose: Inf	fuse 8 mg per kg (mg) IV every	
		4 weeks (doses exceeding 80	- · · · · · · · · · · · · · · · · · · ·	
		recommended)	.	Quantity:
		Giant Cell Arteritis Dose: I	nfuse 6 mg per kg (mg) IV	(# of 80 mg vials)
			ding 600 mg per infusion are not	(# of 200 mg vials)
Tyenne	80 mg/4 mL vial	recommended)		(# of 400 mg vials)
(tocilizumab-	200 mg/10 mL vial	PJIA Dose (> 2 years old weighing < 30 kg): Infuse 10 mg		
aazg)	400 mg/20 mL vial	per kg (mg) IV every 4 weeks		Refills:
aazgj	400 mg/20 mz viat	PJIA Dose (> 2 years old	weighing > 30 kg): Infuse 8 mg	
		per kg (mg) IV every 4 we		
			weighing < 30 kg): Infuse 12 mg	
		per kg (mg) IV every 2 we		
			weighing > 30 kg): Infuse 8 mg	
		per kg (mg) IV every 2 we		
		Other:		
				Our makita m
	☐ 130 mg/26 mL	Single IV Induction Dose:	early 0, # af vialata ha ward 0	Quantity:
	(5 mg/mL) IV single-	55 kg or less 260 mg at w	390 mg at week 0: # of vials to be	2 Vials 3 Vials
Ustekinumab	dose vial	used 3	390 mg at week 0. # of viais to be	4 Vials
			at week 0: # of vials to be used 4	Refills: 0
		more than 85 kg 320 mg a	at week 0. # 01 vials to be useu 4	Quantity:
Other	Strength:	☐ Dose:		Refills:
		HDED (CTAND CLONATI	IDE NOT ALLOWED	
PRESCRIB	EK SIGNA I URE KEQU	JIRED (STAMP SIGNATU	JKE NOT ALLOWED)	
· ·	en" / Brand Medically Necessary / De	o Not Substitute / No Substitution /	May Substitute / Product Selection Permitted /	
DAW / May Not Sub	ostitute ignature:	Date	Substitution Permissible Prescriber's Signature:	Date:
Prescriber S 3	ıyııature:	Date:	Frescriber's Signature:	Date:
CA, MA, NC & PR: I	nterchange is mandated unless Prescri	ber writes the words "No Substitution"	ATTN: New York and Iowa provide	rs, please submit electronic prescription

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Autoimmune IV Enrollment Form Nursing Orders

		se Complete Patient and Prescriber Information	
atient Name:		Patient DOB: Patient Phone:	
atient Address:			
		Prescriber Phone:	
atient Clinical Informat			
Allergies:		NKDA Weight: Ng lb Height:	₋
reatment status: New		Continuation of therapy; Date of last treatment//	
B Test Date//		egative Hepatitis status:	
PRESCRIPTION INFO			
MEDICATION/SUPPLIES		**ITEMS BELOW THIS LINE WILL ONLY BE SENT FOR INFUSIONS DON	QUANTITY/REFILLS
MEDICATION/SUPPLIES	ROUTE	DOSE /STRENGTH/ DIRECTIONS Catheter Care /Flush	QUANTITY/REFILLS
Catheter: PIV PORT CVC/PICC	IV	Catheter Care/Flush – Only on drug admin days – SASH or PRN to maintain IV access and patency PIV: NS 5 mL (Heparin 10 units/mL 3-5 mL if multiple days) CVC/PICC: NS 10 mL & Heparin 10 units/mL or 100 units/mL 3-5 mL. PORT: 10 mL sterile saline to access PORT w/ huber needle NS 10 mL & Heparin 100 units/mL 3-5mL.	Quantity: Refills:
Hydration:	IV	Pre: ☐ 500 mL ☐ 1000 mL ☐ Other: Concurrent: ☐ 500 mL ☐ 1000 mL ☐ Other: Post: ☐ 500 mL ☐ 1000 mL ☐ Other:	Hydration max infusion rate mL/hr (Adult max rate 250 mL/hr unless otherwise indicated)
☐Epinephrine **nursing requires**	□ IM □ SC	☐ 1:1000, 0.3mg/0.3 mL (greater than 30 kg/66 lbs) ☐ 1:1000, 0.15mg/0.3 mL (15-30 kg/33-66 lbs) ☐ 1:1000, 0.1 mg/kg, Max 0.3mg (under 15kg) Mild-Moderate Reactions. May repeat in 3-5 minutes as needed for severe allergic reaction, also call 911	Quantity: Refills:
Diphenhydramine Oral	РО	Premedication: ☐ 12.5 mg/kg (0-30 kg) ☐ 25 mg ☐ 50 mg (Over 30 kg)	Quantity: Refills:
Diphenhydramine 50 mg/mL vial **nursing required**	Slow IV	1 mg/kg (under 15 kg) 12.5 mg-50 mg (15-30 kg) 25 mg-50 mg (Over 30 kg) If mild/moderate reaction: may repeat in 3-5 minutes as needed (Adult max dose: 100 mg/day) If severe allergic reaction: call 911	Quantity: Refills:
☐ Flush Orders:	Peripheral Access Central Venous Access	☐ 10 mL NS post flush ☐ 50 mL NS post flush to clear medication from tubing (recommended if no post-hydration) ☐ Other:	Send quantity sufficient for medication days supply
Additional Medication:			
Patient is interested in patient sup		STAMP SIGNATURE NOT ALLOWED Ancillary supplies and kits JIRED (STAMP SIGNATURE NOT ALLOWED)	provided as needed for administratio
"Dispense As Written" / Brand M DAW / May Not Substitute	ledically Necessary / De	o Not Substitute / No Substitution / May Substitute / Product Selection Permitted / Substitution Permissible Prescriber's Signature:	Date:

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Plan member privacy is important to us. Our employees are trained regarding the appropriate way to handle members' private health information.

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