Ryplazim Enrollment Form

CVS specialty®

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

Phone: 1-808-254-2727
NCPDP: 1203417

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 medical 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):
☐ E88.02 Plasminogen Deficiency Type 1 (PLGD-1)
☐ Other Code: _____Description: _____

Patient Clinical Information:
Allergies: _____Height: _____in/cm Weight: _____lb/kg

Nursing:
Specialty pharmacy to coordinate infusion training/home health nurse visit as necessary? ☐ Yes ☐ No
Site of Care: ☐ MD office ☐ Infusion Clinic ☐ Outpatient Health ☐ Home Health
Infusion training not necessary. Date training occurred: _____
Reason: ☐ MD office training patient ☐ Pt already independent ☐ Referred by MD to alternate trainer

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Ryplazim	☐ 68.8 mg	Infuse _____ mg via slow intravenous infusion ☐ Every 2 days ☐ Every 3 days ☐ Every 4 days ☐ Every _____ days Other: _____	Quantity: ☐ 1 month ☐ 3 months ☐ Other: _____ Refills: ☐ 1 year ☐ Other: _____

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:** _____	May Substitute / Product Selection Permitted / Substitution Permissible **Prescriber's Signature:** _____**Date:** _____
CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "**No Substitution**" _____ **ATTN: New York and Iowa providers,** 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.

Ryplazim Enrollment Form

Please Complete Patient and Prescriber Information

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

Nursing Medications

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Normal Saline	Other: _____	Access Device: ☐ Port ☐ PICC ☐ PIV ☐ Butterfly ☐ Other: _____ ☐ _____ mL every _____	Quantity: ☐ 1 month ☐ 3 months ☐ Other: _____ Refills: ☐ 1 year ☐ Other: _____
☐ Heparin	☐ 10 IU/mL ☐ 100 IU/mL	Access Device: ☐ Port ☐ PICC ☐ PIV ☐ Butterfly ☐ Other: _____ ☐ _____ mL every _____	Quantity: ☐ 1 month ☐ 3 months ☐ Other: _____ Refills: ☐ 1 year ☐ Other: _____

MEDICATION/SUPPLIES	ROUTE	DOSE/STRENGTH/DIRECTIONS	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 u/mL or ☐ 100 units/mL 3-5mL PORT: 10 mL sterile saline to access PORT w/ huber needle NS 10 mL & Heparin 100 units/mL 3-5 mL	Quantity: _____ Refills: _____
☐ Diphenhydramine Oral	PO	☐ 12.25 mg/kg (0-30 kg) ☐ 25 mg ☐ 50 mg (Over 30 kg)	Quantity: _____ Refills: _____
☐ Diphenhydramine 50 mg/mL vial	☐ Slow IV ☐ IM	☐ 1 mg/kg (under 15 kg) ☐ 12.5-50 mg (15-30 kg) ☐ 25 mg ☐ 50 mg (Over 30 kg) May repeat in 3-5 minutes as needed (Max dose-50 mg)	Quantity: _____ Refills: _____
☐ Epinephrine **nursing requires**	☐ IM ☐ SC	☐ 1:1000, 0.3 mg/ 0.3 mL (greater than 30 kg/66lbs) ☐ 1:1000, 0.15 mg/0.3 mL (15-30 kg/33-66lbs) ☐ 1:1000, 0.01 mg/kg, Max 0.3 mg (under 15 kg) Mild-Moderate Reactions. May repeat in 3-5 minutes as needed For severe allergic reaction also call 911	Quantity: _____ Refills: _____
☐ Other: _____	Other: _____	Other: _____	Quantity: _____ Refills: _____
☐ Other: _____	Other: _____	Other: _____	Quantity: _____ Refills: _____

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

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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. 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. Plan member privacy is important to us. Our employees are trained regarding the appropriate way to handle members' private health information. This document contains references to brand-name prescription drugs that are trademarks or registered trademarks of pharmaceutical manufacturers not affiliated with CVS Specialty and/or one of its affiliates.