

Autoimmune IV Enrollment Form



Fax Referral To: 1-800-323-2445 Phone: 1-800-237-2767
Email Referral To: Customer.ServiceFax@CVSHealth.com



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): ☐ Date of Diagnosis ____/____/____

☐ K50.00 Crohn's Disease of Small Intestine Without Complications

☐ K51.90 Ulcerative colitis, unspecified, without complications

☐ L40.50 Arthropathic Psoriasis, Unspecified

☐ L40.54 Juvenile Psoriatic Arthritis (JPsA)

☐ M06.9 Rheumatoid Arthritis, Unspecified

☐ M08.00 Juvenile Idiopathic Arthritis (JIA)

☐ M08.90 Polyarticular Juvenile Idiopathic Arthritis (PJIA)

☐ M08.20 Systemic Juvenile Idiopathic Arthritis (SJIA)

☐ M31.6 Giant Cell Arteritis (GCA)

☐ M32.1 Systemic lupus erythematosus (SLE)

☐ M32.14 Glomerular disease in systemic lupus erythematosus

☐ M45.9 Ankylosing Spondylitis of Unspecified Sites in Spine

☐ M45.A0 Non-Radiographic Axial Spondylarthritis (nr-axSpA)

☐ Other Code: _____ Description: _____

Patient Clinical Information:

Allergies: _____ ☐ NKDA Weight: _____ ☐ kg ☐ lb Height: _____ ☐ cm ☐ in

Treatment status: ☐ New to therapy ☐ Continuation of therapy; Date of last treatment ____/____/____

TB Test Date ____/____/____ ☐ Positive ☐ Negative ☐ Hepatitis status: _____

Prior therapy, treatment dates, and reason(s) for discontinuation: _____

Nursing and Administration:

First dose administration of monoclonal antibodies (mABs) should be administered in a controlled setting (may vary depending upon medication specific policy).

For Remicade/Remicade Biosimilars, the first dose must be administered in a controlled setting.

Specialty pharmacy to coordinate home health Infusion nurse visit as necessary? ☐ Yes ☐ No

Site of Care: ☐ Home Infusion* ☐ Coram Ambulatory Infusion Suite (AIS)* ☐ Prescriber's Office** ☐ Other Infusion Clinic

*Home Infusion/Coram AIS: Diluents, Flushes, Supplies, Nursing Services for drug administration/therapy teach train.

**Prescriber's Office/Other Infusion Clinic: Drug only for facility administration

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Patient Address: _____

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Patient Clinical Information:

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5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Actemra	☐ 80 mg/4 mL ☐ 200 mg/10 mL ☐ 400 mg/20 mL	☐ Induction Dose: Infuse 4 mg/kg every 4 weeks ☐ Maintenance Dose: Infuse 8 mg/kg every 4 weeks	Quantity: _____ Refills: _____
☐ Avsola	☐ 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) every 8 weeks	Quantity: _____ # of 100 mg vial(s) Refills: _____
☐ Benlysta	☐ 120 mg 5 mL vial ☐ 400 mg 20 mL vial	☐ Induction Dose: 10 mg/kg IV (Dose = _____mg) at 2-week intervals for the first 3 doses and at 4-week intervals thereafter. Infuse IV over 1 hour.	Quantity: _____ vials Refills: _____
☐ Entyvio	☐ 300 mg in a single dose vial in individual carton	☐ Induction Dose: 300 mg infused IV over 30 minutes at 0, 2 and 6 weeks, then every 8 weeks thereafter ☐ Maintenance Dose: 300 mg infused IV over 30 minutes every 8 weeks	Quantity: _____ Refills: _____
☐ Other	☐ Strength: _____	☐ Dose: _____	Quantity: _____ Refills: _____

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☐ Inflectra ☐ Infliximab	☐ 100 mg vial	☐ Ankylosing Spondylitis <u>Induction Dose</u> : Infuse IV at 5 mg/kg (Dose = _____mg) at weeks 0, 2, 6 and every 6 weeks thereafter ☐ Ankylosing Spondylitis <u>Maintenance Dose</u> : Infuse IV at 5 mg/kg (Dose = _____mg) every 6 weeks ☐ Crohn's Disease (Adult and Pediatric ≥ 6 years old) <u>Induction Dose</u> : Infuse IV at 5 mg/kg (Dose = _____mg) at weeks 0, 2, 6 and every 8 weeks thereafter ☐ Crohn's Disease (Adult) <u>Maintenance Dose</u> : Infuse IV at 5-10 mg/kg (Dose = _____mg) every 8 weeks ☐ Crohn's Disease (Pediatric ≥ 6 years old) <u>Maintenance Dose</u> : Infuse IV at 5 mg/kg (Dose = _____mg) every 8 weeks ☐ Plaque Psoriasis & Psoriatic Arthritis <u>Induction Dose</u> : Infuse IV at 5 mg/kg (Dose = _____mg) at weeks 0, 2, 6 and every 8 weeks thereafter ☐ Plaque Psoriasis & Psoriatic Arthritis <u>Maintenance Dose</u> : Infuse IV at 5 mg/kg (Dose = _____mg) every 8 weeks ☐ Rheumatoid Arthritis <u>Induction Dose</u> : Infuse IV at 3 mg/kg (Dose = _____mg) at weeks 0, 2, 6 and every 8 weeks thereafter ☐ Rheumatoid Arthritis <u>Maintenance Dose</u> : 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) <u>Induction Dose</u> : 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) <u>Maintenance Dose</u> : Infuse IV at 5 mg/kg (Dose = _____mg) every 8 weeks	Quantity: _____ # of 100 mg vial(s) Refills: _____
☐ Omvoh	☐ 300 mg/15 mL single 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
☐ Orencia	☐ 250 mg vial	☐ Infuse ____ mg at weeks 0, 2 and 4, then every 4 weeks thereafter	Quantity: ____ Refills: ____
☐ Remicade ☐ Renflexis	☐ 100 mg vial	☐ Ankylosing Spondylitis <u>Induction Dose</u> : Infuse IV at 5 mg/kg (Dose = _____mg) at weeks 0, 2, 6 and every 6 weeks thereafter ☐ Ankylosing Spondylitis <u>Maintenance Dose</u> : Infuse IV at 5 mg/kg (Dose = _____mg) every 6 weeks ☐ Crohn's Disease (Adult and Pediatric ≥ 6 years old) <u>Induction Dose</u> : Infuse IV at 5 mg/kg (Dose = _____mg) at weeks 0, 2, 6 and every 8 weeks thereafter ☐ Crohn's Disease (Adult) <u>Maintenance Dose</u> : Infuse IV at 5-10 mg/kg (Dose = _____mg) every 8 weeks ☐ Crohn's Disease (Pediatric ≥ 6 years old) <u>Maintenance Dose</u> : Infuse IV at 5 mg/kg (Dose = _____mg) every 8 weeks ☐ Plaque Psoriasis & Psoriatic Arthritis <u>Induction Dose</u> : Infuse IV at 5 mg/kg (Dose = _____mg) at weeks 0, 2, 6 and every 8 weeks thereafter ☐ Plaque Psoriasis & Psoriatic Arthritis <u>Maintenance Dose</u> : Infuse IV at 5 mg/kg (Dose = _____mg) every 8 weeks ☐ Rheumatoid Arthritis <u>Induction Dose</u> : Infuse IV at 3 mg/kg (Dose = _____mg) at weeks 0, 2, 6 and every 8 weeks thereafter ☐ Rheumatoid Arthritis <u>Maintenance Dose</u> : 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) <u>Induction Dose</u> : 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) <u>Maintenance Dose</u> : Infuse IV at 5 mg/kg (Dose = _____mg) every 8 weeks	Quantity: _____ # of 100 mg vial(s) Refills: _____
☐ Other	☐ Strength: _____	☐ Dose: _____	Quantity: ____ Refills: ____

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Patient Address: _____

Prescriber Name: _____ Prescriber Phone: _____

Patient Clinical Information:

Allergies: _____ ☐ NKDA Weight: _____ ☐ kg ☐ lb Height: _____ ☐ cm ☐ in

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TB Test Date ____/____/____ ☐ Positive ☐ Negative ☐ Hepatitis status: _____

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☐ Riabni ☐ 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-minute period, every 4 weeks	Quantity: _____ vials Refills: _____
☐ Simponi ARIA	☐ 50 mg/4 mL single dose vial	Adult RA, PsA, AS Induction Dose ☐ Week 0: Infuse 2 mg/kg IV (Dose= _____mg) over 30 minutes ☐ Week 4: Infuse 2 mg/kg IV (Dose= _____mg) over 30 minutes	Quantity: _____ vials Refills: 0 Quantity: _____ vials Refills: 0
		Adult RA, PsA, AS Maintenance Dose ☐ Infuse 2 mg/kg IV (Dose= _____mg) over 30 minutes every 8 weeks	Quantity: _____ vials Refills: _____
		Peds JIA or PsA (>2 years old) Induction Dose ☐ Week 0: Infuse 80 mg/m ² IV (Dose= _____mg) over 30 minutes ☐ Week 4: Infuse 80 mg/m ² IV (Dose= _____mg) over 30 minutes	Quantity: _____ vials Refills: 0 Quantity: _____ vials Refills: 0
		Peds JIA or PsA (>2 years old) Maintenance Dose ☐ Infuse 80 mg/m ² IV (Dose= _____mg) over 30 minutes every 8 weeks	Quantity: _____ vials Refills: _____
☐ Skyrizi	☐ 600 mg/10 mL (60 mg/mL) single dose vial	Induction Dose: ☐ Week 0: Infuse 600 mg IV over at least one hour ☐ Week 4: Infuse 600 mg IV over at least one hour ☐ Week 8: Infuse 600 mg IV over at least one hour	Quantity: 1 vial Refills: 0 Quantity: 1 vial Refills: 0 Quantity: 1 vial Refills: 0
		☐ Week 0: Infuse 1,200 mg IV over at least two hours ☐ Week 4: Infuse 1,200 mg IV over at least two hours ☐ Week 8: Infuse 1,200 mg IV over at least two hours	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	Single IV Induction Dose: ☐ 55 kg or less 260 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 be used 3 ☐ more than 85 kg 520 mg at week 0: # of vials to be used 4	Quantity: _____ ☐ 2 Vials ☐ 3 Vials ☐ 4 Vials Refills: 0

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Patient Address: _____

Prescriber Name: _____ Prescriber Phone: _____

Patient Clinical Information:

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TB Test Date ____/____/____ ☐ Positive ☐ Negative ☐ Hepatitis status: _____

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5 PRESCRIPTION INFORMATION

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☐ Tremfya	☐ 200 mg/20 mL (10 mg/mL) single-dose vial	Induction Dose: ☐ Week 0: Infuse 200 mg IV over at least one hour ☐ Week 4: Infuse 200 mg IV over at least one hour ☐ Week 8: Infuse 200 mg IV over at least one hour	Quantity: 1 Vial Refills: 0 Quantity: 1 Vial Refills: 0 Quantity: 1 Vial Refills: 0
☐ Truxima	☐ 100 mg/10 mL vial ☐ 500 mg/50 mL vial	☐ Infuse two doses of 1000 mg separated by 2 weeks ☐ Other: _____	Quantity: _____ Refills: _____
☐ Tysse (tocilizumab-aazg)	☐ 80 mg/4 mL vial ☐ 200 mg/10 mL vial ☐ 400 mg/20 mL vial	☐ RA Induction Dose: Infuse 4 mg per kg (____ mg) IV every 4 weeks ☐ RA Maintenance Dose: Infuse 8 mg per kg (____ mg) IV every 4 weeks (doses exceeding 800 mg per infusion are not recommended) ☐ Giant Cell Arteritis Dose: Infuse 6 mg per kg (____ mg) IV every 4 weeks (doses exceeding 600 mg per infusion are not recommended) ☐ PJIA Dose (≥ 2 years old weighing < 30 kg): Infuse 10 mg per kg (____ mg) IV every 4 weeks ☐ PJIA Dose (≥ 2 years old weighing ≥ 30 kg): Infuse 8 mg per kg (____ mg) IV every 4 weeks ☐ SJIA Dose (≥ 2 years old weighing < 30 kg): Infuse 12 mg per kg (____ mg) IV every 2 weeks ☐ SJIA Dose (≥ 2 years old weighing ≥ 30 kg): Infuse 8 mg per kg (____ mg) IV every 2 weeks ☐ Other: _____	Quantity: ☐ ____ (# of 80 mg vials) ☐ ____ (# of 200 mg vials) ☐ ____ (# of 400 mg vials) Refills: _____
☐ Ustekinumab	☐ 130 mg/26 mL (5 mg/mL) IV single-dose vial	Single IV Induction Dose: ☐ 55 kg or less 260 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 be used 3 ☐ more than 85 kg 520 mg at week 0: # of vials to be used 4	Quantity: ☐ 2 Vials ☐ 3 Vials ☐ 4 Vials Refills: 0
☐ Other	☐ Strength: _____	☐ Dose: _____	Quantity: _____ Refills: _____

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Nursing Orders

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TB Test Date ____/____/____ ☐ Positive ☐ Negative

☐ Hepatitis status: _____

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5 PRESCRIPTION INFORMATION

****ITEMS BELOW THIS LINE WILL ONLY BE SENT FOR INFUSIONS DONE AT HOME/CORAM AIS****

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 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: ☐ NS ☐ D5W	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 <i>**nursing requires**</i>	☐ 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	PO	Premedication: ☐ 12.5 mg/kg (0-30 kg) ☐ 25 mg ☐ 50 mg (Over 30 kg)	Quantity: _____ Refills: _____
☐ Diphenhydramine 50 mg/mL vial <i>**nursing required**</i>	☐ Slow IV ☐ IM	☐ 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 support programs

STAMP SIGNATURE NOT ALLOWED

Ancillary supplies and kits provided as needed for administration

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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.

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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