Dermatology Enrollment Form

CVS specialty®

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

Phone: 1-800-896-1464

Six Simple Steps to Submitting a Referral

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

Patient Name: _____ DOB: _____
Address: _____City, State, ZIP Code: _____
Gender: ☐ Male ☐ Female
Preferred Contact Methods: ☐ Phone (to primary # provided below) ☐ Text (to cell # provided below) ☐ Email (to email provided below)
Note: Carrier charges may apply. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.
Primary Phone: _____ Alternate Phone: _____
If **Minor**, Parent/Caregiver/Guardian Name (Last, First): _____
Relationship to minor: _____
Email: _____ Last Four of SSN: _____ Primary Language: _____

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)

4 DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date:_____
Ship to: ☐ Patient ☐ Office ☐ Other:_____
_____

Diagnosis (ICD-10):

☐ L40.0 Psoriasis Vulgaris ☐ L40.1 Generalized Pustular Psoriasis ☐ L40.4 Guttate Psoriasis
☐ L40.50 Arthropathic Psoriasis, Unspecified ☐ L40.59 Other Psoriatic Arthropathy ☐ L40.8 Other Psoriasis
☐ L40.9 Psoriasis, Unspecified ☐ L73.2 Hidradenitis Suppurativa
☐ Other Code: _____ Description
_____

Patient Clinical Information:

Allergies:_____
Weight:_____lb/kg Height:_____
_____In/cm TB Test Result:_____
Date:_____

Nursing:

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

Dermatology Enrollment Form
Medications A-C
(Avsola, Cimzia)

Please Complete Patient , Prescriber and Patient Clinical Information

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

Patient Clinical Information:

Allergies:_____
Weight:_____lb/kg Height:_____In/cm TB Test Result:_____ Date:_____

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Avsola	100 mg vial	☐ Induction Dose: Infuse IV at 5 mg/kg (Dose = ____mg) at weeks 0, 2, 6 and every 8 weeks thereafter ☐ Maintenance Dose: Infuse IV at 5 mg/kg (Dose = ___mg) every 8 weeks ☐ Other:_____	Quantity: _____ # of 100 mg vial(s) Refills: _____
☐ Cimzia	Cimzia Starter Kit (6 prefilled syringes)	Psoriasis Loading Dose: ☐ 400 mg (given as 2 subcutaneous injections of 200 mg each) every other week ☐ Patients (with body weight ≤ 90 kg): 400 mg (given as 2 subcutaneous injections of 200 mg each) initially and at weeks 2 and 4, followed by 200 mg every other week Psoriatic Arthritis Loading Dose: ☐ 400 mg (given as 2 subcutaneous injections of 200 mg each) initially and at week 2 and 4, followed by 200 mg every other week ☐ Other:_____	Quantity: 1 Kit Refills: 0
☐ Cimzia	☐ 200mg/1 mL prefilled syringe ☐ 200mg vial	Psoriasis Maintenance Dose: ☐ 400 mg (given as 2 subcutaneous injections of 200 mg each) every other week ☐ 200 mg every other week Psoriatic Arthritis Maintenance Dose: ☐ 200 mg every other week ☐ 400 mg (given as 2 subcutaneous injections of 200 mg each) every 4 weeks ☐ Other:_____	Quantity: _____ Refills: _____

☐ 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 **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.

Dermatology Enrollment Form
Medications C-G
(Cosentyx, Enbrel)

Please Complete Patient , Prescriber and Patient Clinical Information

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

Patient Clinical Information:

Allergies:_____
Weight:_____lb/kg Height:_____In/cm TB Test Result:_____ Date:_____

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Cosentyx 150 mg	☐ Sensoready Pen (1x150 mg/mL) ☐ Prefilled Syringe (1x150 mg/mL)	Adult: ☐ Loading Dose: Inject 150 mg subcutaneously on Weeks 0, 1, 2, 3 ☐ Maintenance Dose: Inject 150 mg subcutaneously on Week 4, then every 4 weeks thereafter ☐ Other:_____	Quantity: _____ Refills: _____
☐ Cosentyx 300 mg	☐ Sensoready Pen (2x150 mg/mL) ☐ Prefilled Syringe (2x150 mg/mL)	Adult: ☐ Loading Dose: Inject 300 mg subcutaneously on Weeks 0, 1, 2, 3 ☐ Maintenance Dose: Inject 300 mg subcutaneously on Week 4, then every 4 weeks thereafter ☐ Other:_____	Quantity: _____ Refills: _____
☐ Cosentyx 75 mg (wt ≥ 15 kg and < 50 kg)	Prefilled Syringe (1x75 mg/0.5 mL)	Pediatric: ☐ Loading Dose: Inject 75 mg subcutaneously on Weeks 0, 1, 2, 3 ☐ Maintenance Dose: Inject 75 mg subcutaneously on Week 4, then every 4 weeks thereafter ☐ Other:_____	Quantity: _____ Refills: _____
☐ Cosentyx 150 mg (wt ≥ 50 kg)	☐ Sensoready Pen (1x150 mg/mL) ☐ Prefilled Syringe (1x150 mg/mL)	Pediatric: ☐ Loading Dose: Inject 150 mg subcutaneously on Weeks 0, 1, 2, 3 ☐ Maintenance Dose: Inject 150 mg subcutaneously on Week 4, then every 4 weeks thereafter ☐ Other:_____	Quantity: _____ Refills: _____
☐ Enbrel	☐ 50 mg/mL Sureclick Autoinjector ☐ 50 mg/mL prefilled syringe ☐ 50 mg/mL Enbrel Mini prefilled cartridge for use with the AutoTouch reusable autoinjector only (Prescriber MUST supply). CVS does not order the autoinjector. ☐ 25 mg/0.5 mL prefilled syringe ☐ 25 mg/0.5 mL solution in a single-dose vial	☐ Psoriasis Induction Dose: Inject 50 mg SC TWICE a week (3 to 4 days apart) for 3 months, then maintenance dosing. ☐ Psoriasis Maintenance Dose: Inject 50 mg SC ONCE a week. ☐ Psoriatic Arthritis Dose: Inject 50 mg SC ONCE a week. ☐ Other:_____	Quantity: _____ Refills: _____

☐ 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 **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.

Dermatology Enrollment Form
Medications H
(Humira)

Please Complete Patient , Prescriber and Patient Clinical Information

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

Patient Clinical Information:

Allergies:_____
Weight:_____lb/kg Height:_____In/cm TB Test Result:_____ Date:_____

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Humira	☐ Psoriasis 40 mg/0.4 mL Starter Package **Citrate Free** ☐ Psoriasis 80 mg/0.8 mL and 40 mg/0.4 mL Starter Package **Citrate Free**	☐ Psoriasis Induction Dose: 80 mg SC initial dose, followed by 40 mg SC on day 8, then 40 mg every other week.	Quantity: 1 package Refills: 0
☐ Humira	☐ 40 mg/0.4 mL Pen **Citrate Free** ☐ 40 mg/0.4 prefilled syringe **Citrate Free**	☐ Psoriasis Maintenance Dose: Inject one 40 mg pen/syringe SC every other week. ☐ Psoriatic Arthritis Dose: Inject one 40 mg pen/syringe SC every other week. ☐ Other:_____	Quantity: _____ Refills: _____
☐ Humira	**30 kg (66 lbs) to less than 60 kg (132 lbs); ≥ 12 years:** ☐ Adolescent Hidradenitis Suppurativa 80 mg/0.8 mL and 40 mg/0.4 mL Starter Package **Citrate Free**	Adolescent Hidradenitis Suppurativa Initial Dose: ☐ Inject SC 80mg Day 1, then 40mg every other week on day 8 and subsequent doses ☐ Other:_____	Quantity: 1 kit (3 Pens) Refills: 0
☐ Humira	**60 kg (132 lbs) and greater; ≥ 12 years:** ☐ Adult Hidradenitis Suppurativa 80 mg/0.8 mL Starter Package **Citrate Free**	Hidradenitis Suppurativa Initial Dose: ☐ Inject SC 160mg Day 1, then 80mg two weeks later (Day 15), then 40mg every week (Day 29) and subsequent doses ☐ Inject SC 80mg Day 1, 80mg Day 2, then 80mg two weeks later (Day 15), then 40mg every week (Day 29) and subsequent doses ☐ Inject SC 160mg Day 1, then 80mg two weeks later (Day 15), then 80mg every other week (Day 29) and subsequent doses ☐ Inject SC 80mg Day 1, 80mg Day 2, then 80mg two weeks later (Day 15), then 80mg every other week (Day 29) and subsequent doses ☐ Other:_____	Quantity: 1 kit (3 Pens) Refills: 0
☐ Humira	**30 kg (66 lbs) to less than 60 kg (132 lbs); ≥ 12 years:** ☐ 40 mg/0.4 mL Pen **Citrate Free** ☐ 40 mg/0.4 mL prefilled syringe **Citrate Free**	Adolescent Hidradenitis Suppurativa Maintenance Dose: ☐ Inject SC 40mg every other week ☐ Other:_____	Quantity: _____ Refills: _____
☐ Humira	**60 kg (132 lbs) and greater; ≥ 12 years:** ☐ 40 mg/0.4 mL Pen **Citrate Free** ☐ 40 mg/0.4 prefilled syringe **Citrate Free** ☐ 80 mg/0.8 mL Pen **Citrate Free**	Hidradenitis Suppurativa Maintenance Dose: ☐ Inject SC 40mg every week ☐ Inject SC 80 mg every other week	Quantity: _____ Refills: _____

☐ 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 **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.

Dermatology Enrollment Form
Medications I-S

(Ilumya, Inflectra, Infliximab, Orencia, Otezla, Remicade, Renflexis, Rinvoq, Siliq, Simponi, Simponi ARIA)

Please Complete Patient , Prescriber and Patient Clinical Information

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

Patient Clinical Information:

Allergies:_____
Weight:_____lb/kg Height:_____In/cm TB Test Result:_____ Date:_____

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Ilumya	100 mg/mL prefilled syringe	☐ Psoriasis Induction Dose: Inject one pre-filled syringe (100 mg) SC at weeks 0 and 4, then maintenance dosing. ☐ Psoriasis Maintenance Dose: Inject one pre-filled syringe (100 mg) SC every 12 weeks. ☐ Other: _____	Quantity: _____ Refills: _____
☐ Inflectra ☐ Infliximab	100 mg vial	☐ Induction Dose: Infuse IV at 5 mg/kg (Dose = ____mg) at weeks 0, 2, 6 and every 8 weeks thereafter ☐ Maintenance Dose: Infuse IV at 5 mg/kg (Dose = ___mg) every 8 weeks ☐ Other: _____	Quantity: _____ # of 100 mg vial(s) Refills: _____
☐ Orencia	125 mg/mL prefilled syringe	Inject 125 mg SC once weekly	Quantity: _____ Refills: _____
☐ Otezla	Titration Starter Pack	Day 1: 10 mg PO in the morning. Day 2: 10 mg PO in the morning and 10 mg PO in the evening. Day 3: 10 mg PO in the morning and 20 mg PO in the evening. Day 4: 20 mg PO in the morning and 20 mg PO in the evening. Day 5: 20 mg PO in the morning and 30 mg PO in the evening. Day 6 and thereafter: 30 mg PO twice daily.	Quantity: 1 pack Refills: 0
☐ Otezla	30 mg tablet	☐ Maintenance Dose: 30 mg tablet PO twice daily. ☐ Other: _____	Quantity: _____ Refills: _____
☐ Remicade ☐ Renflexis	100 mg vial	☐ Induction Dose: Infuse IV at 5 mg/kg (Dose = ____mg) at weeks 0, 2, 6 and every 8 weeks thereafter ☐ Maintenance Dose: Infuse IV at 5 mg/kg (Dose = ___mg) every 8 weeks ☐ Other: _____	Quantity: _____ # of 100 mg vial(s) Refills: _____
☐ Rinvoq	15 mg	Take one 15 mg tablet PO daily	Quantity: _____ Refills: _____
☐ Siliq	☐ Carton of two 210 mg/1.5 mL single-dose prefilled syringes	Inject one prefilled syringe (210 mg) SC at weeks 0, 1 and 2, followed by one prefilled syringe (210 mg) every 2 weeks. Prescribers must be certified in the SILIQ REMS Program to prescribe SILIQ. Please visit the following REMS website to register before prescribing SILIQ: SILIQ REMS Website (https://siliqrems.com/SiliqUI/home.u)	Quantity: _____ Refills: _____
☐ Simponi	☐ 50 mg/0.5 mL SmartJect Autoinjector ☐ 50 mg/0.5 mL prefilled syringe	☐ Psoriatic Arthritis Dose: Inject 50 mg SC once a month. ☐ Other: _____	Quantity: _____ Refills: _____
☐ Simponi ARIA	50 mg/4 mL in a single-dose vial	Psoriatic Arthritis Dosing: Induction Dose: 2 mg/kg IV infusion over 30 minutes at weeks 0 and 4, then every 8 weeks thereafter Maintenance Dose: 2 mg/kg IV infusion over 30 minutes every 8 weeks	Quantity: _____ # of 50 mg vial Refills: _____

☐ 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 **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.

Dermatology Enrollment Form
Medications S-Z
(Skyrizi, Stelara, Taltz, Tremfya, Xeljanz)

Please Complete Patient , Prescriber and Patient Clinical Information

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

Patient Clinical Information:

Allergies:_____
Weight:_____lb/kg Height:_____In/cm TB Test Result:_____ Date:_____

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Skyrizi	☐ 150 mg/mL single-dose Pen ☐ 150 mg/mL single-dose prefilled syringe	☐ Psoriasis Induction Dose: Inject 150 mg SC at Weeks 0 and 4, then maintenance dosing. ☐ Psoriasis Maintenance Dose: Inject 150mg SC every 12 weeks. ☐ Other: _____	Quantity: _____ Refills: _____
☐ Stelara	☐ 45 mg/0.5 mL prefilled syringe ☐ 90 mg/mL prefilled syringe	☐ For patients weighing ≤100 kg (220 lbs): Inject 45 mg SC initially and 4 weeks later, followed by 45 mg every 12 weeks. ☐ For patients weighing >100 kg (220 lbs): Inject 90 mg SC initially and 4 weeks later, followed by 90 mg every 12 weeks. ☐ Other: _____	Quantity: _____ Refills: _____
☐ Taltz	☐ 80 mg Single Dose Autoinjector ☐ 80 mg Single Dose prefilled syringe	Psoriasis Dosing: ☐ Starting Dose: Inject SC two 80 mg injections on Day 1, then begin first induction dose 2 weeks later. ☐ Induction Dose: Inject SC one 80 mg injection every 2 weeks (weeks 2-10). ☐ Final Induction Dose: Inject SC one 80 mg injection (week 12). ☐ Maintenance Dose: Inject SC one 80 mg injection every 4 weeks. Pediatric Psoriasis Dosing: For patients weighing less than 25 kg dose: ☐ 40 mg at Week 0, followed by 20 mg every 4 weeks. For patients weighing 25-50 kg dose: ☐ 80 mg at Week 0, followed by 40 mg every 4 weeks. For patients weighing greater than 50 kg dose: ☐ 160 mg (two 80 mg injections) at Week 0, followed by 80 mg every 4 weeks.	Quantity: ☐ 3 Pens/Syringes ☐ 2 Pens/Syringes ☐ 1 Pens/Syringes Refills: _____
☐ Taltz	☐ 80 mg Single Dose Autoinjector ☐ 80 mg Single Dose prefilled syringe	Psoriatic Arthritis Dosing: ☐ Starting Dose: Inject SC two 80 mg injections on Day 1. ☐ Maintenance Dose: Inject SC one 80 mg injection every 4 weeks.	Quantity: _____ Refills: _____
☐ Tremfya	☐ 100 mg/mL prefilled syringe ☐ 100 mg/mL One-Press patient-controlled injector	☐ Starting Dose: Inject 100 mg SC at weeks 0 and 4, then maintenance dosing ☐ Maintenance Dose: Inject 100 mg SC every 8 weeks	Quantity: _____ Refills: _____
☐ Xeljanz	☐ 5 mg Tablet ☐ 11 mg XR Tablet	☐ Take one 5 mg tablet PO twice daily ☐ Take one 11 mg PO once daily ☐ Other: _____	Quantity: _____ Refills: _____

☐ 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 **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.

Dermatology Enrollment Form
Nursing Medications

Please Complete Patient , Prescriber and Patient Clinical Information

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

Patient Clinical Information:

Allergies:_____
Weight:_____lb/kg Height:_____In/cm TB Test Result:_____ Date:_____

5 PRESCRIPTION INFORMATION

Complete Items below, required for Home Infusion/Coram AIS:

MEDICATION/SUPPLIES	ROUTE	DOSE/STRENGTH/DIRECTIONS	QUANTITY/REFILLS
Catheter ☐ PIV ☐ PORT ☐ 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) PORT/PICC – NS 10 mL & Heparin 100 units/mL 3-5mL, and/or 10 mL sterile saline to access port a cath	Quantity: _____ Refills: _____
☐ Epinephrine **nursing requires**	☐ IM ☐ SC	☐ Adult 1:1000, 0.3 mL (>30 kg/>66 lbs) ☐ Peds 1:2000, 0.3 mL (15-30 kg/33-66 lbs) ☐ Infant 0.1mL/0.1 mL, 0.1 mL (7.5-15 kg/16.5-33 lbs) PRN severe allergic reaction – Call 911 May repeat in 5-15 minutes as needed	Quantity: _____ Refills: _____
Premed Antihistamine: ☐ Diphenhydramine ☐ Other: _____	☐ Other: _____	☐ Other: _____	Dose will be rounded to the nearest vial size
☐ Flush Orders	☐ Peripheral Access ☐ Central Venus Access	☐ 0.9% Sodium Chloride flush with _____ mL IV before and after medication and IVP for Maintenance ☐ Heparin _____ units per mL Flush with _____ units as final flush and as directed	Send quantity sufficient for medication days supply

☐ 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 **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.