#### **Hepatitis C Enrollment Form Medications A-L**

(Epclusa, Harvoni, Ledipasvir/Sofosbuvir)



Fax Referral To: 1-877-232-5455

Phone: 1-800-896-1464

Address: 500 Ala Moana Blvd., Ste 1-A Honolulu, HI 96813 NCPDP: 1203417 Six Simple Steps to Submitting a Referral **PATIENT INFORMATION** (Complete or include demographic sheet) Patient Name: City, State, ZIP Code: Address: 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. Alternate Phone: Primary Phone: If **Minor**, Parent/Caregiver/Guardian Name (Last, First): Relationship to minor: \_\_\_\_\_ Last Four of SSN: Primary Language: Email: 2 PRESCRIBER INFORMATION Prescriber's Name: \_\_\_ \_\_\_\_\_ State License #: \_\_\_\_\_ NPI #: \_\_\_\_\_\_ DEA #: \_\_\_\_\_ Group or Hospital: \_\_\_\_\_ INSURANCE INFORMATION Please fax copy of prescription and insurance cards with this form, if available (front and back) 4 DIAGNOSIS AND CLINICAL INFORMATION \_\_\_\_\_\_ Ship to: Patient Office Other: \_\_\_\_\_ Needs by Date: Diagnosis (ICD-10): B17.10 Acute Hepatitis C without hepatic coma B17.11 Acute Hepatitis C with hepatic coma B19.20 Unspecified Viral Hepatitis C without hepatic coma B18.2 Chronic Hepatitis C Other Code: \_\_\_\_\_ Description \_\_\_\_ B20 HIV **Patient Clinical Information:** Height: \_\_\_\_in/cm Alleraies: \_ Weight: \_\_\_\_lb/kg HCV Genotype: 1a 1b 1 2 3 4 5 6 AND No Cirrhosis Compensated Cirrhosis Decompensated Cirrhosis Is patient: Naïve Partial Responder Non-Responder Relapser; Last Date of Therapy: \_\_\_\_\_ Product Name(s): \_\_\_\_\_ Is patient currently on Hepatitis C Virus therapy? No Yes, Therapy Start Date: Product Name(s): \_\_\_\_\_ Specialty pharmacy to coordinate injection training/home health nurse visit as necessary? Tyee 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 5 PRESCRIPTION INFORMATION MEDICATION STRENGTH **DOSE & DIRECTIONS QUANTITY/REFILLS** Fixed-dose combination tablet of Quantity: \_\_\_\_\_ Epclusa 400 mg sofosbuvir / 100 mg Take one tablet once daily. Refills: \_\_\_\_ (sofosbuvir / velpatasvir) velpatasvir Quantity: 28-day supply Fixed-dose combination tablet of Take PO once daily with or without Refills: Harvoni food. Do not take within 4 hours of 90 mg ledipasvir / 400 mg 8 weeks (ledipasvir/sofosbuvir) sofosbuvir antacids. 12 weeks 24 weeks Quantity: 28-day supply Fixed-dose combination tablet of Take PO once daily with or without Refills: food. Do not take within 4 hours of 8 weeks Ledipasvir/ Sofosbuvir 90 mg ledipasvir / 400 mg 12 weeks sofosbuvir antacids. 24 weeks ☐ 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 / May Substitute / Product Selection Permitted / DAW / May Not Substitute Substitution Permissible Prescriber's Signature: Prescriber's Signature:

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.

CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "No Substitution" \_\_\_\_\_\_ ATTN: New York and Iowa providers, please submit electronic prescription

# Medications M-S Hepatitis C Enrollment Form

(Mavyret, Pegasys, Pegintron, Ribavirin, Ribasphere RibaPak, Sofosbuvir/Velpatasvir, Sovaldi)

atient Name:		Pa	atient DOB:	
rescriber Name:		Pr	escriber Phone:	
PRESCRIPTION IN	IFORMATION			
<b>MEDICATION</b>	STRENGTH		DOSE & DIRECTIONS	QUANTITY/REFILLS
Mavyret Tablet (glecaprevir and pibrentasvir)	Fixed-dose combination tablet of 100 mg glecaprevir and 40 mg pibrentasvir	Take t	nree tablets PO once a day with food.	Quantity: 28-day supply Refills: 8 weeks 12 weeks Other
Mavyret Oral Pellet (glecaprevir and pibrentasvir)	Fixed-dose combination oral pellet of 50 mg glecaprevir and 20 mg pibrentasvir	Takonce c	g/lb see three packets of oral pellets PO laily with food. see four packets of oral pellets PO laily with food. see five packets of oral pellets PO once vith food.	Quantity: 28-day supply Refills:  8 weeks 12 weeks Other
Pegasys (peginterferon alfa-2a)	☐ 180 mcg / 0.5 mL ProClick Autoinjector ☐ Other:	☐ Inje	ect 180 mcg SC once a week as	Quantity: Refills:
Pegintron (peginterferon alfa-2b)	☐ 120 mcg REDIPEN ☐ 150 mcg REDIPEN ☐ Other:	☐ Inject mcg SC weekly. ☐ Other:		Quantity: Refills:
Ribavirin	200 mg tablets 200 mg capsules	Take tabs/caps PO q am and tabs/caps q pm for a total of mg daily with food.		Quantity: Refills:
Ribasphere RibaPak (ribavirin)	☐ 600 / 600 mg ☐ 600 / 400 mg ☐ 400 / 400 mg ☐ 200 / 400 mg	Take mg PO q am and mg q pm for a total of mg daily with food.		Quantity: Refills:
Sofosbuvir/ /elpatasvir	Fixed-dose combination tablet of 400 mg sofosbuvir / 100 mg velpatasvir	Take one tablet once daily.		Quantity: Refills:
Sovaldi (sofosbuvir)	400 mg tablets		ne 400 mg tablet PO once a day.	Quantity: 28-day supply Refills:
Patient is interested in patient supp	RIBER SIGNATURE REQUIR			provided as needed for administratio
DAW / May Not Substitute	edically Necessary / Do Not Substitute / No Substitu		May Substitute / Product Selection Permitted / Substitution Permissible <b>Prescriber's Signature:</b>	Date:

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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## Medications M-Z Hepatitis C Enrollment Form

(Technivie, Viekira Pak, Vosevi, Zepatier)

atient Name:	Please Complete Patien		ent DOB:	
			scriber Phone:	
PRESCRIPTION IN	NFORMATION			
<b>MEDICATION</b>	STRENGTH		<b>DOSE &amp; DIRECTIONS</b>	QUANTITY/REFILLS
Technivie (ombitasvir/paritaprevir /ritonavir)	Fixed dose combination tablet of ombitasvir / paritaprevir / ritonavir 12.5 mg / 75 mg / 50 mg	Take tv	vo tablets once daily in the morning.	Quantity: 28-day supply Refills:12 weeks
Viekira Pak (ombitasvir/paritaprevir /ritonavir tabs and dasabuvir tabs)	Copackaged ombitasvir / partiaprevir / ritonavir 12.5 mg / 75 mg / 50 mg and dasabuvir 250 mg	Take 2 pink tablets (ombitasvir, paritaprevir, ritonavir) once daily (morning) and 1 beige tablet (dasabuvir) twice daily (morning and evening) with meals.		Quantity: 28-day supply Refills: 12 weeks 24 weeks
☐ Vosevi (sofosbuvir, velpatasvir, and voxilaprevir)	Fixed-dose combination tablet of 400 mg sofosbuvir / 100 mg velpatasvir/100 mg voxilaprevir	Take one tablet PO once a day with food.		Quantity: 28-day supply Refills: 12 weeks Other
Zepatier (elbasvir/grazoprevir)	Fixed dose combination tablet of 50 mg elbasvir / 100 mg grazoprevir	Take or food.	ne tablet once daily with or without	Quantity: 28-day supply Refills: 12 weeks 16 weeks
	SCRIBER SIGNATURE REQUIRE	ED (STA	AMP SIGNATURE NOT ALLO	provided as needed for administration
DAW / May Not Substitute	ledically Necessary / Do Not Substitute / No Substituti		May Substitute / Product Selection Permitted / Substitution Permissible  Prescriber's Signature:	Date:
CA, MA, NC & PR: Interchange is	mandated unless Prescriber writes the words "No Substitu	tution"	ATTN: New York and Iowa provide	ers. please submit electronic prescrip

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### **Inflammatory Bowel Disease Enrollment Form Medications A** (Avsola)



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 Su	ıbmitting a Referral				
	FORMATION	(Complete or include demographic shee	et)				
Patient Name:		DOB:					
Address:		City, State, ZIP Code:					
Gender: 🗌 Male			_				
			Text (to cell # provided below)   Email (to e				
Note: Carrier cha			ecialty Pharmacy will attempt to contact by ph				
Primary Phone: _			Alternate Phone:				
		rdian Name (Last, First):					
Relationship to	minor:						
			of SSN: Primary Language:				
PRESCRIBE							
rescriber's Nan	ne:		State License #:				
IPI #:	DEA #:	Group or Hospital:					
ddress:		Ci1	ty, State, ZIP Code:Contact's Phone: _				
hone:	Fa>	Contact Person: _	Contact's Phone: _				
			insurance cards with this form, if available (fro	ont and back)			
DIAGNOSIS	AND CLINIC	AL INFORMATION					
leeds by Date:_			Ship to: Patient Office Other:	_			
Diagnosis (ICD	<u>-10):</u>						
			K50.10 Crohn's Disease of Large Intestine	Without Complications			
K50.80 Crohi	n's Disease of S	mall & Large Intestine Without Complicat					
		specified, Without Complications	K51.00 Ulcerative (chronic) pancolitis with	•			
		ectosigmoiditis without complications	K51.50 Left sided colitis without complicat				
		pecified, without complications	Other Code: Description				
<u>Patient Clinical</u>							
llergies:			Weight:lb/kg Height:in/c	cm			
B Test Result: _			s status:				
		? Yes No					
	roduct used:	Last dose given: _	Next dose due:				
<u>lursing:</u>							
		te injection training/ home health infusio					
		fusion Clinic 🔲 Outpatient Health 🔲 Ho	ome Health				
		Date training occurred:	Secretary Management				
Reason: MD	office training p		erred by MD to alternate trainer				
eason: MD Prescriber Phone	office training p e:	Date training occurred:atient  Pt already independent  Ref	erred by MD to alternate trainer				
eason: MD MD rescriber Phone PRESCRIPT	office training pe: e: ION INFORM	Date training occurred:atient  Pt already independent  Ref					
Reason: MD Prescriber Phone PRESCRIPT	office training pe: e: ION INFORM	Date training occurred:atient  Pt already independent  Ref		QUANTITY/REFILLS			
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Reason: MD MD Prescriber Phone PRESCRIPT	office training pe: e: ION INFORM	Date training occurred:atient  Pt already independent Ref  ATION  DOSE & D  Crohn's Disease (Adult and Pediatri 5 mg/kg (Dose =mg) at weeks	DIRECTIONS  c ≥6 years old) <u>Induction Dose</u> : Infuse IV at s 0, 2, 6 and every 8 weeks thereafter	Quantity: # of 100 mg vial(s)			
Reason: MD MD Prescriber Phone PRESCRIPT	office training pe: e: ION INFORM	Date training occurred:  atient Pt already independent Ref  ATION  DOSE & D  Crohn's Disease (Adult and Pediatri 5 mg/kg (Dose =mg) at weeks Crohn's Disease (Adult) Maintenance	DIRECTIONS  c ≥6 years old) Induction Dose: Infuse IV at s 0, 2, 6 and every 8 weeks thereafter ce Dose: Infuse IV at 5-10 mg/kg	Quantity:			
Reason: MD Prescriber Phone PRESCRIPT	office training pe: e: ION INFORM	Date training occurred:atient  Pt already independent Ref  ATION  DOSE & D  Crohn's Disease (Adult and Pediatri 5 mg/kg (Dose =mg) at weeks Crohn's Disease (Adult) Maintenand (Dose =mg) every 8 weeks	DIRECTIONS  c ≥6 years old) <u>Induction Dose</u> : Infuse IV at s 0, 2, 6 and every 8 weeks thereafter the Dose: Infuse IV at 5-10 mg/kg  old) <u>Maintenance Dose</u> : Infuse IV at	Quantity: # of 100 mg vial(s)			
Reason: MD Prescriber Phone PRESCRIPT MEDICATION	office training pe:  ION INFORM  STRENGTH	Date training occurred:  atient ☐ Pt already independent ☐ Ref  ATION  DOSE & D  ☐ 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 5 mg/kg (Dose =mg) every 8 weeks	DIRECTIONS  c ≥6 years old) <u>Induction Dose</u> : Infuse IV at s 0, 2, 6 and every 8 weeks thereafter the Dose: Infuse IV at 5-10 mg/kg  old) <u>Maintenance Dose</u> : Infuse IV at	Quantity: # of 100 mg vial(s)			
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Reason: MD Prescriber Phone PRESCRIPT MEDICATION  Avsola Patient is interested	office training perecent of the strength of th	Date training occurred:  atient ☐ Pt already independent ☐ Ref  ATION  DOSE & D  ☐ 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 5 mg/kg (Dose =mg) every 8 very 8 v	C≥6 years old) Induction Dose: Infuse IV at a co. 2, 6 and every 8 weeks thereafter coe Dose: Infuse IV at 5-10 mg/kg  old) Maintenance Dose: Infuse IV at weeks ic ≥6 years old) Induction Dose: Infuse IV at a co. 2, 6 and every 8 weeks thereafter ic ≥6 years old) Maintenance Dose: Infuse IV at co. 2, 6 and every 8 weeks thereafter ic ≥6 years old) Maintenance Dose: Infuse IV at co. 2, 6 and every 8 weeks Infuse IV at co. 2, 6 and every 8 weeks Infuse IV at co. 2, 6 years old) Maintenance Dose: Infuse IV at co.	Quantity:# of 100 mg vial(s) Refills:			
Reason: MD Prescriber Phone PRESCRIPT MEDICATION  Avsola  Patient is interested  "Dispense As Writt DAW / May Not Sul	office training personal continuity of the strength of the str	Date training occurred:  atient ☐ Pt already independent ☐ Ref  ATION  DOSE & D  ☐ 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 5 mg/kg (Dose =mg) every 8 w ☐ Ulcerative Colitis (Adult and Pediatr 5 mg/kg (Dose =mg) at weeks ☐ Ulcerative Colitis (Adult and Pediatr Infuse IV at 5 mg/kg (Dose =m ☐ Other:	C ≥6 years old) Induction Dose: Infuse IV at s 0, 2, 6 and every 8 weeks thereafter the Dose: Infuse IV at 5-10 mg/kg  old) Maintenance Dose: Infuse IV at weeks  ic ≥6 years old) Induction Dose: Infuse IV at s 0, 2, 6 and every 8 weeks thereafter ic ≥6 years old) Maintenance Dose:  ing) every 8 weeks  OTALLOWED  Ancillary supplies and kits prove the substitution Permissible  May Substitute / Product Selection Permitted / Substitution Permissible	Quantity: # of 100 mg vial(s) Refills:  ided as needed for administration			

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.

### **Inflammatory Bowel Disease Enrollment Form**

Medications C-H (Cimzia, Entyvio, Humira)

	Please Complete Pa	tient <u>and</u> F	Prescriber Information	
Patient Name:		Patient DOB:		
Prescriber Name:			Prescriber Phone:	
Patient Clinical Ir			lh/kg Hoight	In/om
Riergies B Test Result:			lb/kg Height:	III/CIII
	ON INFORMATION	ato	<del></del>	
MEDICATION	STRENGTH		DOSE & DIRECTIONS	QUANTITY/REFILLS
MEDIOATION		Induction I	Dose: Inject SC 400 mg (2 injections) on day	Quantity: 1 kit
☐ Cimzia	Cimzia Starter Kit (6 prefilled syringes)	1, and at w with 400 n	eeks 2 and 4. If response occurs, following every four weeks	(6 prefilled syringes) Refills: 0
Cimzia	200 mg/1 mL prefilled syringe 200 mg vial	Maintenan	oce <u>Dose</u> : Inject SC 400 mg ns) every 4 weeks	Quantity: Refills:
☐ Entyvio	300 mg in a single dose vial in individual carton	30 minutes thereafter Maintes 30 minutes	ion Dose: 300 mg infused IV over s at 0, 2 and 6 weeks, then every 8 weeks nance Dose: 300 mg infused IV over s every 8 weeks	Quantity: Refills:
☐ Humira	Adult Crohn's Disease/Ulcerative Colitis: PEN HUMIRA Starter Pack (CF) 80 mg/0.8 mL	then conting Inject \$ 80 mg on I dose starti	SC 160 mg on Day 1, 80 mg on Day 15, nue with maintenance dose starting Day 29 SC 80 mg on Day 1, 80 mg on Day 2, Day 15, then continue with maintenance	Quantity: 1 kit (3 pens) Refills: 0
☐ Humira	Adult Crohn's Disease/Ulcerative Colitis:  PEN HUMIRA (CF) 40 mg/0.4 mL SYRINGE HUMIRA (CF) 40 mg/0.4 mL PEN HUMIRA 40 mg/0.8 mL SYRINGE HUMIRA 40 mg/0.8 mL	Maintenance Dose:  Inject SC 40 mg every other week  Other:		Quantity:  #2 (1 month) #6 (3 month) Refills:
Humira	17 kg (37 lbs) to less than 40 kg (88 lbs); ≥ 6 years: SYRINGE HUMIRA Starter Pack (CF) 80 mg/0.8 mL, 40 mg/0.4 mL	Pediatric Crohn's Disease Initial Dose:  Inject SC 80 mg Day 1, then 40 mg Day 15, then continue with maintenance dose starting Day 29		Quantity: 1 kit (2 syringes) Refills: 0
☐ Humira	40 kg (88 lbs) and greater; ≥ 6 years:  ☐ PEN HUMIRA Starter Pack (CF)  80 mg/0.8 ml ☐ SYRINGE HUMIRA Starter Pack (CF)  80 mg/0.8 mL ☐ PEN HUMIRA Starter Pack  40 mg/0.8 mL ☐ SYRINGE HUMIRA Starter Pack  40 mg/0.8 mL ☐ SYRINGE HUMIRA Starter Pack  40 mg/0.8 mL	Pediatric Crohn's Disease Initial Dose:  Inject SC 160 mg Day 1, then 80 mg Day 15, then continue with maintenance dose starting Day 29  Inject SC 80 mg Day 1, 80 mg Day 2, 80 mg Day 15, then continue with maintenance dose starting Day 29  Other:		Quantity: QS Refills: 0
Humira	17 kg (37 lbs) to less than 40 kg (88 lbs); ≥ 6 years: SYRINGE HUMIRA (CF) 20 mg/0.2 mL	Pediatric Crohn's Disease Maintenance Dose:  ☐ Inject SC 20 mg every other week ☐ Other:		Quantity:  #2 (1 month)  #6 (3 month)  Refills:
Patient is interested ir	patient support programs  STAMP SIG  PRESCRIBER SIGNATURE REQU	NATURE NOT AI		ided as needed for administration
DAW / May Not Subs Prescriber's Sig	n" / Brand Medically Necessary / Do Not Substitute / No Substitute gnature:Date: terchange is mandated unless Prescriber writes the words "No Substitute"		May Substitute / Product Selection Permitted / Substitution Permissible Prescriber's Signature:  ATTN: New York and Iowa providers, p	

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#### **Inflammatory Bowel Disease Enrollment Form**

Medications H-R (Humira, Inflectra, Infliximab, Remicade, Renflexis)

		Complete Patient and I	Prescriber Information	
Patient Name:			Patient DOB:	
			Prescriber Phone:	
Patient Clinical In			lb/kg Height:	In/cm
B Test Result:	weight	Date:	ib/kg Height.	
	ON INFORMATION	Bute		
MEDICATION	STRENGTH	DOS	SE & DIRECTIONS	QUANTITY/REFILLS
MEDICATION	40 kg (88 lbs) and greater;		SE & DIRECTIONS	Quantity:
☐ Humira	≥ 6 years:  □ PEN HUMIRA (CF)  40 mg/0.4 mL □ SYRINGE HUMIRA (CF)  40 mg/0.4 mL □ PEN HUMIRA  40 mg/0.8 mL □ SYRINGE HUMIRA  40 mg/0.8 mL	Pediatric Crohn's Disease M Inject SC 40 mg every o Other:	other week	#2 (1 month) #6 (3 month) Refills:
☐ Humira	20 kg (44 lbs) to less than 40 kg (88 lbs); ≥ 5 years:  ☐ PEN HUMIRA (CF) 40 mg/0.4 mL ☐ SYRINGE HUMIRA (CF) 40 mg/0.4 mL	Pediatric Ulcerative Colitis II Inject SC 80 mg Day 1, 4 continue with maintenance Other:	0 mg weekly (Day 8 and Day 15), then dose starting Day 29	Quantity: 4 Pens/4 Prefilled syringes Refills: 0
☐ Humira	20 kg (44 lbs) to less than 40 kg (88 lbs); ≥ 5 years:  ☐ PEN HUMIRA (CF) 40 mg/0.4 mL ☐ PEN HUMIRA (CF) 40 mg/0.4 mL ☐ SYRINGE HUMIRA (CF) 20 mg/0.2 mL	Pediatric Ulcerative Colitis M	reek	Quantity:  1-month supply 3-month supply Refills:
☐ Humira	40 kg (88 lbs) and greater; ≥5 years:  □ PEN HUMIRA (CF) 80 mg/0.8 mL □ PEN HUMIRA (CF) 40 mg/0.4 mL □ SYRINGE HUMIRA (CF) 40 mg/0.4 mL	Pediatric Ulcerative Colitis N Inject SC 40 mg every w Inject SC 80 mg every of Other:	reek	Quantity:  1-month supply  3-month supply  Refills:
☐ Inflectra		Dose: Infuse IV at 5 mg/kg every 8 weeks thereafter	and Pediatric ≥6 years old) <u>Induction</u> (Dose =mg) at weeks 0, 2, 6 and <u>Maintenance Dose</u> : Infuse IV at	
☐ Infliximab	100 mg vial		mg) every 8 weeks ric ≥6 years old) <u>Maintenance Dose</u> : =mg) every 8 weeks	Quantity: # of 100 mg vial(s)
Remicade		Ulcerative Colitis (Adult a	and Pediatric ≥6 years old) <u>Induction</u> (Dose =mg) at weeks 0, 2, 6 and	Refills:
Renflexis		Ulcerative Colitis (Adult	and Pediatric ≥6 years old) <u>Maintenance</u> (Dose =mg) every 8 weeks	
Patient is interested in	patient support programs  PRESCRIBER SIGNA	STAMP SIGNATURE NOT AI	Ancillary supplies and kits pure AMP SIGNATURE NOT ALLOW	rovided as needed for administration
•	n" / Brand Medically Necessary / Do No	t Substitute / No Substitution /	May Substitute / Product Selection Permitted /	
DAW / May Not Subs	titute <b>jnature:</b>	Date:	Substitution Permissible  Prescriber's Signature:	Date:
Drocoribar's C:-				Date <sup>,</sup>

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. ©2022 CVS Pharmacy, Inc. and one of its affiliates. 75-35829D 03/24/22

### **Inflammatory Bowel Disease Enrollment Form**

Medications R-Z (Rinvoq, Simponi, Stelara, Tysabri, Xeljanz, Zeposia)

Detient No.		Complete Patient and I		
			Patient DOB:	
Prescriber Name:  Patient Clinical In			Prescriber Phone:	
			lb/kg Height:	ln/cm
TB Test Result:	vveignt.	Date:	lb/kg Height	
_	ON INFORMATION	Duto		
MEDICATION	STRENGTH	DOSI	E & DIRECTIONS	QUANTITY/REFILLS
WEDICATION	STRENGTH	Induction Dose:	L & DIRECTIONS	Quantity: 1 btl = 28
Rinvoq	45 mg	Take 1 tablet once daily fo	or 8 weeks	Refill: 1
Rinvoq	☐ 15 mg ☐ 30 mg	Maintenance Dose:  Take 1 tablet once daily Other:		Quantity: Refills:
Simponi	☐ 100 mg/mL in a single- dose prefilled SmartJect autoinjector ☐ 100 mg/mL in a single- dose prefilled syringe	☐ Induction Dose: Inject SC 2 subcutaneous injections of 100 mg at Week 2 and then 1 ☐ Maintenance Dose: Inject ☐ Other:	100 mg each) at Week 0, followed by 100 mg every 4 weeks	Quantity: Refills:
☐ Stelara	130 mg/26 mL (5 mg/mL)  IV single-dose vial  Date Infusion was completed or scheduled: (This date is needed to determine shipment of Stelara SC maintenance dosage)	more than 55 kg to 85 kg	Veek 0: # of vials to be used 2 390 mg at Week 0: # of vials to be used 3 at Week 0: # of vials to be used 4	Quantity: 2 Vials 3 Vials 4 Vials Refills: 0
Stelara	90 mg/mL SC dose in a single-dose prefilled syringe	every 8 weeks thereafter  Other:	after the initial IV induction dose, then	Quantity: Refills:
Tysabri	NA			Quantity: 0 Refills: 0
☐ Xeljanz	☐ 5 mg ☐ 10 mg	☐ 10 mg twice daily for at least 8 weeks; followed by 5 or 10 mg twice daily, depending on therapeutic response. Use the lowest effective dose to maintain response.  Discontinue Xeljanz after 16 weeks of treatment with 10 mg twice daily if adequate therapeutic benefit is not achieved.  ☐ Other:		Quantity: Refills:
Zeposia	Starter Kit (4 capsules of 0.23 mg, 3 capsules of 0.46 mg and one bottle containing 30 capsules of 0.92 mg)	Take 0.23 mg capsule once daily on days 1-4, followed by 0.46 mg capsule once daily on days 5-7, then take 0.92 mg capsule once daily starting on day 8)		Quantity: 37-day supply Refill: 0
Zeposia	7-Day Starter Pack (4 capsules of 0.23 mg and 3 capsules of 0.46 mg)	☐ Take 0.23 mg capsule once daily on days 1-4, followed by 0.46 mg capsule once daily on days 5-7		Quantity: 7-day supply Refill: 0
Zeposia	0.92 mg capsules	☐ Take 0.92 mg capsule once daily ☐ Other:		Quantity: Refills:
Patient is interested in	n patient support programs  PRESCRIBER SIGNA	STAMP SIGNATURE NOT A	Ancillary supplies and kits p  FAMP SIGNATURE NOT ALLOY	rovided as needed for administration <b>NED</b> )
DAW / May Not Subs Prescriber's Sig	n" / Brand Medically Necessary / Do N	ot Substitute / No Substitution /  Date:	May Substitute / Product Selection Permitted / Substitution Permissible  Prescriber's Signature:	

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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## Inflammatory Bowel Disease Enrollment Form Nursing Medications

	<u>Please Co</u>	<u>mplete Patient and</u>	Prescriber Information	
Patient Name:			Patient DOB:	
Prescriber Name:			Prescriber Phone:	
Patient Clinical Information:				
			lb/kg Height:	In/cm
B Test Result:		Date:		
PRESCRIPTION INFOR				
<u>Complete Items below, req</u>				
MEDICATION/SUPPLIES	ROUTE	DOSE/S	TRENGTH/DIRECTIONS	QUANTITY/REFILLS
Catheter PIV PORT PICC	IV	maintain IV access and p PIV – NS 5 mL (Heparin 1	0 units/mL 3-5 mL if multiple days) & Heparin 100 units/mL 3-5 mL,	Quantity: Refills:
Hydration: NS D5W	IV	Pre: 500 mL 1000 mL Ot Other: (Not to be 500 mL 1000 mL Other:		
Epinephrine **nursing requires**	□ IM □ SC	Adult 1:1000, 0.3 mL   Peds 1:2000, 0.3 mL   Infant 0.1 mL/0.1 mL, PRN severe allergic reac May repeat in 5-15 minut	Quantity: Refills:	
Diphenhydramine Oral	PO	Premedication  12.25 mg/kg (0-30 kg  25 mg  50 mg (Over 30 kg)  PRN severe allergic reac	Quantity: Refills:	
Diphenhydramine 50 mg/mL vial	Slow IV	1 mg/kg (under 15 kg) 12.5-50 mg (15-30 kg) 25 mg 50 mg (Over 30 kg) PRN severe allergic reaction – Call 911 May repeat in 3-5 minutes as needed (Max dose-50 mg)		Quantity: Refills:
☐ Flush Orders	Peripheral Access Central Venus Access	20 mL NS post flush 30 mL NS post flush 40 mL NS post flush 50 mL NS post flush		Send quantity sufficient for medication days supply
Additional Medication:				
Patient is interested in patient support		STAMP SIGNATURE NOT A	Ancillary supplies and kits TAMP SIGNATURE NOT ALLO	s provided as needed for administration
"Dispense As Written" / Brand Medic DAW / May Not Substitute <b>Prescriber's Signature:</b>	cally Necessary / Do Not Su		May Substitute / Product Selection Permitted / Substitution Permissible	D.A.
		Date:	Prescriber's Signature:	Date:

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#### **Other Gastroenterology Enrollment Form**



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 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: Last Four of SSN: \_\_\_\_\_ Primary Language: \_\_\_\_\_ 2 PRESCRIBER INFORMATION \_\_\_\_\_ State License #: \_\_\_\_\_ Prescriber's Name: NPI #: \_\_\_\_\_ DEA #: \_\_\_\_ Group or Hospital: \_\_ \_\_\_\_\_ City, State, ZIP Code: \_\_\_\_\_\_ INSURANCE INFORMATION Please fax copy of prescription and insurance cards with this form, if available (front and back) 4 DIAGNOSIS AND CLINICAL INFORMATION Ship to: Patient Office Other: Needs by Date: Diagnosis (ICD-10): B16.0 Acute Hepatitis B with delta-agent with hepatic coma B16.1 Acute Hepatitis B with delta-agent without hepatic coma B16.2 Acute Hepatitis B without delta-agent with hepatic coma B16.9 Acute Hepatitis B without delta-agent and without hepatic coma B18.0 Chronic Viral Hepatitis B with delta-agent B18.1 Chronic Viral Hepatitis B without delta-agent B19.10 Unspecified Viral Hepatitis B without hepatic coma B19.11 Unspecified Viral Hepatitis B with hepatic coma K90.89 Other intestinal malabsorption K90.9 Intestinal malabsorption, unspecified R15.9 Full incontinence of feces Other Code: \_\_\_\_ Description \_\_\_\_\_ **Patient Clinical Information:** Allergies: lb/kg Height: In/cm TB Test Result: Weight: **Nursing and Administration:** Specialty pharmacy to coordinate injection training/home health nurse visit as necessary? Tyes 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 STAMP SIGNATURE NOT ALLOWED ☐ Patient is interested in patient support programs Ancillary supplies and kits provided as needed for administration

## Other Gastroenterology Enrollment Form Medications H – Z

(Baraclude, Epivir-HBV, Hepsera, Vemlidy, Zorbtive, Solesta Injectable Gel)

atient Name:		•	Prescriber Information attent DOB:	
rescriber Name	:	Pr	rescriber Phone:	
PRESCRIP	TION INFORMATION			
MEDICATION	STRENGTH	DOSE	& DIRECTIONS	QUANTITY/REFILLS
Baraclude	0.5 mg tablet 1 mg tablet 0.05 mg/mL oral solution	-	on an empty stomach (at least two vo hours before the next meal)	Quantity: 30-day supply Other: Refills:
☐ Epivir-HBV	100 mg tablet 5 mg/mL oral solution	Take one tablet once	•	Quantity:  30-day supply Other: Refills:
Hepsera	10 mg tablet	Take one tablet one		Quantity: 30-day supply Other: Refills:
☐ Vemlidy	25 mg tablet	☐ Take one tablet one	ce daily with food	Quantity:  30-day supply  Other:  Refills:
5b PRESCRIP MEDICATION	TION INFORMATION- SH STRENGTH		DROME E&DIRECTIONS	QUANTITY/REFILLS
Zorbtive	8.8 mg vial		mL (dose = mg)	Quantity: packages (7 vials per package) Refills:
	TION INFORMATION- FE			
MEDICATION  Solesta  Injectable Gel	4 pre-filled syringes, each containing 1 mL of Solesta + 4 individually wrapped		e shipped to prescriber's rwise specified	QUANTITY/REFILLS Quantity: 1 Kit Refills:
	SteriJect needles	STAMP SIGNATURE NOT AL	,	its provided as needed for administration
6 F	PRESCRIBER SIGNATU	RE REQUIRED (S	TAMP SIGNATURE NO	T ALLOWED)
	n" / Brand Medically Necessary / Do Not Su	ubstitute / No Substitution /	May Substitute / Product Selection Perm	nitted /
"Dispense As Writter DAW / May Not Subs		Date:	Substitution Permissible	

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