

Rheumatology IV Enrollment Form Medications A

(Actemra, 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 Submitting | a Referral | |
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| Address: | | City, Sta | te, ZIP Code: | |
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| | | ease fax copy of prescription and insurance ca | rds with this form if available | - (front and back) |
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| Veeds by Date | | | Patient 🗌 Office 🗌 Other: | |
| Diagnosis (ICE | | Ship to: | | |
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| PRESCRIPT MEDICATION Actemra Actemra Avsola Patient is interest | ed in patient support programs | me health infusion nurse visit necessary: Yest DOSE & DIRECT Induction Dose: Infuse 4 mg/kg every 6 | s No | Quantity: Refills: Quantity: # of 100 mg vial(s) Refills: |

CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "No Substitution"_ 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. or one of its affiliates. 75-38703C 03/21/22

Rheumatology IV Enrollment Form Medications B-Z

| | | | | cade, Renflexis, Rituxan, Simponi ARIA) r and Patient Clinical Information | |
|-----------------------------|--|--|--|--|--|
| Patient Name: | Ficase of | | | Patient DOB: | |
| Prescriber Name: | | | | Prescriber Phone: | |
| Patient Clinica | | | | | |
| Allergies: | | | | | |
| Weight: | lb/kg He | ight: | In/cm | TB Test Result: | Date: |
| 5 PRESCRIPTI | ON INFORMATION | | | | |
| MEDICATION | STRENGTH | | | SE & DIRECTIONS | QUANTITY/REFILLS |
| ☐ Inflectra ☐ Infliximab | 100 mg vial | (Dose =m Ankylosing Spo (Dose =m Psoriatic Arthrit (Dose =m Psoriatic Arthrit (Dose =m Rheumatoid Art (Dose =m | g) at weeks ndylitis <u>Ma</u> g) every 6 v is <u>Induction</u> g) at weeks g) every 8 v hritis <u>Indur</u> g) at weeks hritis <u>Main</u> | <u>n Dose</u> : Infuse IV at 5 mg/kg s 0, 2, 6 and every 8 weeks thereafter <u>ance Dose</u> : Infuse IV at 5 mg/kg | Quantity: # of 100 mg vial(s) Refills: |
| Orencia | 250 mg vial | | | 2 and 4, then every 4 weeks thereafter. | Quantity: Refills: |
| Remicade Renflexis | 100 mg vial | (Dose =m Ankylosing Spo (Dose =m Psoriatic Arthrit (Dose =m Psoriatic Arthrit (Dose =m Rheumatoid Art (Dose =m | g) at weeks ndylitis <u>Ma</u> g) every 6 v is <u>Induction</u> g) at weeks is <u>Maintens</u> g) every 8 v chritis <u>Induc</u> g) at weeks chritis <u>Main</u> g) every 4, | <u>n Dose</u> : Infuse IV at 5 mg/kg s 0, 2, 6 and every 8 weeks thereafter <u>ance Dose</u> : Infuse IV at 5 mg/kg | Quantity: # of 100 mg vial(s) Refills: |
| Rituxan | ☐ 100 mg/10 mL vial ☐ 500 mg/50 mL vial | Infuse two dose Other: | | ng separated by 2 weeks. | Quantity: Refills: |
| Simponi ARIA | 50 mg/4 mL in a single use vial | Ankylosing Spondy 4, then every 8 wee Pediatric patien | litis: Infuse eks thereaf ts with pol | atoid Arthritis, Psoriatic Arthritis, and e 2 mg/kg over 30 minutes at weeks 0 and ter. yarticular Juvenile Idiopathic Arthritis and intravenous infusion over 30 minutes at | Quantity: # of 50 mg vial Refills: |

Patient is interested in patient support programs

STAMP SIGNATURE NOT ALLOWED

weeks 0 and 4, and every 8 weeks thereafter

Ancillary supplies and kits provided as needed for administration

6 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

| Prescriber's Signature: | Date: | 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 prescripti | | | |

CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "No Substitution" ______ A

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.

Rheumatology IV Enrollment Form Nursing Medications

| | | Ital sing medications | |
|--|---|--|--|
| | Please Comple | ete Patient , Prescriber and Patient Clinical Information | |
| Patient Name: | | Patient DOB: | |
| Prescriber Name: | | | |
| Patient Clinical Informat | ion: | | |
| | | | |
| Weight: | lb/kg Height:_ | In/cm TB Test Result: | Date: |
| PRESCRIPTION INFO | | | |
| Complete Items below, r | | | |
| MEDICATION/SUPPLIES | ROUTE | DOSE/STRENGTH/DIRECTIONS | QUANTITY/REFILLS |
| Catheter | 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 0.1 mL/0.1 mL, 0.1mL (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 | O.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 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 Pres | criber writes the words "No Substitution" | ATTN: New York and Iowa provid | lers, 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.

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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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