## Asthma Enrollment Form Medications A-C

(Cinqair)



Fax Referral To: 1-888-280-1191 OR 787-759-4161

Phone: 1-888-280-1190 OR 787-759-4162

Email Referral To: Customer.ServiceFax@CVSHealth.com

Address: 280 Avenida Jesus T. Pinero Ste B Rio Piedras, PR 00927

referred Contact Methods:   Phone (to primary # provided below)   Text (to cell # provided below)   Email (to email provided below) obte: Carrier charges may apply. If unable to contact via text or email. Specialty Pharmacy will attempt to contact by phone. Irrimary Phone:   Alternate Phone:   Alternate Phone:   Alternate Phone:   Elationship to minor:   Elationsh	atient Name: _			)	ND.
Pereinage   Pere					
Preferred Contact Methods:				Jity, State, ZIP Code: _	
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Minor, Parent/Caregiver/Guardian Name (Last, First):   elationship to minor:					
Last Four of SSN:					
PRESCRIBER INFORMATION   State License #:   State License #:     Primary Language:					
PRESCRIBER INFORMATION    Prescriber's Name:	mail.		Last Four	of SSN: Pri	mary Language:
Person   DEA #:   DEA #:   Group or Hospital:	DDFSCDIRE	ΡΙΝΕΟΡΜΑΤΙΟΝ		51 <b>0011</b> .	mary Language.
Contact's Phone:				State License #:	
Contact's Phone:	IDI #·	DFΔ #·	Group or Hospital:	State Licerise #	
INSURANCE INFORMATION   Please fax copy of prescription and insurance cards with this form, if available (front and back)   DIAGNOSIS AND CLINICAL INFORMATION	1444	DLA #	Group of Flospitat	te 71P Code:	
INSURANCE INFORMATION   Please fax copy of prescription and insurance cards with this form, if available (front and back)   DIAGNOSIS AND CLINICAL INFORMATION	hone:	Fax	Contact Person:		Contact's Phone:
DIAGNOSIS AND CLINICAL INFORMATION	INSURANCI	EINFORMATION DIA	ase fax conv of prescription and in	nsurance cards with th	is form if available (front and back)
Ship to:   Patient   Office   Other:				isaranos saras with ti	io rorm, ii available (iront and back)
Diagnosis (ICD-10):   J45.4 Moderate Persistent Asthma				Office Other:	
J45.4 Moderate Persistent Asthma	-		Ship to. [_] Patient [		
D72.119 Hypereosinophilic syndrome (HES)	<b></b>	<del></del>		avara Daraiatant Aathu	
J33.0 Potyp of the nasal cavity		rate Persistent Astrima			
□ J33.9 Nasal Polyp, unspecified (indication for dupilumab and omalizumab)  □ Other Code: □ Description □  □ Patient Clinical Information:  □ Using the Clinical Information:  □ Using the Clinical Information:  □ Using the Clinical Information:  □ Veight: □ Ib/kg	D72.119 Hyp	ereosinopnilic synaron	ne (HES)		
Other Code:Description	J33.0 Polyp	of the nasal cavity	L 1 J33 1 Polypoid sinus dedi	anaration   1/2/2	
Weight:lb/kg	¬				
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PRESCRIPTION INFORMATION  MEDICATION  STRENGTH  DOSE & DIRECTIONS  QUANTITY/REFILI  Inject 3 mg/kg once every 4 weeks by IV infusion over 20 to 50 minutes   Include sodium chloride and supplies sufficient for medication days   Supply	Other Code:	Polyp, unspecified (ind	lication for dupilumab and omaliz		
PRESCRIPTION INFORMATION  MEDICATION STRENGTH DOSE& DIRECTIONS QUANTITY/REFILE    Inject 3 mg/kg once every 4 weeks by IV infusion over 20 to 50 minutes   Quantity:   Quantity:   yials   supply   Include sodium chloride and supplies sufficient for medication days   supply   IV administration/infusion set (0.2micron filter)   yo-day supply   90-day supply   IV Cath Insyte autoguard or PIV insertion kit   Ultrasyte needle-free connector (one per vial shipped)   30 mL syringe (one per vial shipped)   1 year   50 mL 0.9% NaCl   2 - 10 mL 0.9% NaCl flush   Alcohol swabs    Patient is interested in patient support programs   STAMP SIGNATURE NOT ALLOWED   STAMP SIGNATURE NOT ALLOWED    "Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute   Product Selection Permitted / Substitution Permissible	Other Code: Patient Clinica	Polyp, unspecified (ind Description _ I Information:	lication for dupilumab and omalize	umab) 🔲 K20	0.0 Eosinophilic esophagitis (EoE)
MEDICATION  STRENGTH  DOSE & DIRECTIONS  QUANTITY/REFILE  Inject 3 mg/kg once every 4 weeks by IV infusion over 20 to 50 minutes Include sodium chloride and supplies sufficient for medication days supply Include sodium chloride and supplies sufficient for medication days supply Include sodium chloride and supplies sufficient for medication days supply Include sodium chloride and supplies sufficient for medication days supply Include sodium chloride and supplies sufficient for medication days supply Include sodium chloride and supplies sufficient for medication days Include sodium chloride and supplies sufficient for medication days Include sodium chloride and supplies sufficient for medication days Include sodium chloride and supplies sufficient for medication days Include sodium chloride and supplies sufficient for medication days Include sodium chloride and supplies sufficient for medication days Include sodium chloride and supplies sufficient for medication days Include sodium chloride and supplies sufficient for medication days Include sodium chloride and supplies sufficient for medication days Include sodium chloride and supplies sufficient for medication days Include sodium chloride and supplies sufficient for medication days Include sodium chloride and supplies sufficient for medication days Include sodium chloride and supplies sufficient for medication days Include sodium chloride and supplies sufficient for medication days Include sodium chloride and supplies sufficient for medication days Include sodium chloride and supplies sufficient for medication days Include sodium chloride and supplies sufficient for medication days Include sodium chloride and supplies sufficient for medication days Include sodium chloride and supplies sufficient for medication days Include sodium chloride and supplies sufficient for medication days Include supplies sufficient for medication days Include sodium chloride and supplies supplies and supplies sufficient for medication days Include sodium chloride deviate por case sup	Other Code: Patient Clinica Illergies:	Polyp, unspecified (ind Description _ I Information:	lication for dupilumab and omalize	umab)	0.0 Eosinophilic esophagitis (EoE)  /cm   IgE Level:
Inject 3 mg/kg once every 4 weeks by IV infusion over 20 to 50 minutes   Quantity:   Include sodium chloride and supplies sufficient for medication days supply   IV administration/infusion set (0.2micron filter)   90-day supply   90-day supply   90-day supply   100 mg/10 mL vial   10	Other Code: Patient Clinical Allergies: Osinophil coun	Polyp, unspecified (ind Description _ ! Information: ht: Cells/µL Date	lication for dupilumab and omalize  Weight:lb/kg of test: _/_/ Number of exact	umab)	0.0 Eosinophilic esophagitis (EoE)  /cm   IgE Level:
Include sodium chloride and supplies sufficient for medication days supply	Other Code: atient Clinical llergies: osinophil coun	Polyp, unspecified (ind Description_ Information: ht: Cells/µL Date ION INFORMATION	lication for dupilumab and omalize  Weight:lb/kg of test: _/_/ Number of exac	umab)	0.0 Eosinophilic esophagitis (EoE)  /cm
Cinqair (reslizumab)   100 mg/10 mL vial   Supply   100 mg/10 mL vial   100 mg/10 mL	Other Code: Patient Clinical Allergies: cosinophil coun	Polyp, unspecified (ind Description_ Information: ht: Cells/µL Date ION INFORMATION	lication for dupilumab and omalize  Weight:lb/kg of test: _/_/ Number of exact	Height:in, erbations in the last 12	0.0 Eosinophilic esophagitis (EoE)  /cm
Cinqair (reslizumab)	Other Code: Patient Clinical Allergies: cosinophil coun	Polyp, unspecified (ind Description_ Information: ht: Cells/µL Date ION INFORMATION	Weight:lb/kg of test:/_/ Number of exac  DOSE & Inject 3 mg/kg once every 4 week	Height:in, erbations in the last 12  DIRECTIONS s by IV infusion over 20 to	O.O Eosinophilic esophagitis (EoE)  /cm
Cinqair (reslizumab)  - IV Cath Insyte autoguard or PIV insertion kit - Ultrasyte needle-free connector (one per vial shipped) - 30 mL syringe (one per vial shipped) - 50 mL 0.9% NaCl - 2 − 10 mL 0.9% NaCl flush - Alcohol swabs  - Patient is interested in patient support programs  - STAMP SIGNATURE NOT ALLOWED  - Ancillary supplies and kits provided as needed for administration  - PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)  - "Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / Substitute / Product Selection Permitted / Substitution Permissible	Other Code: Patient Clinical Allergies: cosinophil coun	Polyp, unspecified (ind Description_ Information: ht: Cells/µL Date ION INFORMATION	Weight:lb/kg of test:/_/ Number of exact  DOSE &  Inject 3 mg/kg once every 4 week Include sodium chloride and so	Height:in, erbations in the last 12  DIRECTIONS s by IV infusion over 20 to	O.O Eosinophilic esophagitis (EoE)  O'CM
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• 50 mL 0.9% NaCl     • 2 – 10 mL 0.9% NaCl flush     • Alcohol swabs  Patient is interested in patient support programs  STAMP SIGNATURE NOT ALLOWED  Ancillary supplies and kits provided as needed for administration  PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)  "Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / Substitute / Product Selection Permitted / Substitution Permissible	Other Code: Patient Clinical Allergies: Cosinophil count PRESCRIPT MEDICATION  Cinqair	Polyp, unspecified (ind Description _ ! Information: ht: Cells/µL Date ION INFORMATION STRENGTH	Weight:lb/kg of test:/_/ Number of exact  DOSE &  Inject 3 mg/kg once every 4 week	Height:in/ erbations in the last 12  DIRECTIONS s by IV infusion over 20 to upplies sufficient for medical control of the control of th	O.O Eosinophilic esophagitis (EoE)  O'cm   IgE Level:  months:  QUANTITY/REFILL  O 50 minutes   Quantity: vials   vials   30-day supply   90-day supply  day supply
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• Alcohol swabs  Patient is interested in patient support programs  STAMP SIGNATURE NOT ALLOWED  Ancillary supplies and kits provided as needed for administration  PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)  "Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / Substitute / Product Selection Permitted / Substitution Permissible	Other Code: Patient Clinical Allergies: Cosinophil count PRESCRIPT MEDICATION  Cinqair	Polyp, unspecified (ind Description _ ! Information: ht: Cells/µL Date ION INFORMATION STRENGTH	Weight:lb/kg of test:/_/ Number of exact  DOSE &  Inject 3 mg/kg once every 4 week	Height:in/ erbations in the last 12  DIRECTIONS s by IV infusion over 20 to upplies sufficient for med .2micron filter) insertion kit (one per vial shipped)	O.O Eosinophilic esophagitis (EoE)  O'CM
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Prescriber's Signature:Date:	Other Code: Patient Clinical Allergies: Cosinophil count PRESCRIPT MEDICATION  Cinqair (reslizumab)  Patient is intereste	Polyp, unspecified (ind Description Information:  It: Cells/µL Date  ION INFORMATION  STRENGTH  100 mg/10 mL vial  d in patient support programs  6 PRESCRIBER \$	Weight:lb/kg of test: _/_/ Number of exact  DOSE & Inject 3 mg/kg once every 4 week	Height:in/erbations in the last 12  DIRECTIONS s by IV infusion over 20 to applies sufficient for med applies sufficient for med applies sufficient supplies (one per vial shipped) oped)  Ancillary supplies  AMP SIGNATURE	QUANTITY/REFILE D 50 minutes ication days  Quantity:    30-day supply   90-day supply   90-day supply   1 year   0 ther:
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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.

## Asthma Enrollment Form Medications D-S

(Dupixent, Fasenra, Nucala)
Please Complete Patient and Prescriber Information

			atient DOB:	
escriber Name:		Pi	rescriber Phone:	
	ON INFORMATION			
MEDICATION	STRENGTH	DOSE & D	RECTIONS	QUANTITY/REFILLS
☐ Dupixent dupilumab)	PFS  ☐ 100 mg/0.67 mL pre-filled syringe ☐ 200 mg/1.14 mL pre-filled syringe ☐ 300 mg/2 mL pre-filled syringe  PEN* ☐ 200 mg/1.14 mL pre-filled pen ☐ 300 mg/2 mL pre-filled pen ☐ 300 mg/2 mL pre-filled pen *Comes in cartons of 2	Inject 300 mg SC (one in Asthma: Pediatric ≥30 kg: Inject 200 mg SC (one in Asthma: Adult Initial Dose Inject 400 mg SC (2-200 initially then 200 mg SC eve Inject 600 mg SC (2-300 initially then 300 mg SC eve Asthma: Adult Maintenan	pjection) every other week njection) every four weeks njection) every other week njection) every other week njection) every other week ng injections in different injection sites) ery other week ng injections in different injection sites) ery other week ng Dose: etion) SC every other week ntion) SC every other week	Quantity:
] Fasenra penralizumab)	PFS  ☐ 30 mg/mL pre-filled syringe  Auto-injector ☐ 30 mg/mL Pen/Self-administered	Administer 30 mg/mL b	y subcutaneous injection every 4 weeks for y injection once every 8 weeks thereafter	Quantity:  1 PFS/Pen 3 PFS/Pen Refills: 1 year Other:
□ Nucala mepolizumab)	Vial  ☐ 100 mg vial  PEN ☐ Auto-injector 100 mg/mL auto-injector  PFS ☐ 100 mg/mL pre-filled syringe	arm, thigh, or abdomen  EOSINOPHILIC GRANULO Inject 300 mg as 3 sepa every 4 weeks into the upper  HYPEREOSINOPHILIC SYI Inject 300 mg as 3 sepa every 4 weeks into the upper Include sterile water and supply No supplies requested (sindicated) One 10 mL vial sterile water and dispensed Alcohol swabs 3 mL Luer Lock injection NDL 21G needle for reco	NDROME (HES) rate 100 mg subcutaneous injections once er arm, thigh, or abdomen d supplies sufficient for medication days supplies will be sent with shipment unless ater for injection for every vial of Nucala	Quantity:  30-day supply  90-day supply  -day supply  Refills:  Other:  Other:
	6 PRESCRIBER SIGNA 1" / Brand Medically Necessary / Do No		Ancillary supplies and kits pro  TAMP SIGNATURE NOT ALLOW  May Substitute / Product Selection Permitted /	vided as needed for administration
	titute		Substitution Permissible	
PAW / May Not Subst Prescriber's Sig		Date:	Prescriber's Signature:	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.

## **Asthma Enrollment Form Medications T-Z**

(Tezspire, Xolair)

	Plea	ase Complete Patient and I	Prescriber Information		
Patient Name:			tient DOB:		
rescriber Name		Pi	rescriber Phone:		
PRESCRIPTION	ON INFORMATION				
Tezspire (Tezepelumab)	210 mg/1.91 mL (110 mg/mL) pre-filled syringe	210 mg injected subcutaneo	usly every 4 weeks	Quantity: 1 Refills: 1 Year	
☐ Xolair (omalizumab)	Vial ☐ 150 mg vial kit  PFS ☐ 75 mg/0.5 mL pre-filled syringe ☐ 150 mg/1 mL pre-filled syringe	Administer 150 mg per do Administer 225 mg per do Administer 300 mg per do Other: Administer 4 weeks  Every 2 weeks dosing: Administer 225 mg per do Administer 300 mg per do Administer 375 mg per do Other: Administer 2 weeks  For Xolair Vials only: Include sterile water and supply No supplies requested (so indicated) One 10 mL vial sterile wat dispensed Alcohol swabs Flexible bandages 1" x 3" 3 mL Luer Lock injection NDL 18G x 1½" Safety Glid NDL 25G x 5%" Safety Glid		Quantity:  30-day supply 90-day supplyday supply Refills: Other: Other:	
	ON INFORMATION	Nursing Med (Epipen, Epipe	ications		
MEDICATION		DOS	E & DIRECTIONS	QUANTITY/REFILLS	
Other:				Quantity: Refills:	
Epipen	Other:	Use as directed.		Quantity: 1 Refills:	
Epipen Jr.	Other:	Use as directed.		Quantity: 1 Refills:	
Patient is interested i	in patient support programs	STAMP SIGNATURE NOT ALLOWED	Ancillary supplies and kits p	orovided as needed for administration	
	6 PRESCRIBER SIG	GNATURE REQUIRED (ST	FAMP SIGNATURE NOT ALLO	WED)	
DAW / May Not Subs	n" / Brand Medically Necessary /	Do Not Substitute / No Substitution /	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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