Hepatitis C Enrollment Form Medications A-L



(Epclusa, Harvoni, Ledipasvir/Sofosbuvir) Fax Referral To: 1-888-280-1191 OR 787-759-4161 Phone: 1-888-280-1190 OR 787-759-4162

Address: 280 Avenida Jesus T. Pinero Ste B Rio Piedras, PR 00927	Email Referral To: Customer.ServiceFax@CVSHealth.com Address: 280 Avenida Jesus T. Pinero Ste B Rio Piedras. PR 0092
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Address:			City, State, ZIP Code:	
Gender: Male Female	· Phone (to primary # provided belo	,,,,\ □ ⊤ -	ovt (to poll # provided below)	mail (to amail provided below)
	ply. If unable to contact via text or en			
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	iuardian Name (Last, First):			
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PRESCRIBER INFORM				
PI #: DEA #:	Group or Hospital:			
.ddress:	FaxContac	City,	, State, ZIP Code:	
INSURANCE INFORM	ATION Please fax copy of prescription	n and insu	rance cards with this form, if availab	le (front and back)
DIAGNOSIS AND CLIN	IICAL INFORMATION			
eeds by Date:	Ship to: 🗌 Patient [Office	Other:	
iagnosis (ICD-10):				
B17.10 Acute Hepatitis C v	vithout hepatic coma B17.11 A	cute Hep	atitis C with hepatic coma	
B18.2 Chronic Hepatitis C			ed Viral Hepatitis C without hepat	ic coma
B20 HIV			Description	
atient Clinical Information				
llergies:	V	/eight:	lb/kg Height:in/c	em
ICV Genotype: 1a 1b	1 2 3 4 5 6 AND	☐ No Cirr	hosis Compensated Cirrhosis	Decompensated Cirrhosis
	Responder Non-Responder R			
	tis C Virus therapy? No Yes, Th			
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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.

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			
MEDICATION	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	kg/lb Take three packets of oral pellets PO once daily with food. Take four packets of oral pellets PO once daily with food. Take five packets of oral pellets PO once daily with food.		Quantity: 28-day supply Refills: 8 weeks 12 weeks Other
Pegasys (peginterferon alfa-2a)	☐ 180 mcg / 0.5 mL ProClick Autoinjector ☐ Other:	☐ Inject 180 mcg SC once a week as directed. ☐ Other:		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	tabs/c	tabs/caps PO q am and aps q pm for a total of mg /ith 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 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.

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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			
MEDICATION	STRENGTH		DOSE & DIRECTIONS	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 one tablet once daily with or without food.		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

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 A (Avsola) 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

CVS specialty®

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

	Six Simple Steps to Subn (Complete or include demographic sheet)	•	
Address: Gender:	······································	City, State, ZIP Code:	
	Phone (to primary # provided below) Te:	xt (to cell # provided below) Fmail (to e	mail provided below)
	y. If unable to contact via text or email, Specia		
Primary Phone:		Alternate Phone:	
	ardian Name (Last, First):	Alternate Friend.	
Relationship to minor:			
mail:		SN: Primary Language:	
PRESCRIBER INFORMA			
Prescriber's Name:		_State License #:	
IPI #: DEA #:	Group or Hospital:		
ddress:	City, S	State, ZIP Code:	
hone: Fa	City, S x Contact Person:	Contact's Phone: _	
INSURANCE INFORMAT	TION Please fax copy of prescription and ins	surance cards with this form, if available (fro	ont and back)
DIAGNOSIS AND CLINIC	CAL INFORMATION		
leeds by Date:		nip to: 🗌 Patient 🗌 Office 🔲 Other:	
Diagnosis (ICD-10):		. – – – –	
	Small Intestine Without Complications	K50.10 Crohn's Disease of Large Intestine	Without Complications
K50.80 Crohn's Disease of S	Small & Large Intestine Without Complication		
		K51.00 Ulcerative (chronic) pancolitis with	out complications
		K51.50 Left sided colitis without complicat	
	• • • • —	Other Code: Description	
Patient Clinical Information:			
Allergies:	W	/eight:lb/kg Height:in/c	em
B Test Result:	Date: Hepatitis st	atus:	
irst time receiving IBD Therap			
	Last dose given:	Next dose due:	
lursing:			
	ate injection training/ home health infusion n		
	nfusion Clinic	e Health	
	oatient Pt already independent Referre	ed by MD to alternate trainer	
Prescriber Phone:	Satient Traileady independent Therent	ed by MD to atternate trainer	
PRESCRIPTION INFORM	MATION		
MEDICATION STRENGTH	DOSE & DIRE	ECTIONS	QUANTITY/REFILLS
MEDICATION STRENGTH	_		QUANTITI I/REFILES
	☐ Crohn's Disease (Adult and Pediatric ≥		
	5 mg/kg (Dose =mg) at weeks 0,		Quantity:
	Crohn's Disease (Adult) Maintenance E	Dose: Infuse IV at 5-10 mg/kg	# of 100 mg vial(s)
	(Dose =mg) every 8 weeks ☐ Crohn's Disease (Pediatric ≥6 years old	N Maintananaa Dasa: Infusa IV at	Refills:
Avsola 100 mg vial	5 mg/kg (Dose =mg) every 8 wee		
Avsola 100 mg viai	Ulcerative Colitis (Adult and Pediatric ≥		
	5 mg/kg (Dose =mg) at weeks 0,		
	Ulcerative Colitis (Adult and Pediatric ≥		
	Infuse IV at 5 mg/kg (Dose =mg)		
	Other:		
Patient is interested in patient support p	ograms STAMP SIGNATURE NOT AI	LLOWED Ancillary supplies and kits provi	ded as needed for administration
JAKE C.	RIBER SIGNATURE REQUIRED (ST	I AMP SIGNATURE NOT ALLOW	נט)
OF RESO		May Substitute / Product Selection Permitted /	
"Dispense As Written" / Brand Medica	ally Necessary / Do Not Substitute / No Substitution /		
		Substitution Permissible 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. ©2022 CVS Pharmacy, Inc. and one of its affiliates. 75-35829D 03/24/22

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		
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	Induction Dose: 300 mg infused IV over 30 minutes at 0, 2 and 6 weeks, then 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	Maintenan		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 C Inject S continue w Inject S then contin	Crohn's Disease Initial Dose: 6C 160 mg Day 1, then 80 mg Day 15, then with maintenance dose starting Day 29 6C 80 mg Day 1, 80 mg Day 2, 80 mg Day 15, nue with maintenance dose starting Day 29	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	☐ Inject S	Crohn's Disease Maintenance Dose: CC 20 mg every other week	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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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 Inject SC 20 mg every w Inject SC 40 mg every of Other:	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 jnature:	Date:	Substitution Permissible Prescriber's Signature:	Date:
Drocoribar's C:-				Date [,]

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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	CVS/specialty as your prefer	CH/Tysabri enrollment form and indicate red pharmacy provider. (For questions, cribing Program at 1-800-456-2255)	Quantity: 0 Refills: 0
☐ Xeljanz	☐ 5 mg ☐ 10 mg	daily, depending on theraped dose to maintain response.	ast 8 weeks; followed by 5 or 10 mg twice utic response. Use the lowest effective weeks of treatment with 10 mg twice daily efit is not achieved.	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 on	ce daily on days 1-4, followed by on days 5-7, then take 0.92 mg capsule	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 on 0.46 mg capsule once daily o	Quantity: 7-day supply Refill: 0	
Zeposia	0.92 mg capsules	Take 0.92 mg capsule on 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 NED)
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:	

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Page 4 of 5

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	PRN severe allergic read May repeat in 5-15 minu	(15-30 kg/33-66 lbs) 0.1 mL (7.5-15 kg/16.5-33 lbs) :tion – Call 911	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 (0ve PRN severe allergic reac May repeat in 3-5 minute) er 30 kg)	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 Prescriber's Signature:	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: 1-888-280-1191 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

PATIENT I		Complete or inclu			
Address:			City, State, 2	ZIP Code:	
Gender: 🗌 Male					
				ovided below) 🗌 Email (to	
-				l attempt to contact by pho	
Primary Phone:			Alternate F	Phone:	
Relationship to	minor:			5 · .	
Email:			Last Four of SSN:	Primary Langua	age:
PRESCRIE	BER INFORMATION	ON			
			State Licens	se #:	
NPI #	DFA #·	Group or Hospital	. Otate Licens		
Address:		Group or ricopitat	City State ZIP Code		
Phone:	Fax	Cont	act Person:	e: Contact's P	hone.
Needs by Date:_ Diagnosis (ICI B16.0 Acute I	D-10): Hepatitis B with delta-a	AL INFORMATION agent with hepatic com	Ship to: 🗌 P	atient 🗌 Office 🗌 Othe	r:
_	=	agent without hepatic co ta-agent with hepatic c			
B16.9 Acute H	Hepatitis B without del	ta-agent and without h			
=	c Viral Hepatitis B with	•			
_	Viral Hepatitis B with	_			
		Without hepatic coma			
	cified Viral Hepatitis B r intestinal malabsorpt				
	nal malabsorption, uns				
=	ontinence of feces	specified			
=	Description				
	al Information:				
Allergies:	<u>at iiiiOiiiiatiOii.</u>				
Weight:	lb/kg Hei	ght:	n/cm TB Test Resu	ıl t .	Date:
-	dministration:	giiti	ii/ciii ib rest kesu		Date
-		ction training/home he	alth nurse visit as nec	essary? TVos TNo	
Site of Care: 🔲	MD office Infusion	Clinic Outpatient H			
	not necessary. Date t office training patient	training occurred: Pt already independ	 dent	MD to alternate trainer	
☐ Patient is interested i	in patient support programs	STAMP SIGN	ATURE NOT ALLOWED	Ancillary supplies and kits pro	ovided 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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