

Inflammatory Bowel Disease Enrollment Form

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

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



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):

K50.00 Crohn's Disease of Small Intestine Without Complications K50.10 Crohn's Disease of Large Intestine Without Complications

K50.80 Crohn's Disease of Small & Large Intestine Without Complications

K50.90 Crohn's Disease, Unspecified, Without Complications K51.00 Ulcerative (chronic) pancolitis without complications

K51.30 Ulcerative (chronic) rectosigmoiditis without complications K51.50 Left sided colitis without complications

K51.90 Ulcerative colitis, unspecified, without complications Other Code: _____ Description: _____

Patient Clinical Information:

Allergies: _____ Weight: _____ lb/kg Height: _____ in/cm

TB Test Result: _____ Date: _____ Hepatitis status: _____

First time receiving IBD Therapy? Yes No

If No, previous product used: _____ Last dose given: _____ Next dose due: _____

Nursing:

Specialty pharmacy to coordinate injection training/ home health infusion nurse visit 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

Prescriber Phone: _____

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Avsola	100 mg vial	<input type="checkbox"/> Crohn's Disease (Adult and Pediatric ≥6 years old) <u>Induction Dose</u> : Infuse IV at 5 mg/kg (Dose = _____mg) at weeks 0, 2, 6 and every 8 weeks thereafter <input type="checkbox"/> Crohn's Disease (Adult) <u>Maintenance Dose</u> : Infuse IV at 5-10 mg/kg (Dose = _____mg) every 8 weeks <input type="checkbox"/> Crohn's Disease (Pediatric ≥6 years old) <u>Maintenance Dose</u> : Infuse IV at 5 mg/kg (Dose = _____mg) every 8 weeks <input type="checkbox"/> Ulcerative Colitis (Adult and Pediatric ≥6 years old) <u>Induction Dose</u> : Infuse IV at 5 mg/kg (Dose = _____mg) at weeks 0, 2, 6 and every 8 weeks thereafter <input type="checkbox"/> Ulcerative Colitis (Adult and Pediatric ≥6 years old) <u>Maintenance Dose</u> : Infuse IV at 5 mg/kg (Dose = _____mg) every 8 weeks <input type="checkbox"/> Other: _____	Quantity: _____ # of 100 mg vial(s) 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.

Inflammatory Bowel Disease Enrollment Form

Medications C-H (Cimzia, Entyvio, Humira)

Please Complete Patient and Prescriber 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
<input type="checkbox"/> Cimzia	Cimzia Starter Kit (6 prefilled syringes)	Induction Dose: Inject SC 400 mg (2 injections) on day 1, and at weeks 2 and 4. If response occurs, follow with 400 mg every four weeks <input type="checkbox"/> Other: _____	Quantity: 1 kit (6 prefilled syringes) Refills: 0
<input type="checkbox"/> Cimzia	<input type="checkbox"/> 200 mg/1 mL prefilled syringe <input type="checkbox"/> 200 mg vial	Maintenance Dose: Inject SC 400 mg (2 injections) every 4 weeks <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Entyvio	300 mg in a single dose vial in individual carton	<input type="checkbox"/> Induction Dose: 300 mg infused IV over 30 minutes at 0, 2 and 6 weeks, then every 8 weeks thereafter <input type="checkbox"/> Maintenance Dose: 300 mg infused IV over 30 minutes every 8 weeks <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Humira	<u>Adult Crohn's Disease/Ulcerative Colitis:</u> PEN HUMIRA Starter Pack (CF) 80 mg/0.8 mL	Initial Dose: <input type="checkbox"/> Inject SC 160 mg on Day 1, 80 mg on Day 15, then continue with maintenance dose starting Day 29 <input type="checkbox"/> Inject SC 80 mg on Day 1, 80 mg on Day 2, 80 mg on Day 15, then continue with maintenance dose starting Day 29 <input type="checkbox"/> Other: _____	Quantity: 1 kit (3 pens) Refills: 0
<input type="checkbox"/> Humira	<u>Adult Crohn's Disease/Ulcerative Colitis:</u> <input type="checkbox"/> PEN HUMIRA (CF) 40 mg/0.4 mL <input type="checkbox"/> SYRINGE HUMIRA (CF) 40 mg/0.4 mL <input type="checkbox"/> PEN HUMIRA 40 mg/0.8 mL <input type="checkbox"/> SYRINGE HUMIRA 40 mg/0.8 mL	Maintenance Dose: <input type="checkbox"/> Inject SC 40 mg every other week <input type="checkbox"/> Other: _____	Quantity: _____ <input type="checkbox"/> #2 (1 month) <input type="checkbox"/> #6 (3 month) Refills: _____
<input type="checkbox"/> 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: <input type="checkbox"/> Inject SC 80 mg Day 1, then 40 mg Day 15, then continue with maintenance dose starting Day 29 <input type="checkbox"/> Other: _____	Quantity: 1 kit (2 syringes) Refills: 0
<input type="checkbox"/> Humira	40 kg (88 lbs) and greater; ≥ 6 years: <input type="checkbox"/> PEN HUMIRA Starter Pack (CF) 80 mg/0.8 mL <input type="checkbox"/> SYRINGE HUMIRA Starter Pack (CF) 80 mg/0.8 mL <input type="checkbox"/> PEN HUMIRA Starter Pack 40 mg/0.8 mL <input type="checkbox"/> SYRINGE HUMIRA Starter Pack 40 mg/0.8 mL	Pediatric Crohn's Disease Initial Dose: <input type="checkbox"/> Inject SC 160 mg Day 1, then 80 mg Day 15, then continue with maintenance dose starting Day 29 <input type="checkbox"/> Inject SC 80 mg Day 1, 80 mg Day 2, 80 mg Day 15, then continue with maintenance dose starting Day 29 <input type="checkbox"/> Other: _____	Quantity: QS Refills: 0
<input type="checkbox"/> 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: <input type="checkbox"/> Inject SC 20 mg every other week <input type="checkbox"/> Other: _____	Quantity: _____ <input type="checkbox"/> #2 (1 month) <input type="checkbox"/> #6 (3 month) 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.

Inflammatory Bowel Disease Enrollment Form

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

Please Complete Patient and Prescriber 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
<input type="checkbox"/> Humira	40 kg (88 lbs) and greater; ≥ 6 years: <input type="checkbox"/> PEN HUMIRA (CF) 40 mg/0.4 mL <input type="checkbox"/> SYRINGE HUMIRA (CF) 40 mg/0.4 mL <input type="checkbox"/> PEN HUMIRA 40 mg/0.8 mL <input type="checkbox"/> SYRINGE HUMIRA 40 mg/0.8 mL	Pediatric Crohn's Disease Maintenance Dose: <input type="checkbox"/> Inject SC 40 mg every other week <input type="checkbox"/> Other: _____	Quantity: <input type="checkbox"/> #2 (1 month) <input type="checkbox"/> #6 (3 month) Refills: _____
<input type="checkbox"/> Humira	20 kg (44 lbs) to less than 40 kg (88 lbs); ≥ 5 years: <input type="checkbox"/> PEN HUMIRA (CF) 40 mg/0.4 mL <input type="checkbox"/> SYRINGE HUMIRA (CF) 40 mg/0.4 mL	Pediatric Ulcerative Colitis Initial Dose: <input type="checkbox"/> Inject SC 80 mg Day 1, 40 mg weekly (Day 8 and Day 15), then continue with maintenance dose starting Day 29 <input type="checkbox"/> Other: _____	Quantity: 4 Pens/4 Prefilled syringes Refills: 0
<input type="checkbox"/> Humira	20 kg (44 lbs) to less than 40 kg (88 lbs); ≥ 5 years: <input type="checkbox"/> PEN HUMIRA (CF) 40 mg/0.4 mL <input type="checkbox"/> PEN HUMIRA (CF) 40 mg/0.4 mL <input type="checkbox"/> SYRINGE HUMIRA (CF) 20 mg/0.2 mL	Pediatric Ulcerative Colitis Maintenance Dose: <input type="checkbox"/> Inject SC 20 mg every week <input type="checkbox"/> Inject SC 40 mg every other week <input type="checkbox"/> Other: _____	Quantity: <input type="checkbox"/> 1-month supply <input type="checkbox"/> 3-month supply Refills: _____
<input type="checkbox"/> Humira	40 kg (88 lbs) and greater; ≥ 5 years: <input type="checkbox"/> PEN HUMIRA (CF) 80 mg/0.8 mL <input type="checkbox"/> PEN HUMIRA (CF) 40 mg/0.4 mL <input type="checkbox"/> SYRINGE HUMIRA (CF) 40 mg/0.4 mL	Pediatric Ulcerative Colitis Maintenance Dose: <input type="checkbox"/> Inject SC 40 mg every week <input type="checkbox"/> Inject SC 80 mg every other week <input type="checkbox"/> Other: _____	Quantity: <input type="checkbox"/> 1-month supply <input type="checkbox"/> 3-month supply Refills: _____
<input type="checkbox"/> Inflectra <input type="checkbox"/> Infliximab <input type="checkbox"/> Remicade <input type="checkbox"/> Renflexis	100 mg vial	<input type="checkbox"/> Crohn's Disease (Adult and Pediatric ≥6 years old) <u>Induction Dose:</u> Infuse IV at 5 mg/kg (Dose = _____mg) at weeks 0, 2, 6 and every 8 weeks thereafter <input type="checkbox"/> Crohn's Disease (Adult) <u>Maintenance Dose:</u> Infuse IV at 5-10 mg/kg (Dose = _____mg) every 8 weeks <input type="checkbox"/> Crohn's Disease (Pediatric ≥6 years old) <u>Maintenance Dose:</u> Infuse IV at 5 mg/kg (Dose = _____mg) every 8 weeks <input type="checkbox"/> Ulcerative Colitis (Adult and Pediatric ≥6 years old) <u>Induction Dose:</u> Infuse IV at 5 mg/kg (Dose = _____mg) at weeks 0, 2, 6 and every 8 weeks thereafter <input type="checkbox"/> Ulcerative Colitis (Adult and Pediatric ≥6 years old) <u>Maintenance Dose:</u> Infuse IV at 5 mg/kg (Dose = _____mg) every 8 weeks <input type="checkbox"/> Other: _____	Quantity: _____ # of 100 mg vial(s) 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.

Inflammatory Bowel Disease Enrollment Form

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

Please Complete Patient and Prescriber 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
<input type="checkbox"/> Rinvoq	45 mg	Induction Dose: <input type="checkbox"/> Take 1 tablet once daily for 8 weeks <input type="checkbox"/> Other: _____	Quantity: 1 btl = 28 Refill: 1
<input type="checkbox"/> Rinvoq	<input type="checkbox"/> 15 mg <input type="checkbox"/> 30 mg	Maintenance Dose: <input type="checkbox"/> Take 1 tablet once daily <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Simponi	<input type="checkbox"/> 100 mg/mL in a single-dose prefilled SmartJect autoinjector <input type="checkbox"/> 100 mg/mL in a single-dose prefilled syringe	<input type="checkbox"/> Induction Dose: Inject SC 200 mg initially (given as 2 subcutaneous injections of 100 mg each) at Week 0, followed by 100 mg at Week 2 and then 100 mg every 4 weeks <input type="checkbox"/> Maintenance Dose: Inject SC 100 mg every 4 weeks <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> 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)	Single IV Induction Dose: <input type="checkbox"/> 55 kg or less 260 mg at Week 0: # of vials to be used 2 <input type="checkbox"/> more than 55 kg to 85 kg 390 mg at Week 0: # of vials to be used 3 <input type="checkbox"/> more than 85 kg 520 mg at Week 0: # of vials to be used 4 <input type="checkbox"/> Other: _____	Quantity: _____ <input type="checkbox"/> 2 Vials <input type="checkbox"/> 3 Vials <input type="checkbox"/> 4 Vials Refills: 0
<input type="checkbox"/> Stelara	90 mg/mL SC dose in a single-dose prefilled syringe	<input type="checkbox"/> 90 mg SC dose 8 weeks after the initial IV induction dose, then every 8 weeks thereafter <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Tysabri	NA	Please complete a MS TOUCH/Tysabri enrollment form and indicate CVS/specialty as your preferred pharmacy provider. (For questions, please contact TOUCH Prescribing Program at 1-800-456-2255)	Quantity: 0 Refills: 0
<input type="checkbox"/> Xeljanz	<input type="checkbox"/> 5 mg <input type="checkbox"/> 10 mg	<input type="checkbox"/> 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. <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> 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)	<input type="checkbox"/> 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
<input type="checkbox"/> Zeposia	7-Day Starter Pack (4 capsules of 0.23 mg and 3 capsules of 0.46 mg)	<input type="checkbox"/> 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
<input type="checkbox"/> Zeposia	0.92 mg capsules	<input type="checkbox"/> Take 0.92 mg capsule once daily <input type="checkbox"/> 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.

Inflammatory Bowel Disease Enrollment Form

Nursing Medications

Please Complete Patient and Prescriber 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 <input type="checkbox"/> PIV <input type="checkbox"/> PORT <input type="checkbox"/> 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 3-5 mL, and/or 10 mL sterile saline to access port a cath	Quantity: _____ Refills: _____
Hydration: NS D5W	IV	Pre: 500 mL 1000 mL Other: _____ Concurrent: 500 mL 1000 mL Other: _____ (Not to be infused using the same access as Ig) Post: 500 mL 1000 mL Other: _____	Hydration max infusion rate _____ mL/hr (Adult max rate 250 mL/hr unless otherwise indicated)
<input type="checkbox"/> Epinephrine **nursing requires**	<input type="checkbox"/> IM <input type="checkbox"/> SC	<input type="checkbox"/> Adult 1:1000, 0.3 mL (>30 kg/>66 lbs) <input type="checkbox"/> Peds 1:2000, 0.3 mL (15-30 kg/33-66 lbs) <input type="checkbox"/> Infant 0.1 mL/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: _____
<input type="checkbox"/> Diphenhydramine Oral	PO	<input type="checkbox"/> Premedication <input type="checkbox"/> 12.25 mg/kg (0-30 kg) <input type="checkbox"/> 25 mg <input type="checkbox"/> 50 mg (Over 30 kg) PRN severe allergic reaction – Call 911	Quantity: _____ Refills: _____
<input type="checkbox"/> Diphenhydramine 50 mg/mL vial	<input type="checkbox"/> Slow IV <input type="checkbox"/> IM	<input type="checkbox"/> 1 mg/kg (under 15 kg) <input type="checkbox"/> 12.5-50 mg (15-30 kg) <input type="checkbox"/> 25 mg <input type="checkbox"/> 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: _____
<input type="checkbox"/> Flush Orders	<input type="checkbox"/> Peripheral Access <input type="checkbox"/> Central Venous Access	<input type="checkbox"/> 20 mL NS post flush <input type="checkbox"/> 30 mL NS post flush <input type="checkbox"/> 40 mL NS post flush <input type="checkbox"/> 50 mL NS post flush <input type="checkbox"/> _____	Send quantity sufficient for medication days supply
Additional Medication: _____	_____	_____	_____

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.

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by telephone and destroy all copies of this communication and any attachments.

Plan member privacy is important to us. Our employees are trained regarding the appropriate way to handle members' private health information.

This document contains references to brand-name prescription drugs that are trademarks or registered trademarks of pharmaceutical manufacturers not affiliated with CVS Specialty and/or one of its affiliates.