Rheumatology IV Enrollment Form

Medications A

(Actemra, 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

Relationship to	t/Caregiver/Guardian I o minor:	Name (Last, First):		
mail:		Last Fou	ır of SSN: Primary Langua	ge:
PRESCRIBE	R INFORMATION			
Prescriber's Na	ıme:	State	e License #:	
NPI #:	DEA #:	Group or Hospital:		
Address:		City, State	e, ZIP Code: Contact's Phone:	
hone:	Fax	Contact Person:	Contact's Phone:	
			rance cards with this form, if available	(front and back)
	S AND CLINICAL INF			
Needs by Date:		S	hip to: 🗌 Patient 🗌 Office 🗌 Other:_	
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	ropathic Psoriasis, Uns		L40.59 Other Psoriatic Arthropathy	
	specified Juvenile knet I l Information:	imatola Arthritis of Unspecified Site [Other Code: Description _	
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	dministration:	in gritn/ cm	B restrictant.	Date
lursing and A				
		Coram Ambulatory Infusion Suite	Prescriber's Office	
Place of infusio	n: Home Infusion	Coram Ambulatory Infusion Suite		
lace of infusio	n: Home Infusion nacy to coordinate hon	ne health infusion nurse visit necessa		
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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. ©2022 CVS Pharmacy, Inc. or one of its affiliates. 75-38703C 03/21/22

Rheumatology IV Enrollment Form Medications B-Z

(Inflectra, Infliximab, Orencia, Remicade, Renflexis, Rituxan, Simponi ARIA)

atient Name	Please Co		and Patient Clinical Information		
			Patient DOB:		
	le l Information:		Prescriber Phone:		
ergies:					
eight:	lb/ka He	ight: In/cm	TB Test Result:	Date:	
	ON INFORMATION	.9.1.1			
EDICATION	STRENGTH	DOS	SE & DIRECTIONS	QUANTITY/REFILL	
☐ Inflectra ☐ Infliximab	100 mg vial	(Dose =mg) at weeks Ankylosing Spondylitis Main (Dose =mg) every 6 w Psoriatic Arthritis Induction (Dose =mg) at weeks Psoriatic Arthritis Maintena (Dose =mg) every 8 w Rheumatoid Arthritis Induction	Dose: Infuse IV at 5 mg/kg 0, 2, 6 and every 8 weeks thereafter unce Dose: Infuse IV at 5 mg/kg veeks tion Dose: Infuse IV at 3 mg/kg 0, 2, 6 and every 8 weeks thereafter enance Dose: Infuse IV at 3-10 mg/kg	Quantity: # of 100 mg vial(s) Refills:	
Orencia	250 mg vial		and 4, then every 4 weeks thereafter.	Quantity:	
Remicade	100 mg vial	(Dose =mg) at weeks Ankylosing Spondylitis Main (Dose =mg) every 6 w Psoriatic Arthritis Induction (Dose =mg) at weeks Psoriatic Arthritis Maintena (Dose =mg) every 8 w Rheumatoid Arthritis Induction (Dose =mg) at weeks	Dose: Infuse IV at 5 mg/kg 0, 2, 6 and every 8 weeks thereafter unce Dose: Infuse IV at 5 mg/kg veeks tion Dose: Infuse IV at 3 mg/kg 0, 2, 6 and every 8 weeks thereafter enance Dose: Infuse IV at 3-10 mg/kg	Quantity: # of 100 mg vial(s) Refills:	
Rituxan	☐ 100 mg/10 mL vial ☐ 500 mg/50 mL vial	☐ Infuse two doses of 1000 m	ng separated by 2 weeks.	Quantity: Refills:	
] Simponi RIA	50 mg/4 mL in a single use vial	☐ Adult patients with Rheumatoid Arthritis, Psoriatic Arthritis, and Ankylosing Spondylitis: Infuse 2 mg/kg over 30 minutes at weeks 0 and 4, then every 8 weeks thereafter. ☐ Pediatric patients with polyarticular Juvenile Idiopathic Arthritis and Psoriatic Arthritis: 80 mg/m2 intravenous infusion over 30 minutes at weeks 0 and 4, and every 8 weeks thereafter ☐ Other:		Quantity: # of 50 mg vial Refills:	
Patient is interested	d in patient support programs	STAMP SIGNATURE NOT		vided as needed for administrati	
	6 PRESCRIBER	SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOW	ED)	
AW / May Not Su	bstitute	ary / Do Not Substitute / No Substitution /	May Substitute / Product Selection Permitted / Substitution Permissible	D .4	
Prescriber's Signature: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.

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Page 2 of 3

Rheumatology IV Enrollment Form Nursing Medications

PRESCRIPTION INFORMATION Complete Items below, required for Home Infusion/Coram AIS: MEDICATION/SUPPLIES ROUTE DOSE/STRENGTH/DIRECTIONS QUANTITY/REFI Catheter Care/Flush - Only on drug admin days - SASH or PRN to maintain IN access and patency Quantity: Refills: 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 Adult 1:1000, 0.3 mL (5-30 kg/3-66 lbs) PORT/PICC - NS 10 mL (5-15 kg/16.5-33 lbs) Quantity: Refills: Poets 1:2000, 0.3 mL (15-30 kg/3-66 lbs) PRN severe allergic reaction - Call 911 May repeat in 5-15 minutes as needed Dose will be rour to the nearest via size Peripheral Other: Other: Other: Diphenhydramine Other: Other: Dose will be rour to the nearest via size Peripheral Access Access Access Access Access Heparin units per mL Flush with units as final Send quantity sufficient for medication and IVP for Maintenance Heparin units per mL Flush with units as final Send quantity Sufficient for medication days Supply Patient is interested in patient support programs STAMP SIGNATURE NOT ALLOWED May Substitute / Product Selection Permitted / Substitution / DAW / May Not Substitute Product Selection Permitted / Substitution Permissible Substitutio		Diagon Comple	to Deticat Droseriber			
Prescriber Name:						
Illergies:						
Date:						
PRESCRIPTION INFORMATION Catheter Card-/Flush - Only on drug admin days - SASH or PRN to maintain IV access and patency PIV PORT IV PORT PORT PORT/PICC - NS 10 mL & Heparin 100 units/mL 3-5 mL if multiple days) PORT/PICC - NS 10 mL & Heparin 100 units/mL 3-5 mL, and/or 10mL steriles saline to access port a cath Adult 1:1000, 0.3 mL (5-30 kg/3-66 lbs) Port of the severe allergic reaction - Call 911 May repeat in 5-15 minutes as needed	lergies:					
Catheter	/eight:	lb/kg Height:_	In/cm T	B Test Result:	Date:	
Catheter Care/Flush - Only on drug admin days - SASH or PRN to maintain IV access and patency PIV PORT IV 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 Adult 1:1000, 0.3 mL (>30 kg/>66 lbs) Peds 1:2000, 0.3 mL (>5-30 kg/>66 lbs) Post 1:2000, 0.3 mL (15-30 kg/3-66 lbs) PRN severe allergic reaction - Call 911 May repeat in 5-15 minutes as needed Dose will be rour to the nearest via size Peripheral Access Central Venus Access Heparin _ units per mL Flush with _ units as final Venus Access Patient is interested in patient support programs STAMP SIGNATURE NOT ALLOWED Substitute / Product Selection Permitted / Substitute Product Selection Permitted / Substitution Permissible Substitution Permissible Substitution Permissible Substitution Permissible Patient Product Selection Permitted / Substitution Permissible Product Selection Permitted / Substitution Permissible Patient Product Selection Permitted / Product Selection Permitted / Substitution Permissible Product Selection Permitted / Product Selection Permite			e Infusion/Coram AIS:			
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Epinephrine	PIV PORT	IV	to maintain IV access and PIV – NS 5 mL (Heparin 10 PORT/PICC – NS 10 mL &	Quantity: Refills:		
Diphenhydramine Other:		_	Peds 1:2000, 0.3 mL (1 Infant 0.1 mL/0.1 mL, 0 PRN severe allergic reacti	Quantity: Refills:		
Flush Orders Access after medication and IVP for Maintenance units as final venus Access flush and as directed Patient is interested in patient support programs STAMP SIGNATURE NOT ALLOWED Ancillary supplies and kits provided as needed for administ support programs The properties of the program of the program of the program of the properties of the provided as needed for administ support program of the properties of t	Diphenhydramine	Other:			Dose will be rounded to the nearest vial size	
Dispense As Written / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute **Dispense As Written** / Brand Medically Necessary / Do Not Substitute / No Substitution / Substitution Permissible	Flush Orders	Flush Orders Access after medication and IVP for Maintenance Central Heparin units per mL Flush with units as final			sufficient for medication days	
"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute May Substitute / Product Selection Permitted / Substitution Permissible	Patient is interested in patient supp	port programs	STAMP SIGNATURE NOT A	ALLOWED Ancillary supplies and kits pr	ovided as needed for administration	
	"Dispense As Written" / Brand M DAW / May Not Substitute	edically Necessary / Do	Not Substitute / No Substitution /	May Substitute / Product Selection Permitted / Substitution Permissible		
CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "No Substitution" ATTN: New York and Iowa providers, please submit electronic pre						

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.

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