

# Dermatology Enrollment Form



Fax Referral To: 1-800-323-2445

Email Referral To: Customer.ServiceFax@CVSHealth.com

Phone: 1-800-237-2767

## 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):

L40.0 Psoriasis Vulgaris

L40.1 Generalized Pustular Psoriasis  L40.4 Guttate Psoriasis

L40.50 Arthropathic Psoriasis, Unspecified  L40.59

Other Psoriatic Arthropathy  L40.8 Other Psoriasis

L40.9 Psoriasis, Unspecified  L73.2

Hidradenitis Suppurativa

Other Code: \_\_\_\_\_ Description \_\_\_\_\_

#### Patient Clinical Information:

Allergies: \_\_\_\_\_

Weight: \_\_\_\_\_ lb/kg Height: \_\_\_\_\_

\_\_\_\_\_ In/cm TB Test Result: \_\_\_\_\_

Date: \_\_\_\_\_

#### Nursing:

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

# Dermatology Enrollment Form Medications A-C

(Avsola, Cimzia)

## Please Complete Patient, Prescriber and Patient Clinical 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"/> Avsola	100 mg vial	<input type="checkbox"/> <b>Induction Dose:</b> Infuse IV at 5 mg/kg (Dose = ____ mg) at weeks 0, 2, 6 and every 8 weeks thereafter <input type="checkbox"/> <b>Maintenance Dose:</b> Infuse IV at 5 mg/kg (Dose = ____ mg) every 8 weeks <input type="checkbox"/> Other: _____	Quantity: _____ # of 100 mg vial(s) Refills: _____
<input type="checkbox"/> Cimzia	Cimzia Starter Kit (6 prefilled syringes)	<b>Psoriasis Loading Dose:</b> <input type="checkbox"/> 400 mg (given as 2 subcutaneous injections of 200 mg each) every other week <input type="checkbox"/> Patients (with body weight ≤ 90 kg): 400 mg (given as 2 subcutaneous injections of 200 mg each) initially and at weeks 2 and 4, followed by 200 mg every other week <b>Psoriatic Arthritis Loading Dose:</b> <input type="checkbox"/> 400 mg (given as 2 subcutaneous injections of 200 mg each) initially and at week 2 and 4, followed by 200 mg every other week <input type="checkbox"/> Other: _____	Quantity: 1 Kit Refills: 0
<input type="checkbox"/> Cimzia	<input type="checkbox"/> 200mg/1 mL prefilled syringe <input type="checkbox"/> 200mg vial	<b>Psoriasis Maintenance Dose:</b> <input type="checkbox"/> 400 mg (given as 2 subcutaneous injections of 200 mg each) every other week <input type="checkbox"/> 200 mg every other week <b>Psoriatic Arthritis Maintenance Dose:</b> <input type="checkbox"/> 200 mg every other week <input type="checkbox"/> 400 mg (given as 2 subcutaneous injections of 200 mg each) every 4 weeks <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 <b>Prescriber's Signature:</b> _____ <b>Date:</b> _____	May Substitute / Product Selection Permitted / Substitution Permissible <b>Prescriber's Signature:</b> _____ <b>Date:</b> _____
<b>CA, MA, NC &amp; PR:</b> Interchange is mandated unless Prescriber writes the words "No Substitution" _____ <b>ATTN: New York and Iowa providers,</b> 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.

# Dermatology Enrollment Form

## Medications C-G

(Cosentyx, Enbrel)

### Please Complete Patient, Prescriber and Patient Clinical 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"/> Cosentyx 150 mg	<input type="checkbox"/> Sensoready Pen (1x150 mg/mL) <input type="checkbox"/> Prefilled Syringe (1x150 mg/mL)	Adult: <input type="checkbox"/> <u>Loading Dose:</u> Inject 150 mg subcutaneously on Weeks 0, 1, 2, 3 <input type="checkbox"/> <u>Maintenance Dose:</u> Inject 150 mg subcutaneously on Week 4, then every 4 weeks thereafter <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Cosentyx 300 mg	<input type="checkbox"/> Sensoready Pen (2x150 mg/mL) <input type="checkbox"/> Prefilled Syringe (2x150 mg/mL)	Adult: <input type="checkbox"/> <u>Loading Dose:</u> Inject 300 mg subcutaneously on Weeks 0, 1, 2, 3 <input type="checkbox"/> <u>Maintenance Dose:</u> Inject 300 mg subcutaneously on Week 4, then every 4 weeks thereafter <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Cosentyx 75 mg (wt ≥ 15 kg and < 50 kg)	Prefilled Syringe (1x75 mg/0.5 mL)	Pediatric: <input type="checkbox"/> <u>Loading Dose:</u> Inject 75 mg subcutaneously on Weeks 0, 1, 2, 3 <input type="checkbox"/> <u>Maintenance Dose:</u> Inject 75 mg subcutaneously on Week 4, then every 4 weeks thereafter <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Cosentyx 150 mg (wt ≥ 50 kg)	<input type="checkbox"/> Sensoready Pen (1x150 mg/mL) <input type="checkbox"/> Prefilled Syringe (1x150 mg/mL)	Pediatric: <input type="checkbox"/> <u>Loading Dose:</u> Inject 150 mg subcutaneously on Weeks 0, 1, 2, 3 <input type="checkbox"/> <u>Maintenance Dose:</u> Inject 150 mg subcutaneously on Week 4, then every 4 weeks thereafter <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Enbrel	<input type="checkbox"/> 50 mg/mL Sureclick Autoinjector <input type="checkbox"/> 50 mg/mL prefilled syringe <input type="checkbox"/> 50 mg/mL Enbrel Mini prefilled cartridge for use with the <u>AutoTouch reusable autoinjector only</u> (Prescriber MUST supply). CVS does <u>not</u> order the autoinjector. <input type="checkbox"/> 25 mg/0.5 mL prefilled syringe <input type="checkbox"/> 25 mg/0.5 mL solution in a single-dose vial	<input type="checkbox"/> <u>Psoriasis Induction Dose:</u> Inject 50 mg SC TWICE a week (3 to 4 days apart) for 3 months, then maintenance dosing. <input type="checkbox"/> <u>Psoriasis Maintenance Dose:</u> Inject 50 mg SC ONCE a week. <input type="checkbox"/> <u>Psoriatic Arthritis Dose:</u> Inject 50 mg SC ONCE a week. <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)

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# Dermatology Enrollment Form

## Medications H

(Humira)

### Please Complete Patient, Prescriber and Patient Clinical 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	<input type="checkbox"/> Psoriasis 40 mg/0.4 mL Starter Package <b>Citrate Free</b> <input type="checkbox"/> Psoriasis 80 mg/0.8 mL and 40 mg/0.4 mL Starter Package <b>Citrate Free</b>	<input type="checkbox"/> <b>Psoriasis Induction Dose:</b> 80 mg SC initial dose, followed by 40 mg SC on day 8, then 40 mg every other week.	Quantity: 1 package Refills: 0
<input type="checkbox"/> Humira	<input type="checkbox"/> 40 mg/0.4 mL Pen <b>Citrate Free</b> <input type="checkbox"/> 40 mg/0.4 prefilled syringe <b>Citrate Free</b>	<input type="checkbox"/> <b>Psoriasis Maintenance Dose:</b> Inject one 40 mg pen/syringe SC every other week. <input type="checkbox"/> <b>Psoriatic Arthritis Dose:</b> Inject one 40 mg pen/syringe SC every other week. <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Humira	<b>30 kg (66 lbs) to less than 60 kg (132 lbs); ≥ 12 years:</b> <input type="checkbox"/> Adolescent Hidradenitis Suppurativa 80 mg/0.8 mL and 40 mg/0.4 mL Starter Package <b>Citrate Free</b>	<b>Adolescent Hidradenitis Suppurativa Initial Dose:</b> <input type="checkbox"/> Inject SC 80mg Day 1, then 40mg every other week on day 8 and subsequent doses <input type="checkbox"/> Other: _____	Quantity: 1 kit (3 Pens) Refills: 0
<input type="checkbox"/> Humira	<b>60 kg (132 lbs) and greater; ≥ 12 years:</b> <input type="checkbox"/> Adult Hidradenitis Suppurativa 80 mg/0.8 mL Starter Package <b>Citrate Free</b>	<b>Hidradenitis Suppurativa Initial Dose:</b> <input type="checkbox"/> Inject SC 160mg Day 1, then 80mg two weeks later (Day 15), then 40mg every week (Day 29) and subsequent doses <input type="checkbox"/> Inject SC 80mg Day 1, 80mg Day 2, then 80mg two weeks later (Day 15), then 40mg every week (Day 29) and subsequent doses <input type="checkbox"/> Inject SC 160mg Day 1, then 80mg two weeks later (Day 15), then 80mg every other week (Day 29) and subsequent doses <input type="checkbox"/> Inject SC 80mg Day 1, 80mg Day 2, then 80mg two weeks later (Day 15), then 80mg every other week (Day 29) and subsequent doses <input type="checkbox"/> Other: _____	Quantity: 1 kit (3 Pens) Refills: 0
<input type="checkbox"/> Humira	<b>30 kg (66 lbs) to less than 60 kg (132 lbs); ≥ 12 years:</b> <input type="checkbox"/> 40 mg/0.4 mL Pen <b>Citrate Free</b> <input type="checkbox"/> 40 mg/0.4 mL prefilled syringe <b>Citrate Free</b>	<b>Adolescent Hidradenitis Suppurativa Maintenance Dose:</b> <input type="checkbox"/> Inject SC 40mg every other week <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Humira	<b>60 kg (132 lbs) and greater; ≥ 12 years:</b> <input type="checkbox"/> 40 mg/0.4 mL Pen <b>Citrate Free</b> <input type="checkbox"/> 40 mg/0.4 prefilled syringe <b>Citrate Free</b> <input type="checkbox"/> 80 mg/0.8 mL Pen <b>Citrate Free</b>	<b>Hidradenitis Suppurativa Maintenance Dose:</b> <input type="checkbox"/> Inject SC 40mg every week <input type="checkbox"/> Inject SC 80 mg every other week	Quantity: _____ Refills: _____

Patient is interested in patient support programs **STAMP SIGNATURE NOT ALLOWED** Ancillary supplies and kits provided as needed for administration

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<b>CA, MA, NC &amp; PR:</b> Interchange is mandated unless Prescriber writes the words "No Substitution" _____ <b>ATTN: New York and Iowa providers,</b> please submit electronic prescription	

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# Dermatology Enrollment Form

## Medications I-S

(Ilumya, Inflectra, Infliximab, Ocrencia, Otezla, Remicade, Renflexis, Rinvoq, Siliq, Simponi, Simponi ARIA)

### Please Complete Patient, Prescriber and Patient Clinical 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"/> Ilumya	100 mg/mL prefilled syringe	<input type="checkbox"/> <u>Psoriasis Induction Dose:</u> Inject one pre-filled syringe (100 mg) SC at weeks 0 and 4, then maintenance dosing. <input type="checkbox"/> <u>Psoriasis Maintenance Dose:</u> Inject one pre-filled syringe (100 mg) SC every 12 weeks. <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Inflectra <input type="checkbox"/> Infliximab	100 mg vial	<input type="checkbox"/> <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"/> <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: _____
<input type="checkbox"/> Ocrencia	125 mg/mL prefilled syringe	Inject 125 mg SC once weekly	Quantity: _____ Refills: _____
<input type="checkbox"/> Otezla	Titration Starter Pack	Day 1: 10 mg PO in the morning. Day 2: 10 mg PO in the morning and 10 mg PO in the evening. Day 3: 10 mg PO in the morning and 20 mg PO in the evening. Day 4: 20 mg PO in the morning and 20 mg PO in the evening. Day 5: 20 mg PO in the morning and 30 mg PO in the evening. Day 6 and thereafter: 30 mg PO twice daily.	Quantity: 1 pack Refills: 0
<input type="checkbox"/> Otezla	30 mg tablet	<input type="checkbox"/> <u>Maintenance Dose:</u> 30 mg tablet PO twice daily. <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Remicade <input type="checkbox"/> Renflexis	100 mg vial	<input type="checkbox"/> <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"/> <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: _____
<input type="checkbox"/> Rinvoq	15 mg	Take one 15 mg tablet PO daily	Quantity: _____ Refills: _____
<input type="checkbox"/> Siliq	<input type="checkbox"/> Carton of two 210 mg/1.5 mL single-dose prefilled syringes	Inject one prefilled syringe (210 mg) SC at weeks 0, 1 and 2, followed by one prefilled syringe (210 mg) every 2 weeks. Prescribers must be certified in the SILIQ REMS Program to prescribe SILIQ. Please visit the following REMS website to register before prescribing SILIQ: <a href="https://siliqrems.com/SiliqUI/home.u">SILIQ REMS Website (https://siliqrems.com/SiliqUI/home.u)</a>	Quantity: _____ Refills: _____
<input type="checkbox"/> Simponi	<input type="checkbox"/> 50 mg/0.5 mL SmartJect Autoinjector <input type="checkbox"/> 50 mg/0.5 mL prefilled syringe	<input type="checkbox"/> <u>Psoriatic Arthritis Dose:</u> Inject 50 mg SC once a month. <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Simponi ARIA	50 mg/4 mL in a single-dose vial	Psoriatic Arthritis Dosing: <u>Induction Dose:</u> 2 mg/kg IV infusion over 30 minutes at weeks 0 and 4, then every 8 weeks thereafter <u>Maintenance Dose:</u> 2 mg/kg IV infusion over 30 minutes every 8 weeks	Quantity: _____ # of 50 mg vial Refills: _____

Patient is interested in patient support programs

**STAMP SIGNATURE NOT ALLOWED**

Ancillary supplies and kits provided as needed for administration

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<b>CA, MA, NC &amp; PR:</b> Interchange is mandated unless Prescriber writes the words "No Substitution" _____ <b>ATTN: New York and Iowa providers,</b> please submit electronic prescription	

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# Dermatology Enrollment Form

## Medications S-Z

(Skyrizi, Stelara, Taltz, Tremfya, Xeljanz)

### Please Complete Patient, Prescriber and Patient Clinical 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"/> Skyrizi	<input type="checkbox"/> 150 mg/mL single-dose Pen <input type="checkbox"/> 150 mg/mL single-dose prefilled syringe	<input type="checkbox"/> <u>Psoriasis Induction Dose:</u> Inject 150 mg SC at Weeks 0 and 4, then maintenance dosing. <input type="checkbox"/> <u>Psoriasis Maintenance Dose:</u> Inject 150mg SC every 12 weeks. <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Stelara	<input type="checkbox"/> 45 mg/0.5 mL prefilled syringe <input type="checkbox"/> 90 mg/mL prefilled syringe	<input type="checkbox"/> <u>For patients weighing ≤100 kg (220 lbs):</u> Inject 45 mg SC initially and 4 weeks later, followed by 45 mg every 12 weeks. <input type="checkbox"/> <u>For patients weighing &gt;100 kg (220 lbs):</u> Inject 90 mg SC initially and 4 weeks later, followed by 90 mg every 12 weeks. <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Taltz	<input type="checkbox"/> 80 mg Single Dose Autoinjector <input type="checkbox"/> 80 mg Single Dose prefilled syringe	<u>Psoriasis Dosing:</u> <input type="checkbox"/> <u>Starting Dose:</u> Inject SC two 80 mg injections on Day 1, then begin first induction dose 2 weeks later. <input type="checkbox"/> <u>Induction Dose:</u> Inject SC one 80 mg injection every 2 weeks (weeks 2-10). <input type="checkbox"/> <u>Final Induction Dose:</u> Inject SC one 80 mg injection (week 12). <input type="checkbox"/> <u>Maintenance Dose:</u> Inject SC one 80 mg injection every 4 weeks. <u>Pediatric Psoriasis Dosing:</u> For patients weighing less than 25 kg dose: <input type="checkbox"/> 40 mg at Week 0, followed by 20 mg every 4 weeks. For patients weighing 25-50 kg dose: <input type="checkbox"/> 80 mg at Week 0, followed by 40 mg every 4 weeks. For patients weighing greater than 50 kg dose: <input type="checkbox"/> 160 mg (two 80 mg injections) at Week 0, followed by 80 mg every 4 weeks.	Quantity: _____ <input type="checkbox"/> 3 Pens/Syringes <input type="checkbox"/> 2 Pens/Syringes <input type="checkbox"/> 1 Pens/Syringes Refills: _____
<input type="checkbox"/> Taltz	<input type="checkbox"/> 80 mg Single Dose Autoinjector <input type="checkbox"/> 80 mg Single Dose prefilled syringe	<u>Psoriatic Arthritis Dosing:</u> <input type="checkbox"/> <u>Starting Dose:</u> Inject SC two 80 mg injections on Day 1. <input type="checkbox"/> <u>Maintenance Dose:</u> Inject SC one 80 mg injection every 4 weeks.	Quantity: _____ Refills: _____
<input type="checkbox"/> Tremfya	<input type="checkbox"/> 100 mg/mL prefilled syringe <input type="checkbox"/> 100 mg/mL One-Press patient-controlled injector	<input type="checkbox"/> <u>Starting Dose:</u> Inject 100 mg SC at weeks 0 and 4, then maintenance dosing <input type="checkbox"/> <u>Maintenance Dose:</u> Inject 100 mg SC every 8 weeks	Quantity: _____ Refills: _____
<input type="checkbox"/> Xeljanz	<input type="checkbox"/> 5 mg Tablet <input type="checkbox"/> 11 mg XR Tablet	<input type="checkbox"/> Take one 5 mg tablet PO twice daily <input type="checkbox"/> Take one 11 mg PO 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

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# Dermatology Enrollment Form

## Nursing Medications

### Please Complete Patient , Prescriber and Patient Clinical 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 3-5mL, and/or 10 mL sterile saline to access port a cath	Quantity: _____ Refills: _____
<input type="checkbox"/> Epinephrine <b>**nursing requires**</b>	<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 0.1mL/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: _____
Premed Antihistamine: <input type="checkbox"/> Diphenhydramine <input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____	Dose will be rounded to the nearest vial size
<input type="checkbox"/> Flush Orders	<input type="checkbox"/> Peripheral Access <input type="checkbox"/> Central Venus Access	<input type="checkbox"/> 0.9% Sodium Chloride flush with _____ mL IV before and after medication and IVP for Maintenance <input type="checkbox"/> 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

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<b>CA, MA, NC &amp; PR:</b> Interchange is mandated unless Prescriber writes the words "No Substitution" _____ <b>ATTN: New York and Iowa providers,</b> 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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