# Hepatitis C Enrollment Form
# Medications A-L
**(Epclusa, Harvoni, Ledipasvir/Sofosbuvir)**

CVS specialty®

**Fax Referral To:** 1-877-552-2907
**Email Referral To:** Customer.ServiceFax@CVSHealth.com
**Phone:** 1-888-345-1678

## 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):**

☐ B17.10 Acute Hepatitis C without hepatic coma
☐ B17.11 Acute Hepatitis C with hepatic coma
☐ B18.2 Chronic Hepatitis C
☐ B19.20 Unspecified Viral Hepatitis C without hepatic coma
☐ B20 HIV
☐ Other Code: _____ Description _____

**Patient Clinical Information:**

Allergies: _____ Weight: _____lb/kg Height: _____in/cm
HCV Genotype: ☐1a ☐1b ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 AND ☐ No Cirrhosis ☐ Compensated Cirrhosis ☐ Decompensated Cirrhosis
Is patient: ☐Naïve ☐Partial Responder ☐Non-Responder ☐Relapser; Last Date of Therapy: _____ Product Name(s): _____
Is patient currently on Hepatitis C Virus therapy? ☐No ☐Yes, Therapy Start Date: _____ Product Name(s): _____
Is patient post-liver transplant? ☐ Yes ☐ No For Zepatier genotype 1a patients, NS5A polymorphism present? ☐ Yes ☐ No

**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

### 5 PRESCRIPTION INFORMATION

| MEDICATION | STRENGTH | DOSE & DIRECTIONS | QUANTITY/REFILLS |
|---|---|---|---|
| ☐ Epclusa (sofosbuvir / velpatasvir) | Fixed-dose combination tablet of 400 mg sofosbuvir / 100 mg velpatasvir | Take one tablet once daily. | Quantity: _____ Refills: _____ |
| ☐ Harvoni (ledipasvir/ sofosbuvir) | Fixed-dose combination tablet of 90 mg ledipasvir / 400 mg sofosbuvir | Take PO once daily with or without food. Do not take within 4 hours of antacids. | Quantity: 28-day supply Refills: ☐ 8 weeks ☐ 12 weeks ☐ 24 weeks |
| ☐ Ledipasvir/ Sofosbuvir | Fixed-dose combination tablet of 90 mg ledipasvir / 400 mg sofosbuvir | Take PO once daily with or without food. Do not take within 4 hours of antacids. | Quantity: 28-day supply Refills: ☐ 8 weeks ☐ 12 weeks ☐ 24 weeks |

☐ 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.

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# Medications M-S
# Hepatitis C Enrollment Form

**(Mavyret, Pegasys, Pegintron, Ribavirin, Ribasphere RibaPak , Sofosbuvir/Velpatasvir, Sovaldi)**

**Please Complete Patient and Prescriber Information**

Patient Name: _____ Patient DOB: _____

Prescriber Name: _____ Prescriber Phone: _____

## 5 PRESCRIPTION INFORMATION

| MEDICATION | STRENGTH | DOSE & DIRECTIONS | QUANTITY/REFILLS |
|---|---|---|---|
| ☐ Mavyret Tablet (glecaprevir and pibrentasvir) | Fixed-dose combination tablet of 100 mg glecaprevir and 40 mg pibrentasvir | Take three tablets PO once a day with food. | Quantity: 28-day supply<br>Refills:<br>☐ 8 weeks<br>☐ 12 weeks<br>☐ Other_____ |
| ☐ Mavyret Oral Pellet (glecaprevir and pibrentasvir) | Fixed-dose combination oral pellet of 50 mg glecaprevir and 20 mg pibrentasvir | _____kg/lb<br>☐ Take three packets of oral pellets PO once daily with food.<br>☐ Take four packets of oral pellets PO once daily with food.<br>☐ Take five packets of oral pellets PO once daily with food. | Quantity: 28-day supply<br>Refills:<br>☐ 8 weeks<br>☐ 12 weeks<br>☐ Other_____ |
| ☐ Pegasys (peginterferon alfa-2a) | ☐ 180 mcg / 0.5 mL ProClick Autoinjector<br>☐ Other: _____ | ☐ Inject 180 mcg SC once a week as directed.<br>☐ Other: _____ | Quantity: _____<br>Refills: _____ |
| ☐ Pegintron (peginterferon alfa-2b) | ☐ 120 mcg REDIPEN<br>☐ 150 mcg REDIPEN<br>☐ Other: _____ | ☐ Inject _____ mcg SC weekly.<br>☐ Other: _____ | Quantity: _____<br>Refills: _____ |
| ☐ Ribavirin | ☐ 200 mg tablets<br>☐ 200 mg capsules | Take ____ tabs/caps PO q am and _____ tabs/caps q pm for a total of _____ mg daily with food. | Quantity: _____<br>Refills: _____ |
| ☐ Ribasphere RibaPak (ribavirin) | ☐ 600 / 600 mg<br>☐ 600 / 400 mg<br>☐ 400 / 400 mg<br>☐ 200 / 400 mg | Take _____ mg PO q am and _____ mg q pm for a total of _____ mg daily with food. | Quantity: _____<br>Refills: _____ |
| ☐ Sofosbuvir/ Velpatasvir | Fixed-dose combination tablet of 400 mg sofosbuvir / 100 mg velpatasvir | Take one tablet once daily. | Quantity: _____<br>Refills: _____ |
| ☐ Sovaldi (sofosbuvir) | ☐ 400 mg tablets | Take one 400 mg tablet PO once a day. | Quantity: 28-day supply<br>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<br>**Prescriber's Signature: _____Date: _____** | May Substitute / Product Selection Permitted / Substitution Permissible<br>**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.

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# Medications M-Z
# Hepatitis C Enrollment Form
**(Technivie, Viekira Pak, Vosevi, Zepatier)**

**Please Complete Patient and Prescriber Information**

Patient Name: _____ Patient DOB: _____

Prescriber Name: _____ Prescriber Phone: _____

## 5 PRESCRIPTION INFORMATION

| 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 two tablets once daily in the morning. | Quantity: 28-day supply<br>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<br>Refills:<br>☐ 12 weeks<br>☐ 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<br>Refills:<br>☐ 12 weeks<br>☐ 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<br>Refills:<br>☐ 12 weeks<br>☐ 16 weeks |

☐ 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<br>**Prescriber's Signature: _____Date: _____** | May Substitute / Product Selection Permitted / Substitution Permissible<br>**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.
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# Inflammatory Bowel Disease Enrollment Form

## Medications A (Avsola)

**Fax Referral To:** 1-800-323-2445 **Phone:** 1-800-237-2767
**Email Referral To:** Customer.ServiceFax@CVSHealth.com
**Coram National Call Center Fax :** 1-866-843-3221

**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 |
|---|---|---|---|
| ☐ Avsola | 100 mg vial | ☐ Crohn's Disease (Adult and Pediatric ≥6 years old) Induction Dose: Infuse IV at 5 mg/kg (Dose = _____mg) at weeks 0, 2, 6 and every 8 weeks thereafter<br>☐ Crohn's Disease (Adult) Maintenance Dose: Infuse IV at 5-10 mg/kg (Dose = _____mg) every 8 weeks<br>☐ Crohn's Disease (Pediatric ≥6 years old) Maintenance Dose: Infuse IV at 5 mg/kg (Dose = _____mg) every 8 weeks<br>☐ Ulcerative Colitis (Adult and Pediatric ≥6 years old) Induction Dose: Infuse IV at 5 mg/kg (Dose = _____mg) at weeks 0, 2, 6 and every 8 weeks thereafter<br>☐ Ulcerative Colitis (Adult and Pediatric ≥6 years old) Maintenance Dose: Infuse IV at 5 mg/kg (Dose = _____mg) every 8 weeks<br>☐ Other: _____ | Quantity: _____<br># of 100 mg vial(s)<br>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

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# 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 |
|---|---|---|---|
| ☐ 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<br>☐ Other: _____ | Quantity: 1 kit (6 prefilled syringes)<br>Refills: 0 |
| ☐ Cimzia | ☐ 200 mg/1 mL prefilled syringe<br>☐ 200 mg vial | Maintenance Dose: Inject SC 400 mg (2 injections) every 4 weeks<br>☐ Other: _____ | Quantity: _____<br>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 thereafter<br>☐ Maintenance Dose: 300 mg infused IV over 30 minutes every 8 weeks<br>☐ Other: _____ | Quantity: _____<br>Refills: _____ |
| ☐ Humira | Adult Crohn's Disease/Ulcerative Colitis:<br>PEN HUMIRA Starter Pack (CF)<br>80 mg/0.8 mL | Initial Dose:<br>☐ Inject SC 160 mg on Day 1, 80 mg on Day 15, then continue with maintenance dose starting Day 29<br>☐ 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<br>☐ Other: _____ | Quantity: 1 kit (3 pens)<br>Refills: 0 |
| ☐ Humira | Adult Crohn's Disease/Ulcerative Colitis:<br>☐ PEN HUMIRA (CF) 40 mg/0.4 mL<br>☐ SYRINGE HUMIRA (CF) 40 mg/0.4 mL<br>☐ PEN HUMIRA 40 mg/0.8 mL<br>☐ SYRINGE HUMIRA 40 mg/0.8 mL | Maintenance Dose:<br>☐ Inject SC 40 mg every other week<br>☐ Other: _____ | Quantity:<br>☐ #2 (1 month)<br>☐ #6 (3 month)<br>Refills: _____ |
| ☐ Humira | **17 kg (37 lbs) to less than 40 kg (88 lbs); ≥ 6 years:**<br>SYRINGE HUMIRA Starter Pack (CF)<br>80 mg/0.8 mL, 40 mg/0.4 mL | Pediatric Crohn's Disease Initial Dose:<br>☐ Inject SC 80 mg Day 1, then 40 mg Day 15, then continue with maintenance dose starting Day 29<br>☐ Other: _____ | Quantity: 1 kit (2 syringes)<br>Refills: 0 |
| ☐ Humira | **40 kg (88 lbs) and greater; ≥ 6 years:**<br>☐ PEN HUMIRA Starter Pack (CF)<br>80 mg/0.8 ml<br>☐ SYRINGE HUMIRA Starter Pack (CF)<br>80 mg/0.8 mL<br>☐ PEN HUMIRA Starter Pack<br>40 mg/0.8 mL<br>☐ SYRINGE HUMIRA Starter Pack<br>40 mg/0.8 mL | Pediatric Crohn's Disease Initial Dose:<br>☐ Inject SC 160 mg Day 1, then 80 mg Day 15, then continue with maintenance dose starting Day 29<br>☐ Inject SC 80 mg Day 1, 80 mg Day 2, 80 mg Day 15, then continue with maintenance dose starting Day 29<br>☐ Other: _____ | Quantity: QS<br>Refills: 0 |
| ☐ Humira | **17 kg (37 lbs) to less than 40 kg (88 lbs); ≥ 6 years:**<br>SYRINGE HUMIRA (CF) 20 mg/0.2 mL | Pediatric Crohn's Disease Maintenance Dose:<br>☐ Inject SC 20 mg every other week<br>☐ Other: _____ | Quantity:<br>☐ #2 (1 month)<br>☐ #6 (3 month)<br>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<br>**Prescriber's Signature: _____ Date: _____** | May Substitute / Product Selection Permitted / Substitution Permissible<br>**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

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

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# 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 |
|---|---|---|---|
| ☐ Rinvoq | 45 mg | Induction Dose:<br>☐ Take 1 tablet once daily for 8 weeks<br>☐ Other: _____ | Quantity: 1 btl = 28<br>Refill: 1 |
| ☐ Rinvoq | ☐ 15 mg<br>☐ 30 mg | Maintenance Dose:<br>☐ Take 1 tablet once daily<br>☐ Other: _____ | Quantity: _____<br>Refills: _____ |
| ☐ Simponi | ☐ 100 mg/mL in a single-dose prefilled SmartJect autoinjector<br>☐ 100 mg/mL in a single-dose prefilled syringe | ☐ 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<br>☐ Maintenance Dose: Inject SC 100 mg every 4 weeks<br>☐ Other: _____ | Quantity: _____<br>Refills: _____ |
| ☐ Stelara | 130 mg/26 mL (5 mg/mL) IV single-dose vial<br>Date Infusion was completed or scheduled: _____. (This date is needed to determine shipment of Stelara SC maintenance dosage) | Single IV Induction Dose:<br>☐ 55 kg or less 260 mg at Week 0: # of vials to be used 2<br>☐ more than 55 kg to 85 kg 390 mg at Week 0: # of vials to be used 3<br>☐ more than 85 kg 520 mg at Week 0: # of vials to be used 4<br>☐ Other: _____ | Quantity:<br>☐ 2 Vials<br>☐ 3 Vials<br>☐ 4 Vials<br>Refills: 0 |
| ☐ Stelara | 90 mg/mL<br>SC dose in a single-dose prefilled syringe | ☐ 90 mg SC dose 8 weeks after the initial IV induction dose, then every 8 weeks thereafter<br>☐ Other: _____ | Quantity: _____<br>Refills: _____ |
| ☐ 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<br>Refills: 0 |
| ☐ Xeljanz | ☐ 5 mg<br>☐ 10 mg | ☐ 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.<br>Discontinue Xeljanz after 16 weeks of treatment with 10 mg twice daily if adequate therapeutic benefit is not achieved.<br>☐ Other: _____ | Quantity: _____<br>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 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<br>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 once daily on days 1-4, followed by 0.46 mg capsule once daily on days 5-7 | Quantity: 7-day supply<br>Refill: 0 |
| ☐ Zeposia | 0.92 mg capsules | ☐ Take 0.92 mg capsule once daily<br>☐ Other: _____ | Quantity: _____<br>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<br>**Prescriber's Signature: _____ Date: _____** | May Substitute / Product Selection Permitted / Substitution Permissible<br>**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.

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# 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<br>☐ PIV ☐ PORT<br>☐ PICC | IV | Catheter Care/Flush – Only on drug admin days – SASH or PRN to maintain IV access and patency<br>PIV – NS 5 mL (Heparin 10 units/mL 3-5 mL if multiple days)<br>PORT/PICC – NS 10 mL & Heparin 100 units/mL 3-5 mL, and/or 10 mL sterile saline to access port a cath | Quantity: _____<br>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) |
| ☐ Epinephrine<br>**nursing requires** | ☐ IM<br>☐ SC | ☐ Adult 1:1000, 0.3 mL (>30 kg/>66 lbs)<br>☐ Peds 1:2000, 0.3 mL (15-30 kg/33-66 lbs)<br>☐ Infant 0.1 mL/0.1 mL, 0.1 mL (7.5-15 kg/16.5-33 lbs)<br>PRN severe allergic reaction – Call 911<br>May repeat in 5-15 minutes as needed | Quantity: _____<br>Refills: _____ |
| ☐ Diphenhydramine Oral | PO | ☐ Premedication<br>☐ 12.25 mg/kg (0-30 kg)<br>☐ 25 mg<br>☐ 50 mg (Over 30 kg)<br>PRN severe allergic reaction – Call 911 | Quantity: _____<br>Refills: _____ |
| ☐ Diphenhydramine 50 mg/mL vial | ☐ Slow IV<br>☐ IM | ☐ 1 mg/kg (under 15 kg)<br>☐ 12.5-50 mg (15-30 kg)<br>☐ 25 mg ☐ 50 mg (Over 30 kg)<br>PRN severe allergic reaction – Call 911<br>May repeat in 3-5 minutes as needed (Max dose-50 mg) | Quantity: _____<br>Refills: _____ |
| ☐ Flush Orders | ☐ Peripheral Access<br>☐ Central Venus Access | ☐ 20 mL NS post flush<br>☐ 30 mL NS post flush<br>☐ 40 mL NS post flush<br>☐ 50 mL NS post flush<br>☐ _____ | Send quantity sufficient for medication days supply |
| Additional Medication:<br>_____ | _____ | _____ | _____ |

☐ 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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**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.
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# Other Gastroenterology Enrollment Form

CVS specialty®

**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):**

☐ B16.0 Acute Hepatitis B with delta-agent with hepatic coma
☐ B16.1 Acute Hepatitis B with delta-agent without hepatic coma
☐ B16.2 Acute Hepatitis B without delta-agent with hepatic coma
☐ B16.9 Acute Hepatitis B without delta-agent and without hepatic coma
☐ B18.0 Chronic Viral Hepatitis B with delta-agent
☐ B18.1 Chronic Viral Hepatitis B without delta-agent
☐ B19.10 Unspecified Viral Hepatitis B without hepatic coma
☐ B19.11 Unspecified Viral Hepatitis B with hepatic coma
☐ K90.89 Other intestinal malabsorption
☐ K90.9 Intestinal malabsorption, unspecified
☐ R15.9 Full incontinence of feces
☐ Other Code: ____ Description _____

**Patient Clinical Information:**

Allergies:_____
Weight:_____lb/kg Height:_____In/cm TB Test Result:_____ Date:_____

**Nursing and Administration:**

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

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

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# Other Gastroenterology Enrollment Form
# Medications H – Z

**(Baraclude, Epivir-HBV, Hepsera, Vemlidy, Zorbtive, Solesta Injectable Gel)**

**Please Complete Patient and Prescriber Information**

Patient Name:_____ Patient DOB:_____

Prescriber Name:_____ Prescriber Phone:_____

## 5 PRESCRIPTION INFORMATION

| MEDICATION | STRENGTH | DOSE & DIRECTIONS | QUANTITY/REFILLS |
|---|---|---|---|
| ☐ Baraclude | ☐ 0.5 mg tablet<br>☐ 1 mg tablet<br>☐ 0.05 mg/mL oral solution | ☐ Take one tablet daily on an empty stomach (at least two hours after a meal and two hours before the next meal)<br>☐ Other: _____ | Quantity:<br>☐ 30-day supply<br>☐ Other: _____<br>Refills: _____ |
| ☐ Epivir-HBV | ☐ 100 mg tablet<br>☐ 5 mg/mL oral solution | ☐ Take one tablet once daily<br>☐ Other: _____ | Quantity:<br>☐ 30-day supply<br>☐ Other: _____<br>Refills: _____ |
| ☐ Hepsera | ☐ 10 mg tablet | ☐ Take one tablet once daily<br>☐ Other: _____ | Quantity:<br>☐ 30-day supply<br>☐ Other: _____<br>Refills: _____ |
| ☐ Vemlidy | ☐ 25 mg tablet | ☐ Take one tablet once daily with food | Quantity:<br>☐ 30-day supply<br>☐ Other: _____<br>Refills: _____ |

## 5b PRESCRIPTION INFORMATION- SHORT BOWEL SYNDROME

| MEDICATION | STRENGTH | DOSE & DIRECTIONS | QUANTITY/REFILLS |
|---|---|---|---|
| ☐ Zorbtive | ☐ 8.8 mg vial | ☐ Inject _____ mL (dose = _____ mg) subcutaneously daily. | Quantity: _____ packages (7 vials per package)<br>Refills: _____ |

## 5c PRESCRIPTION INFORMATION- FECAL INCONTINENCE

| MEDICATION | STRENGTH | DOSE & DIRECTIONS | QUANTITY/REFILLS |
|---|---|---|---|
| ☐ Solesta Injectable Gel | 4 pre-filled syringes, each containing 1 mL of Solesta + 4 individually wrapped SteriJect needles | ☐ Product will be shipped to prescriber's office unless otherwise specified | Quantity: 1 Kit<br>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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**CA, MA, NC & PR**: Interchange is mandated unless Prescriber writes the words "**No Substitution**" _____ **ATTN: New York and Iowa providers,** please submit electronic prescription

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