

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

	ATION (Complete or include of	demographic sheet)			
			DB: Gender: 🗌 Male 📗	Female	
Address:		City, State, ZIP Code	e:		
referred Contact Met	hods: Phone (to primary # pro	vided below) \Box Text (to	o cell # provided below) 🗌 Email (to email pro	vided below)	
			Pharmacy will attempt to contact by phone.	,	
Email:		Last Four of SSN:	Primary Language:		
arent/Caregiver/Lega	al Guardian Name (Last, First):	Relat	ionship to patient:		
PRESCRIBER INFO	ORMATION				
	escriber's Name: State License #: State License State L				
NPI #: D	DEA #: Group or Hos	spital:			
ddress:		City, State	e, ZIP Code:		
hone:	Fax C	ontact Person:	e, ZIP Code:Contact's Phone:		
INSURANCE INFO	RMATION Please fax copy of pr	escription and insuranc	e cards with this form, if available (front and b	ack)	
	CLINICAL INFORMATION	•	,	,	
leeds by Date:		S	hip to: Patient Office Other:		
Diagnosis (ICD-10):			p to:		
	ease, unspecified, without compli	cations \(\subseteq \text{ \(\subseteq \text{ \(\subseteq \) \\ \end{equation} \)	Date of Diagnosis//		
	olitis, unspecified, without compli		Date of Diagnosis//		
_	Description				
Patient Clinical Inform					
Allergies:		NKDA Weight:	kg lb Height: cm in		
reatment status:	New to therapy	of therapy; Date of last t	reatment/_/		
s the patient on sample	es? 🔲 No 🗒 Yes; If yes, how ma	ny samples has patient	received?		
B Test Date//	Positive Negative	☐ Hepatiti	s status:		
rior therapy, treatmer	nt dates, and reason(s) for discont	inuation:			
lursing and Administ	ration:				
Specialty pharmacy to	coordinate home health Infusion	nurse visit as necessary	? ☐ Yes ☐ No		
Specialty pharmacy to Site of Care: Home	coordinate home health Infusion Infusion* Coram Ambulatory	nurse visit as necessary / Infusion Suite (AIS)* [? ☐ Yes ☐ No ☐ Prescriber's Office** ☐ Other Infusion Clin	nic	
Site of Care: 🔲 Home	Infusion* 🔲 Coram Ambulatory	/ Infusion Suite (AIS)* [Prescriber's Office** Other Infusion Clin	nic	
Site of Care:	e Infusion*	/ Infusion Suite (AIS)* [s to be given in control	Prescriber's Office** Other Infusion Clinled setting.	nic	
Site of Care:	e Infusion*	/ Infusion Suite (AIS)* [s to be given in control l Nursing Services for dr	Prescriber's Office** Other Infusion Clin	nic	
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Site of Care: Home For Remicade/Remica Home Infusion/Coran *Prescriber's Office/O PRESCRIPTION MEDICATION Adalimumab-	e Infusion*	Infusion Suite (AIS)* Is to be given in control Nursing Services for dr facility administration Inject 40 mg SC Inject 160 mg SC	Prescriber's Office** Other Infusion Clinical Red Setting. Ug administration/therapy teach train. POSE & DIRECTIONS every other week C on Day 1 (given in one day or split over two 80 mg on Day 15, then 40 mg SC every other	QUANTITY/REFILLS Quantity: ☐ 28 days	
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Site of Care: Home For Remicade/Remica Home Infusion/Coran Prescriber's Office/O PRESCRIPTION Adalimumab- aacf (unbranded version of Idacio) Amjevita (adalimumab-atto) Other	e Infusion*	Infusion Suite (AIS)* Is to be given in control Nursing Services for dr facility administration Inject 40 mg SC Inject 160 mg SC consecutive days), week starting Day 2 Inject 40 mg SC Inject 40 mg SC Inject 40 mg SC Inject 80 mg SC very other week st Inject 160 mg SC consecutive days), starting Day 29 Dose: (STAMP SIGNAT	Prescriber's Office** Other Infusion Clinical Red setting. Ug administration/therapy teach train. POSE& DIRECTIONS every other week C on Day 1 (given in one day or split over two 80 mg on Day 15, then 40 mg SC every other 199 every other week every other week every other week on Day 1, 40 mg on Day 15, then 20 mg tarting Day 29 C on Day 1 (given in one day or split over two 80 mg on Day 15, 40 mg every other week 80 mg on Day 15, 40 mg every other week	QUANTITY/REFILLS Quantity: 28 days 84 days Refills: 28 days Quantity: 28 days 84 days Refills: Quantity: Quantity: Quantity: Quantity: Quantity:	
Site of Care: Home For Remicade/Remica Home Infusion/Coram *Prescriber's Office/O PRESCRIPTION Adalimumab- aacf (unbranded version of Idacio) Amjevita (adalimumab-atto) Other PRESCRIBER *Dispense As Written" / E	e Infusion*	Infusion Suite (AIS)* Is to be given in control Nursing Services for dr facility administration Inject 40 mg SC Inject 160 mg SC consecutive days), week starting Day 2 Inject 40 mg SC Inject 40 mg SC Inject 40 mg SC Inject 80 mg SC very other week st Inject 160 mg SC consecutive days), starting Day 29 Dose: (STAMP SIGNAT	Prescriber's Office** Other Infusion Clinical Red Setting. Ug administration/therapy teach train. POSE& DIRECTIONS every other week C on Day 1 (given in one day or split over two 80 mg on Day 15, then 40 mg SC every other 199 every other week every other week every other week on Day 1, 40 mg on Day 15, then 20 mg tarting Day 29 C on Day 1 (given in one day or split over two 80 mg on Day 15, 40 mg every other week	QUANTITY/REFILLS Quantity: 28 days 84 days Refills: 28 days Quantity: 28 days 84 days Refills: Quantity: Quantity: Quantity: Quantity: Quantity:	
Site of Care: Home For Remicade/Remica Home Infusion/Coram *Prescriber's Office/O PRESCRIPTION Adalimumab- aacf (unbranded version of Idacio) Amjevita (adalimumab-atto) Other PRESCRIBER *Dispense As Written" / E DAW / May Not Substitut	e Infusion*	Infusion Suite (AIS)* Is to be given in control Nursing Services for dr facility administration Inject 40 mg SC Inject 160 mg SC consecutive days), week starting Day 2 Inject 40 mg SC Consecutive days), starting Day 29 Dose: (STAMP SIGNAT	Prescriber's Office** Other Infusion Clinical Red Setting. Ug administration/therapy teach train. POSE& DIRECTIONS every other week C on Day 1 (given in one day or split over two 80 mg on Day 15, then 40 mg SC every other every other week every other week every other week on Day 1, 40 mg on Day 15, then 20 mg tarting Day 29 C on Day 1 (given in one day or split over two 80 mg on Day 15, 40 mg every other week TURE NOT ALLOWED) May Substitute / Product Selection Permitted /	QUANTITY/REFILLS Quantity: 28 days 84 days Refills: Quantity: 28 days 84 days Refills: Quantity: Refills:	

Patient Name:			Prescriber Information Patient Phone:	
Prescriber Name:	Patie	nt DOB:	Patient Phone: Prescriber Phone:	
Patient Clinical In				
Allergies:		DA V	Veight: 🗌 kg 🗌 lb Height: 🗀	cm 🗌 in
	☐ New to therapy ☐ Continuation			
	amples? No Yes; If yes, how many sa			
			tis status:	
	tment dates, and reason(s) for discontinuati			
MEDICATION	N INFORMATION STRENGTH		DOSE & DIRECTIONS	QUANTITY/REFILLS
MEDICATION	OTKEROTTI	Crohn's [Disease (Adult and Pediatric ≥ 6 years old)	QOARTITIVICETIEES
☐ Avsola	100 mg vial	Induction Do Infuse IV at 8 6 and every Crohn's I Infuse IV at 8 weeks Crohn's I Maintenance Infuse IV at 8 Ulcerativ Induction Do Infuse IV at 8 6 and every Ulcerativ Maintenance	ose: 5 mg/kg (Dose =mg) at weeks 0, 2, 8 weeks thereafter Disease (Adult) Maintenance Dose: 5-10 mg/kg (Dose =mg) every 8 Disease (Pediatric ≥6 years old) e Dose: 5 mg/kg (Dose =mg) every 8 weeks e Colitis (Adult and Pediatric ≥ 6 years old) ose: 5 mg/kg (Dose =mg) at weeks 0, 2, 8 weeks thereafter e Colitis (Adult and Pediatric ≥ 6 years old) e Dose: Infuse IV at 5 mg/kg	Quantity: # of 100 mg vial(s) Refills:
Adalimumabadaz (unbranded version of Hyrimoz)	40 mg/0.4 mL PEN 40 mg/0.4 mL PFS (with needle guard)	☐ Inject 40 ☐ Inject 160 over two cor	mg) every 8 weeks mg SC every other week mg SC on Day 1 (given in one day or split nsecutive days), 80 mg on Day 15, then 40 her week starting Day 29	Quantity: 28 days 84 days Refills:
Adalimumab- fkjp (unbranded version of Hulio)	☐ 20 mg/0.4 mL PFS ☐ 40 mg/0.8 mL PFS ☐ 40 mg/0.8 mL PEN	Inject 40 Inject 80 every other Inject 160 over two cor mg every otl	mg SC every other week mg SC every week mg SC on Day 1, 40mg Day 15, then 20 mg week starting Day 29 D mg SC on Day 1 (given in one day or split assecutive days), 80 mg on Day 15, then 40 her week starting Day 29	Quantity: 28 days 84 days 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		Quantity: 1 kit (6 prefilled syringes) Refills: 0
Cimzia	200 mg/1 mL prefilled syringe 200 mg vial	Maintenance Dose: Inject SC 400 mg (2 injections) every 4 weeks		Quantity: Refills:
☐ Entyvio	300 mg vial	Induction Dose: Week 0: Infusion 300 mg IV Week 2: Infusion 300 mg IV Week 6: Infusion 300 mg IV Maintenance Dose: Inject 300 mg IV every 8 weeks		Quantity: 1 Vial 2 Vials 3 Vials Refills: 0 Quantity: 1 Vial Refills:
	108 mg/0.68 mL PEN	☐ Inject 108 mg SC every 2 weeks		Quantity: 2 pens Refills:
Other	Strength:	Dose:		Quantity: Refills:
6 PRESCRIBER S	SIGNATURE REQUIRED (STAMP SIGNAT	URE NOT AL	LOWED)	
"Dispense As Writter DAW / May Not Subs Prescriber's Siç	"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute Prescriber's Signature:Date:Date:Date:Date:Date:Date:			
CA, MA, NC & PR: Int	terchange is mandated unless Prescriber writes the words " No	Substitution"	ATTN: New York and Iowa providers, ple	ease submit electronic prescription

	Please Complete Pat	ient and	Prescriber Information	
	Patient		Patient Phone:	
	e:		Prescriber Phone:	
Patient Clinical Allergies:	l Information:	١٨	/eight: 🗌 kg 🗌 lb Height: 🗍 cm	□in
			Date of last treatment/_/	□ '''
	samples? No Yes; If yes, how many samp	oles has pa	tient received?	_
			is status:	
Prior therapy, tr	eatment dates, and reason(s) for discontinuation			
	ON INFORMATION			
MEDICATION	STRENGTH		DOSE & DIRECTIONS	QUANTITY/REFILLS
			.0 mg SC every other week 60 mg SC on Day 1 (given in one day or split over two	Out and the state of
	☐ 40 mg/0.4 mL PEN		ou mg SC on Day 1 (given in one day or split over two ve days), 80 mg on Day 15,	Quantity: 28 days
☐ Hadlima	☐ 40 mg/0.8 mL PEN		g every other week starting Day 29	84 days
	40 mg/0.4 mL PFS		60 mg SC on Day 1 (given in one day or split over two	Refills:
	☐ 40 mg/0.8 mL PFS		ve days), 80 mg on Day 15, then	
			ry other week starting Day 29	
			0 mg SC every other week	
			0 mg SC every other week	Quantity:
	20 mg/0.4 mL PFS		0 mg SC on Day 1, 40 mg Day 15, then 20 mg every	28 days
☐ Hulio	☐ 40 mg/0.8 mL PFS		s starting Day 29	84 days
	☐ 40 mg/0.8 mL PEN		60 mg SC on Day 1 (given in one day or split over two ve days), 80 mg on Day 15, then	Refills:
			ry other week starting Day 29	
			0 mg SC every week	
			0 mg SC every other week	
	ļ ,		0 mg SC every week	
		☐ Inject 4	0 mg SC every other week	
			0 mg SC every other week	
	ļ ,		0 mg SC on day 1, 40 mg on day 15, then 20 mg	
			r week starting Day 29	Q
	☐ 20 mg/0.2 mL PFS		0 mg SC on day 1, 40 mg on day 8, 40 mg on day 15, g every week starting day 29	Quantity: 28 days
_	☐ 40 mg/0.4 mL PFS		g every week starting day 29 0 mg SC on day 1, 40 mg on day 8, 40 mg on day 15,	84 days
☐ Humira	40 mg/0.4 mL Pen		g every other week starting day 29	Refills:
	☐ 80 mg/0.8 mL PFS		60 mg SC on Day 1 (single-dose or split over two	110
	☐ 80 mg/0.8 mL Pen		ve days), 80 mg on Day 8, 80 mg day 15, then	
		80 mg ever	ry other week starting on Day 29	
		-	60 mg SC on Day 1 (single-dose or split over two	
			ve days), 80 mg on Day 8, 80 mg day 15, then	
	ļ ,		ry week starting on Day 29	
		-	60 mg SC on Day 1 (single-dose or split over two re days), 80 mg on Day 15, then 40 mg every other	
			re days), 80 mg on Day 15, then 40 mg every other ing on Day 29	
	20 mg/0.2 mL PFS			
	☐ 40 mg/0.4 mL PEN		20 mg SC every other week	
	☐ 80 mg/0.8 mL PEN		40 mg SC every other week 30 mg SC on Day 1, 40mg Day 15, then 20 mg every	Quantity:
Hyrimoz	40 mg/0.4 mL PFS (with needle guard)		starting Day 29	28 days
L Hymmoz	80 mg/0.8 mL PFS (with needle guard)		60 mg SC on Day 1 (given in one day or split over	84 days
	Pediatric Crohn's Starter Pack (<40kg)	-	cutive days), 80 mg on Day 15, then 40 mg every	Refills:
	☐ Pediatric Crohn's Starter Pack (≥40kg) ☐ Adult Crohn's and UC Starter Pack (carton of 3)		starting Day 29	
	Addit Cronins and OC Starter Fack (carton or 5)	☐ Inject 4	0 mg SC every other week	Quantity:
_	☐ 40 mg/0.8mL PEN		60 mg SC on Day 1 (given in one day or split over two	28 days
☐ Idacio	☐ 40 mg/0.8mL PFS		ve days), 80 mg on Day 15, then 40 mg every other	84 days
		week starti		Refills:
Other	Chronothi	Dose:	3 -7	Quantity:
☐ Otner	Strength:			Refills:
6 PRESCRIBE	ER SIGNATURE REQUIRED (STAMP SIGN	IATURE N	NOT ALLOWED)	
· ·	tten" / Brand Medically Necessary / Do Not Substitute / No Subs	stitution /	May Substitute / Product Selection Permitted /	
DAW / May Not Su			Substitution Permissible	Data
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.

ATTN: New York and Iowa providers, please submit electronic prescription

CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "No Substitution" _

			Prescriber Information	
		Patient DOB:	Patient Phone:	
Prescriber Name	o:		Prescriber Phone:	
Patient Clinical I	<u>Information:</u>	_		_
Allergies:		☐ NKDA W	/eight: 🗌 kg 🗌 lb Height: 🗌 c	m 🗌 in
	s: New to therapy Cor			
			tient received?	
TB Test Date	//_ Dositive Negative	☐ Hepatiti	is status:	
Prior therapy, tre	eatment dates, and reason(s) for disc	continuation:		
PRESCRIPT	ION INFORMATION			
MEDICATION	STRENGTH		DOSE & DIRECTIONS	QUANTITY/REFILLS
			dult and Pediatric ≥ 6 years old) <u>Induction</u>	
			g/kg (Dose =mg) at weeks 0, 2, 6 and	
☐ Inflectra		every 8 weeks thereaft		
iiiilectia		Crohn's Disease (A		
			use IV at 5-10 mg/kg (Dose =mg) every	0
☐ Infliximab		8 weeks	- diatria > 0	Quantity:
	100 mg vial	Crohn's Disease (Pe	· ·	
			use IV at 5 mg/k (Dose =mg) every 8	# of 100 mg vial(s)
Remicade		weeks		Refills:
			Adult and Pediatric \geq 6 years old) Induction	
		-	g/kg (Dose =mg) at weeks 0, 2, 6 and	
Renflexis		every 8 weeks thereaft		
			Adult and Pediatric \geq 6 years old) Maintenance	
		Dose: Infuse IV at 5 mg	g/kg (Dose =mg) every 8 weeks	
		Induction Dose		Quantity:
		_	mg via IV infusion over at least 30 minutes	1 Vial
			mg via IV infusion over at least 30 minutes	2 Vials
Omvoh	200 mg/4F ml single deservial		mg via IV infusion over at least 30 minutes	3 Vials
☐ Omvon	300 mg/15 mL single dose vial 2 x 100 mg/ mL PEN	Week 6. Illiuse 300	ring via iv iniusion over at least 30 minutes	Refills: 0
		Maintanana Dasa		Quantity:
		Maintenance Dose		28 days
			given as two consecutive injections of 100 mg	☐ 84 days
		each) at week 12 ai	nd every 4 weeks thereafter	Refills:
		Induction Dose:		Quantity:
Rinvoq	45 mg	Take 1 tablet once of	daily for 8 weeks	Refills:
		Take 1 tablet once daily for 12 weeks		
	☐ 15 mg	Maintenance Dose:	•	Quantity:
Rinvoq	☐ 30 mg	Take 1 tablet once of	daily	Refills:
	100 mg/mL in a single-dose		ect SC 200 mg initially (given as 2	
_	prefilled SmartJect autoinjector		ctions of 100 mg each) at Week 0, followed by	Quantity:
Simponi	100 mg/mL in a single-dose	100 mg at Week 2 and then 100 mg every 4 weeks		Refills:
	prefilled syringe	Maintenance Dose: Inject SC 100 mg every 4 weeks		Nonus.
	p. c.moa ojimigo		,551. 55 155 mg 5101, 7 Wooks	Quantity: 1 Vial
		Induction Dose:		Refills: 0
	☐ 600 mg/10 mL	_		Quantity: 1 Vial
	(60 mg/mL) single dose vial	Week 0: Infuse 600 mg IV over at least one hour		Refills: 0
_) mg IV over at least one hour	Quantity: 1 Vial
Skyrizi	☐ 360 mg/2.4 mL	Week 8: Infuse 600	mg IV over at least one hour	· , —
	1			Refills: <u>0</u>
	(150 mg/mL) single-dose prefilled	Maintenance Dose:		Ougatitus 1 daysiga
	cartridge with on-body injector	☐ Inject 360 mg SC week 12 and every 8 weeks thereafter		Quantity: 1 device with
				prefilled cartridge
				Refills:
Other	Strength:	☐ Dose:		Quantity:
_		_		Refills:
PRESCRIB	ER SIGNATURE REQUIRED	(STAMP SIGNAT	URE NOT ALLOWED)	
"Dispense As Writte	en" / Brand Medically Necessary / Do Not Subs	titute / No Substitution /	May Substitute / Product Selection Permitted /	
DAW / May Not Sub	ostitute		Substitution Permissible	
Prescriber's S	ignature:	Date:	Prescriber's Signature:	Date:
CA, MA, NC & PR: I	nterchange is mandated unless Prescriber writes the	he words " No Substitution "	ATTN: New York and Iowa providers, pleas	e submit electronic prescription

	Please Complete	Patient and	Prescriber Information	
Patient Name: _	Pa	tient DOB:	Patient Phone:	
Prescriber Name			Prescriber Phone:	
Patient Clinical				
Allergies:			/eight: 🗌 kg 🗌 lb Height: 🔲 c	m ∐ in
	s: New to therapy Continuat			
			tient received?	
IB Test Date	//_ Positive Negative	Hepatit	is status:	
	eatment dates, and reason(s) for discontinu	ation:		
	ION INFORMATION			
MEDICATION	STRENGTH		DOSE & DIRECTIONS	QUANTITY/REFILLS
	130 mg/26 mL (5 mg/mL) IV single-dose	Single IV Induc		Quantity:
	vial		s 260 mg at Week 0: # of vials to be used 2	2 Vials
Stelara	Date Infusion was completed or		55 kg to 85 kg 390 mg at Week 0: # of vials to	3 Vials 4 Vials
1	scheduled: (This date is needed to determine shipment of Stelara SC	be used 3		Refills: 0
1	maintenance dosage)		35 kg 520 mg at Week 0: # of vials to be used 4	Remis. O
	90 mg/mL		lose 8 weeks after the initial IV induction dose,	Quantity:
Stelara	SC dose in a single-dose prefilled syringe		eeks thereafter.	Refills:
	30 dose in a single-dose premied syninge	then every 6 we	eeks triefearter.	itemia.
1		Please complet	te a MS TOUCH/Tysabri enrollment form and	Quantity: 0
☐ Tysabri	NA		pecialty as your preferred pharmacy provider.	Refills: 0
			please contact TOUCH Prescribing Program	
		at 1-800-456-2		
			•	Quantity:
	2 mg		30 days	
☐ Velsipity		☐ Take 1 tablet by mouth once daily		90 days
				Refills:
		10 mg twice	e daily for at least 8 weeks; followed by 5 or 10	
_	☐ 5 mg	mg twice daily,	depending on therapeutic response. Use the	
☐ Xeljanz	☐ 10 mg		e dose to maintain response.	Quantity:
			ljanz after 16 weeks of treatment with 10 mg	Refills:
			dequate therapeutic benefit is not achieved.	
	☐ 40 mg/0.4 mL PEN		g SC every other week	Quantity:
☐ Yuflyma	40 mg/0.4 mL PFS		ng SC on Day 1 (given in one day or split over re days), 80 mg on Day 15, then 40 mg every	28 days
-	40 mg/0.4 mL PFS (with safety guard)		84 days	
	80 mg/0.8 mL PEN	other week star		Refills:
	28-day Starter Kit: (Four 0.23 mg		ng capsule orally once daily on days 1-4, then	Overtitud IVit (00 dev
Zeposia	capsules, three 0.46 mg capsules, and one bottle containing twenty-one 0.92 mg	0.46 mg capsule once daily on days 5-7, then 0.92 mg capsule once daily starting on day 8 and thereafter.		Quantity: 1 Kit (28-day
	capsules)	capsule office u	ally starting on day 6 and thereafter.	supply) Refill: 0
	7-Day Starter Pack	Take 0.23 mg capsule orally once daily on days 1-4,		Quantity: 7-day supply
Zeposia	(4 capsules of 0.23 mg and 3 capsules of		16 mg capsule once daily on days 5-7.	Refill: 0
	0.46 mg)	The second secon		Troma. G
	ū.	П		Quantity:
	0.92 mg capsules	☐ Take 0.92 r	ng capsule orally once daily.	Refills:
				Quantity:
7	☐ 120 mg/ mL PEN	Maintenance dose only starting at week 10:		28 days
Zymfentra	120 mg/ mL PFS (with needle guard)		once every two weeks	84 days
		·		Refills:
Other	☐ Strangth:	Dose:		Quantity:
Outer	Strength:			Refills:
6 PRESCRIB	ER SIGNATURE REQUIRED (STA	MP SIGNAT	URE NOT ALLOWED)	
			<u>, </u>	
"Dispense As Writt DAW / May Not Sul	ten" / Brand Medically Necessary / Do Not Substitute / N bstitute	o Substitution /	May Substitute / Product Selection Permitted / Substitution Permissible	
•		ite:	Prescriber's Signature:	Date:
CA, MA, NC & PR:	Interchange is mandated unless Prescriber writes the words	"No Substitution"	ATTN: New York and Iowa providers, pleas	e submit electronic prescription

Inflammatory Bowel Disease Enrollment Form Nursing Orders

		se Complete Patient and F		
Patient Name:		Patient DOB:	Patient Phone:	
			Prescriber Phone:	
Patient Clinical Informatio			63.10	
Allergies:	+ a + b a va va v	NKDA W	/eight: ☐ kg ☐ lb Height: pate of last treatment//	cm _ in
			ient received?	
TB Test Date//			is status:	
) for discontinuation:		
PRESCRIPTION INFO			ONLY BE SENT FOR INFUSIONS DONE	AT HOME/CORAM AIS**
MEDICATION/SUPPLIES	ROUTE		NGTH/ DIRECTIONS	QUANTITY/REFILLS
Catheter: PIV PORT CVC/PICC	IV	Catheter Care/Flush – Only or maintain IV access and paten PIV: NS 5 mL (Heparin 10 units	n drug admin days – SASH or PRN to acy s/mL 3-5 mL if multiple days) eparin 10 units/mL or 100 units/mL access PORT w/ huber needle	Quantity: Refills:
Hydration:	IV	Pre:	☐Other: 00 mL	Hydration max infusion rate mL/hr (Adult max rate 250 mL/hr unless otherwise indicated)
☐Epinephrine **nursing requires**	□ IM □ SC	for severe allergic reaction, al	i-30 kg/33-66 lbs) 3mg (under 15kg) ay repeat in 3-5 minutes as needed	Quantity: Refills:
☐ Diphenhydramine Oral	РО	Premedication: 12.5 mg/kg (0-30 kg) 25 mg 50 mg (Over 30 kg)		Quantity: Refills:
☐ Diphenhydramine 50 mg/mL vial **nursing required**	Slow IV	1 mg/kg (under 15 kg) 12.5 mg-50 mg (15-30 kg) 25 mg-50 mg (Over 30 kg) If mild/moderate reaction: may repeat in 3-5 minutes as needed (Adult max dose: 100 mg/day) If severe allergic reaction: call 911		Quantity: Refills:
☐ Flush Orders:	Peripheral Access Central Venous Access	☐ 10 mL NS post flush ☐ 50 mL NS post flush (recommended if no post-hydration) ☐ Other:		Send quantity sufficient for medication days supply
Additional Medication:				
Patient is interested in patient supp PRESCRIBER SIGN		STAMP SIGNATURE NOT ALLOWED JIRED (STAMP SIGNAT	,	provided as needed for administration
"Dispense As Written" / Brand M DAW / May Not Substitute Prescriber's Signature:	edically Necessary / De	Date:	May Substitute / Product Selection Permitted / Substitution Permissible Prescriber's Signature: ATTN: New York and Iowa provides	

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 requests as my signature.

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