

# Ryplazim Enrollment Form



Fax Referral To: 1-866-811-7450

Phone: 1-866-792-2731

Email Referral To: hemophilaintaketeam@cvshealth.com



CVS specialty infusion services

## Six Simple Steps to Submitting a Referral

### 1 PATIENT INFORMATION (Complete or include demographic sheet)

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender:  Male  Female

Address: \_\_\_\_\_ City, State, ZIP Code: \_\_\_\_\_

Preferred Contact Methods:  Phone (to primary # provided below)  Text (to cell # provided below)  Email (to email provided below)

Note: Carrier charges may apply. By providing the phone number(s) and email address above, you are consenting to receive automated calls, emails and/or text messages from CVS Specialty® about your prescription(s), account, and health care. Standard data rates apply. Message frequency varies. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.

Primary Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_

Email: \_\_\_\_\_ Last Four of SSN: \_\_\_\_\_ Primary Language: \_\_\_\_\_

Parent/Caregiver/Legal Guardian Name (Last, First): \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

### 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 medical 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):

E88.02 Plasminogen Deficiency Type 1 (PLGD-1)

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

#### Patient Clinical Information:

Allergies: \_\_\_\_\_ Height: \_\_\_\_\_ in/cm Weight: \_\_\_\_\_ lb/kg

#### Nursing:

Specialty pharmacy to coordinate infusion training/home health nurse visit as necessary?  Yes  No

Site of Care:  MD office  Infusion Clinic  Outpatient Health  Home Health

Infusion 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
<input type="checkbox"/> Ryplazim	<input type="checkbox"/> 68.8 mg	Infuse _____ mg via slow intravenous infusion <input type="checkbox"/> Every 2 days <input type="checkbox"/> Every 3 days <input type="checkbox"/> Every 4 days <input type="checkbox"/> Every _____ days Other: _____	Quantity: <input type="checkbox"/> 1 month <input type="checkbox"/> 3 months <input type="checkbox"/> Other: _____ Refills: <input type="checkbox"/> 1 year <input type="checkbox"/> Other: _____

### 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.

# Ryplazim Enrollment Form

## Please Complete Patient and Prescriber Information

Patient Name: \_\_\_\_\_ Patient DOB: \_\_\_\_\_ Patient Phone: \_\_\_\_\_  
 Prescriber Name: \_\_\_\_\_ Prescriber Phone: \_\_\_\_\_

## Nursing Medications

### 5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Normal Saline	Other: _____	Access Device: <input type="checkbox"/> Port <input type="checkbox"/> PICC <input type="checkbox"/> PIV <input type="checkbox"/> Butterfly <input type="checkbox"/> Other: _____ <input type="checkbox"/> _____ mL every _____	Quantity: <input type="checkbox"/> 1 month <input type="checkbox"/> 3 months <input type="checkbox"/> Other: _____ Refills: <input type="checkbox"/> 1 year <input type="checkbox"/> Other: _____
<input type="checkbox"/> Heparin	<input type="checkbox"/> 10 IU/mL <input type="checkbox"/> 100 IU/mL	Access Device: <input type="checkbox"/> Port <input type="checkbox"/> PICC <input type="checkbox"/> PIV <input type="checkbox"/> Butterfly <input type="checkbox"/> Other: _____ <input type="checkbox"/> _____ mL every _____	Quantity: <input type="checkbox"/> 1 month <input type="checkbox"/> 3 months <input type="checkbox"/> Other: _____ Refills: <input type="checkbox"/> 1 year <input type="checkbox"/> Other: _____

MEDICATION/SUPPLIES	ROUTE	DOSE/STRENGTH/DIRECTIONS	QUANTITY/REFILLS
Catheter <input type="checkbox"/> PIV <input type="checkbox"/> PORT <input type="checkbox"/> CVC/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) CVC/PICC: NS 10 mL & <input type="checkbox"/> Heparin 10 u/mL or <input type="checkbox"/> 100 units/mL 3-5mL PORT: 10 mL sterile saline to access PORT w/ huber needle NS 10 mL & Heparin 100 units/mL 3-5 mL	Quantity: _____ Refills: _____
<input type="checkbox"/> Diphenhydramine Oral	PO	<input type="checkbox"/> 12.25 mg/kg (0-30 kg) <input type="checkbox"/> 25 mg <input type="checkbox"/> 50 mg (Over 30 kg)	Quantity: _____ Refills: _____
<input type="checkbox"/> Diphenhydramine 50 mg/mL vial	<input type="checkbox"/> Slow IV <input type="checkbox"/> IM	<input type="checkbox"/> 1 mg/kg (under 15 kg) <input type="checkbox"/> 12.5-50 mg (15-30 kg) <input type="checkbox"/> 25 mg <input type="checkbox"/> 50 mg (Over 30 kg) May repeat in 3-5 minutes as needed (Max dose-50 mg)	Quantity: _____ Refills: _____
<input type="checkbox"/> Epinephrine **nursing requires**	<input type="checkbox"/> IM <input type="checkbox"/> SC	<input type="checkbox"/> 1:1000, 0.3 mg/ 0.3 mL (greater than 30 kg/66lbs) <input type="checkbox"/> 1:1000, 0.15 mg/0.3 mL (15-30 kg/33-66lbs) <input type="checkbox"/> 1:1000, 0.01 mg/kg, Max 0.3 mg (under 15 kg) Mild-Moderate Reactions. May repeat in 3-5 minutes as needed For severe allergic reaction also call 911	Quantity: _____ Refills: _____
<input type="checkbox"/> Other: _____	Other: _____	Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Other: _____	Other: _____	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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