Asthma Enrollment Form



Fax Referral To: 1-877-232-5455 Address: 500 Ala Moana Blvd., Bldg 1 Honolulu, HI 96813 Phone: 1-808-254-2727 NCPDP: 1203417

referred Contact Methods: Phone (to primary # provided below) Text (to cell # provided below) Email (to email provided below) Indication I	PAHENIIN	IFURIVIA LIVIV (COMD		h+1	
City, State, ZIP Code:	atient Name:		nete or include demographic shee	Gender:	Male Female
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D72.119 Hypereosinophilic syndrome (HES) J33.0 Polyp of the nasal cavity J33.1 Polypoid sinus degeneration J33.8 Other polyp of sinus J33.9 Nasal Polyp, unspecified (indication for dupilumab and omalizumab) Other Code: Description attent Clinical Information: Ulergies: Weight: BYRESCRIPTION INFORMATION MEDICATION STRENGTH DOSE & DIRECTIONS QUANTITY/REFILL Quantity: Inject 3 mg/kg once every 4 weeks by IV infusion over 20 to 50 minutes Unit and supply Inject 3 mg/kg once every 4 weeks by IV infusion over 20 to 50 minutes Ultrasyte needle-free connector (one per vial shipped) 30 mL syringe (one per vial shipped) 30 mL syringe (one per vial shipped) 30 mL syringe (one per vial shipped) 40 alcohol swabs Patient is interested in patient support programs STAMP SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED) DAW/ May Not Substitute M30.1 Eosinophilic Granulomators with Polyangiitis (EGPA) J33.8 Other polyp of sinus K20.0 Eosinophilic esophagitis (EoE) K20.0 Eosinophilic esophagitis (EoE) M20.1 Eosinophilic esophagitis (EoE) M20.2 Eosinophilic esophagiti			Пибб	Sovera Parciatent Acthma	
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J33.9 Nasal Polyp, unspecified (indication for dupitumab and omalizumab)] 102.119 Hyp	ereosinophilic synarom	e (HES)		
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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.

Asthma Enrollment Form

	ete Patient and Prescri			
		Patient DOB: Patient Phone:		
	:	Pr	rescriber Phone:	
	ON INFORMATION			
MEDICATION	STRENGTH		RECTIONS	QUANTITY/REFILLS
☐ Dupixent (dupilumab)	PFS ☐ 100 mg/0.67 mL pre-filled syringe ☐ 200 mg/1.14 mL pre-filled syringe ☐ 300 mg/2 mL pre-filled syringe PEN* ☐ 200 mg/1.14 mL pre-filled pen ☐ 300 mg/2 mL pre-filled pen *Comes in cartons of 2	initially then 200 mg SC eve	jection) every other week sjection) every four weeks sjection) every other week sijection) every other week sijection every other week sijection in different injection sites) ery other week sijection in different injection sites) ery other week sijection every other week	Quantity: Refills:
☐ Fasenra (benralizumab)	PFS ☐ 30 mg/mL pre-filled syringe Auto-injector ☐ 30 mg/mL Pen/Self-administered	☐ Administer 30 mg/mL b	y subcutaneous injection every 4 weeks for y injection once every 8 weeks thereafter	Quantity: 1 PFS/Pen 3 PFS/Pen Refills: 1 year Other:
□ Nucala (mepolizumab)	Vial ☐ 100 mg vial PEN ☐ Auto-injector 100 mg/mL auto-injector PFS ☐ 100 mg/mL pre-filled syringe ☐ 40 mg/0.4 mL pre-filled syringe	subcutaneously once every abdomen Pediatric (6-11 years old 4 weeks into the upper arm Chronic Rhinosinusitis with Inject 100 mg subcutane arm, thigh, or abdomen Eosinophilic Granulomatos Inject 300 mg as 3 sepal every 4 weeks into the upper Include sterile water and supply No supplies requested (sindicated) One 10 mL vial sterile water and dispensed Alcohol swabs 3 mL Luer Lock injection NDL 21G needle for record	h Nasal Polyps: eously once every 4 weeks into the upper sis with Polyagniitis (Egpa) rate 100 mg subcutaneous injections once er arm, thigh, or abdomen me (Hes) rate 100 mg subcutaneous injections once er arm, thigh, or abdomen d supplies sufficient for medication days supplies will be sent with shipment unless after for injection for every vial of Nucala	Quantity: 28-day supply 84-day supply day supply Refills: 1 year Other:
Patient is intereste	ed in patient support programs	•	JRE NOT ALLOWED Ancillary supplies and kits prov	I vided as needed for administration
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Asthma Enrollment Form

	Pleas	e Complete Patient and	Prescriber Information	
Patient Name:				
Prescriber Name:		Pı	rescriber Phone:	
5 PRESCRIPTION MEDICATION	ON INFORMATION STRENGTH	DOSE & DIRECTIONS		QUANTITY/REFILLS
☐ Tezspire (Tezepelumab)	PFS ☐ 210 mg/1.91 mL (110 mg/mL) pre-filled syringe PEN ☐ 210 mg/1.91 mL (110 mg/mL) pre-filled pen	Inject 210mg subcutaneously	y every 4 weeks	Quantity: 1 Refills: 1 Year
☐ Xolair (omalizumab)	Vial ☐ 150 mg vial kit PFS ☐ 75 mg/0.5 mL pre-filled syringe ☐ 150 mg/1 mL pre-filled syringe ☐ 300 mg/2 mL pre-filled syringe Auto-injector ☐ 75 mg/0.5 mL ☐ 150 mg/mL ☐ 300 mg/2 mL	Administer 150 mg per do Administer 225 mg per do Administer 300 mg per do Other: Administer 4 weeks Every 2 weeks dosing: Administer 225 mg per do Administer 300 mg per do Administer 375 mg per do Other: Administer 2 weeks For Xolair Vials only: Include sterile water and supply No supplies requested (so indicated) One 10 mL vial sterile wat dispensed Alcohol swabs Flexible bandages 1" x 3" 3 mL Luer Lock injection so NDL 18G x 1½" Safety Glice		Quantity: 28-day supply 84-day supply
I certify that the rational e		sthma is necessary for this patient and I Nursing Medi	will be supervising the patient's treatment accordin	gly.
MEDICATION		DOSE	& DIRECTIONS	QUANTITY/REFILLS
☐ Other:	Other:	Other:		Quantity: Refills:
☐ EpiPen	Other:	Use as directed.		Quantity: 1 Refills:
☐ EpiPen Jr.	Other:	Use as directed.		Quantity: 1 Refills:
_	l in patient support programs PRESCRIBER SIG	STAMP SIGNATURE NOT ALLOWED NATURE REQUIRED (ST	Ancillary supplies and kits TAMP SIGNATURE NOT ALLO	provided as needed for administration
"Dispense As Written DAW / May Not Subst Prescriber's Sig	n" / Brand Medically Necessary / titute gnature:	Do Not Substitute / No Substitution / Date:	May Substitute / Product Selection Permitted / Substitution Permissible Prescriber's Signature: ATTN: New York and Iowa provide	Date:

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