

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

NCPDP: 1203417

Six Simple Steps to Submitting a Referral PATIENT INFORMATION (Complete or include demographic sheet) \_City, State, ZIP Code: \_\_\_ Address: \_\_ 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. \_\_\_\_\_ Alternate Phone: Primary Language: \_\_\_\_\_ Email: \_\_\_\_\_ Last Four of SSN: \_\_\_\_\_ Parent/Caregiver/Legal Guardian Name (Last, First): \_\_\_\_\_\_\_Relationship to patient: \_\_\_\_\_ PRESCRIBER INFORMATION Prescriber's Name: \_\_\_\_ \_\_\_\_\_ State License #: \_\_\_\_\_\_ NPI #: \_\_\_\_\_ DEA #: \_\_\_\_ Group or Hospital: \_\_\_\_ Address: \_\_\_\_\_ \_\_ City, State, ZIP Code: \_\_\_\_ \_\_\_\_\_\_Fax\_\_\_\_\_Contact Person: \_\_\_\_\_\_\_Contact's Phone: \_\_\_\_\_ Phone: \_\_\_\_ INSURANCE INFORMATION Please fax copy of prescription and insurance cards with this form, if available (front and back)
INSURANCE INFORMATION
INSURANCE INFORMATION Needs by Date: Ship to: Patient Office Other: Diagnosis (ICD-10): K50.90 Crohn's Disease, unspecified, without complications Date of Diagnosis \_\_\_/\_\_\_/ Date of Diagnosis \_\_/\_\_/\_\_ K51.90 Ulcerative colitis, unspecified, without complications Other Code: \_\_\_\_\_ Description \_\_\_\_\_ **Patient Clinical Information:** ☐ NKDA Weight: \_\_\_\_ ☐ kg ☐ lb Height: \_\_\_\_ ☐ cm ☐ in Allergies: \_\_\_ Treatment status: New to therapy Continuation of therapy; Date of last treatment \_\_/\_\_/\_\_ Is the patient on samples? 🔲 No 🗋 Yes; If yes, how many samples has patient received? \_\_\_\_\_\_ TB Test Date \_\_/\_\_/ Positive Negative Prior therapy, treatment dates, and reason(s) for discontinuation: \_\_\_\_ Hepatitis status: **Nursing and Administration:** Specialty pharmacy to coordinate home health Infusion nurse visit as necessary? Yes No Site of Care: Home Infusion\* Coram Ambulatory Infusion Suite (AIS)\* Prescriber's Office\*\* Other Infusion Clinic For Remicade/Remicade Biosimilars: First three doses to be given in controlled setting. \*Home Infusion/Coram AIS: Diluents, Flushes, Supplies, Nursing Services for drug administration/therapy teach train. \*\*Prescriber's Office/Other Infusion Clinic: Drug only for facility administration 5 PRESCRIPTION INFORMATION **MEDICATION** STRENGTH **DOSE & DIRECTIONS** QUANTITY/REFILLS Quantity: Adalimumab-☐ Inject 40 mg SC every other week 28 days Inject 160 mg SC on Day 1 (given in one day or split over two aacf 40 mg/0.8 mL PEN 84 days consecutive days), 80 mg on Day 15, then 40 mg SC every other (unbranded version Refills: of Idacio) week starting Day 29 ☐ Inject 20 mg SC every other week ☐ Inject 40 mg SC every other week Ouantity: ☐ 20 mg/0.4 mL PFS ☐ Inject 80 mg SC on Day 1, 40 mg on Day 15, then 20 mg 28 days Amjevita ☐ 40 mg/0.8 mL PFS every other week starting Day 29 ☐ 84 days (adalimumab-atto) ☐ 40 mg/0.8 mL PEN ☐ Inject 160 mg SC on Day 1 (given in one day or split over two Refills: \_\_\_\_ consecutive days), 80 mg on Day 15, 40 mg every other week starting Day 29 Strength: Quantity: \_\_\_\_\_ Other Dose: \_\_\_ Refills: 6 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED) "Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / May Substitute / Product Selection Permitted / DAW / May Not Substitute Substitution Permissible Prescriber's Signature: Prescriber's 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" \_\_\_\_

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			<del></del>
	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)	QOARTITIVREITEES
☐ 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 Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute  Prescriber's Signature: Date: Date: Date:				
CA, MA, NC & PR: Int	terchange is mandated unless Prescriber writes the words " <b>No</b>	Substitution"	ATTN: New York and Iowa providers, pl	ease submit electronic prescription

	Please Complete Pat	ient and	Prescriber Information		
Patient Name: Patient D			DOB: Patient Phone:		
	e:		Prescriber Phone:		
Patient Clinical Allergies:	l Information:	١٨	/eight: 🗌 kg 🗌 lb Height: 🗍 cm	□in	
			Date of last treatment/_/	<b>□</b> '''	
	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		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:	
<b></b>	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		
			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)		
"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / 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		
		Ulcerative Colitis (A		
		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
	Z X 100 mg/ mL PEN	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 of	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	•	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
_	(00 mg/me) single dose vial		) 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			Quantity: 1 device with
		☐ Inject 360 mg SC w	reek 12 and every 8 weeks thereafter	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 " <b>No Substitution</b> "	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:	<del></del>
	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
_	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:
			30 days	
☐ Velsipity	2 mg	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	☐ Inject 160 mg SC on Day 1 (given in one day or split over		28 days
-	40 mg/0.4 mL PFS (with safety guard)	two consecutive days), 80 mg on Day 15, then 40 mg every		84 days
	80 mg/0.8 mL PEN	other week star		Refills:
	28-day Starter Kit: (Four 0.23 mg	Take 0.23 mg 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		Quantity: 1 Kit (28-day
	capsules)	capsule once daily starting on day 8 and thereafter.		supply) Refill: 0
	7-Day Starter Pack	☐ Take 0.23 m	ng capsule orally once daily on days 1-4,	Quantity: 7-day supply
Zeposia	(4 capsules of 0.23 mg and 3 capsules of	followed by 0.46 mg capsule once daily on days 5-7.		Refill: 0
	0.46 mg)	Tollowed by C.	io mg superio chos daily on days o 1.	Troma. G
	<u>.</u>	П		Quantity:
	0.92 mg capsules	☐ Take 0.92 r	ng capsule orally once daily.	Refills:
				Quantity:
	☐ 120 mg/ mL PEN	Maintenance d	ose 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	<del></del>		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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