

Asthma Enrollment Form



Fax Referral To: 1-855-297-1270

Phone: 1-888-280-1190

Address: 280 Avenida Jesus T. Pinero Ste B Rio Piedras, PR 00927

NCPDP: 4026325

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 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):

- J45.4 Moderate Persistent Asthma J45.5 Severe Persistent Asthma
 D72.119 Hypereosinophilic syndrome (HES) M30.1 Eosinophilic Granulomatosis with Polyangiitis (EGPA)
 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) K20.0 Eosinophilic esophagitis (EoE)
 Other Code: _____ Description: _____

Patient Clinical Information:

Allergies: _____ Weight: _____ lb/kg Height: _____ in/cm IgE Level: _____

Eosinophil count: _____ Cells/ μ L Date of test: ___/___/___ Number of exacerbations in the last 12 months: _____

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Cinqair (reslizumab)	100 mg/10 mL vial	Inject 3 mg/kg once every 4 weeks by IV infusion over 20 to 50 minutes <input type="checkbox"/> Include sodium chloride and supplies sufficient for medication days supply • IV administration/infusion set (0.2micron filter) • IV Cath Insyte auto guard or PIV insertion kit • Ultrasyte needle-free connector (one per vial shipped) • 30 mL syringe (one per vial shipped) • 50 mL 0.9% NaCl • 2 – 10 mL 0.9% NaCl flush • Alcohol swabs	Quantity: _____ vials <input type="checkbox"/> 28-day supply <input type="checkbox"/> 84-day supply <input type="checkbox"/> ___-day supply Refills: <input type="checkbox"/> 1 year <input type="checkbox"/> Other: _____

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.

Asthma Enrollment Form

Please Complete Patient and Prescriber Information

Patient Name: _____ Patient DOB: _____ Patient Phone: _____

Prescriber Name: _____ Prescriber Phone: _____

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Dupixent (dupilumab)	<p>PFS</p> <input type="checkbox"/> 100 mg/0.67 mL pre-filled syringe <input type="checkbox"/> 200 mg/1.14 mL pre-filled syringe <input type="checkbox"/> 300 mg/2 mL pre-filled syringe <p>PEN*</p> <input type="checkbox"/> 200 mg/1.14 mL pre-filled pen <input type="checkbox"/> 300 mg/2 mL pre-filled pen *Comes in cartons of 2	<p>Asthma: Pediatric 15 to <30 kg:</p> <input type="checkbox"/> Inject 100 mg SC (one injection) every other week <input type="checkbox"/> Inject 300 mg SC (one injection) every four weeks <p>Asthma: Pediatric ≥30 kg:</p> <input type="checkbox"/> Inject 200 mg SC (one injection) every other week <p>Asthma: Adult Initial Dose:</p> <input type="checkbox"/> Inject 400 mg SC (2-200 mg injections in different injection sites) initially then 200 mg SC every other week <input type="checkbox"/> Inject 600 mg SC (2-300 mg injections in different injection sites) initially then 300 mg SC every other week <p>Asthma: Adult Maintenance Dose:</p> <input type="checkbox"/> Inject 200 mg (one injection) SC every other week <input type="checkbox"/> Inject 300 mg (one injection) SC every other week <p>Chronic Sinusitis with Nasal Polyposis</p> <input type="checkbox"/> Inject 300 mg (one injection) SC every other week <p>Eosinophilic Esophagitis (EoE)</p> <input type="checkbox"/> Inject 300 mg SC every week	Quantity: _____ Refills: _____
<input type="checkbox"/> Fasenna (benralizumab)	<p>PFS</p> <input type="checkbox"/> 30 mg/mL pre-filled syringe <p>Auto-injector</p> <input type="checkbox"/> 30 mg/mL Pen/Self-administered	<input type="checkbox"/> Administer 30 mg/mL by subcutaneous injection every 4 weeks for the first 3 doses, followed by injection once every 8 weeks thereafter <input type="checkbox"/> Other: Administer _____	Quantity: <input type="checkbox"/> 1 PFS/Pen <input type="checkbox"/> 3 PFS/Pen Refills: <input type="checkbox"/> 1 year <input type="checkbox"/> Other: _____
<input type="checkbox"/> Nucala (mepolizumab)	<p>Vial</p> <input type="checkbox"/> 100 mg vial <p>PEN</p> <input type="checkbox"/> Auto-injector 100 mg/mL auto-injector <p>PFS</p> <input type="checkbox"/> 100 mg/mL pre-filled syringe <input type="checkbox"/> 40 mg/0.4 mL pre-filled syringe	<p>Severe Asthma</p> <input type="checkbox"/> Adults & Adolescents 12 years and older: Inject 100 mg subcutaneously once every 4 weeks into the upper arm, thigh, or abdomen <input type="checkbox"/> Pediatric (6-11 years old): Inject 40 mg subcutaneously once every 4 weeks into the upper arm, thigh, or abdomen <p>Chronic Rhinosinusitis with Nasal Polyps:</p> <input type="checkbox"/> Inject 100 mg subcutaneously once every 4 weeks into the upper arm, thigh, or abdomen <p>Eosinophilic Granulomatosis with Polyangiitis (Egpa)</p> <input type="checkbox"/> Inject 300 mg as 3 separate 100 mg subcutaneous injections once every 4 weeks into the upper arm, thigh, or abdomen <p>Hypereosinophilic Syndrome (Hes)</p> <input type="checkbox"/> Inject 300 mg as 3 separate 100 mg subcutaneous injections once every 4 weeks into the upper arm, thigh, or abdomen <input type="checkbox"/> Include sterile water and supplies sufficient for medication days supply <input type="checkbox"/> No supplies requested (supplies will be sent with shipment unless indicated) <ul style="list-style-type: none"> One 10 mL vial sterile water for injection for every vial of Nucala dispensed Alcohol swabs 3 mL Luer Lock injection syringe NDL 21G needle for reconstitution 1 mL polypropylene syringe with 21G to 27G x 1/2" needle for subcutaneous injection 	Quantity: <input type="checkbox"/> 28-day supply <input type="checkbox"/> 84-day supply <input type="checkbox"/> ___-day supply Refills: <input type="checkbox"/> 1 year <input type="checkbox"/> Other: _____

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

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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

Please Complete Patient and Prescriber Information

Patient Name: _____ Patient DOB: _____ Patient Phone: _____

Prescriber Name: _____ Prescriber Phone: _____

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Tezspire (Tezepelumab)	PFS <input type="checkbox"/> 210 mg/1.91 mL (110 mg/mL) pre-filled syringe PEN <input type="checkbox"/> 210 mg/1.91 mL (110 mg/mL) pre-filled pen	Inject 210mg subcutaneously every 4 weeks	Quantity: 1 Refills: 1 Year
<input type="checkbox"/> Xolair (omalizumab)	Vial <input type="checkbox"/> 150 mg vial kit PFS <input type="checkbox"/> 75 mg/0.5 mL pre-filled syringe <input type="checkbox"/> 150 mg/1 mL pre-filled syringe Auto-injector <input type="checkbox"/> 75 mg/0.5 mL <input type="checkbox"/> 150 mg/mL <input type="checkbox"/> 300 mg/2 mL	Every 4 weeks dosing: <input type="checkbox"/> Administer 75 mg per dose subcutaneously every 4 weeks <input type="checkbox"/> Administer 150 mg per dose subcutaneously every 4 weeks <input type="checkbox"/> Administer 225 mg per dose subcutaneously every 4 weeks <input type="checkbox"/> Administer 300 mg per dose subcutaneously every 4 weeks <input type="checkbox"/> Other: Administer _____ mg per dose subcutaneously every 4 weeks Every 2 weeks dosing: <input type="checkbox"/> Administer 225 mg per dose subcutaneously every 2 weeks <input type="checkbox"/> Administer 300 mg per dose subcutaneously every 2 weeks <input type="checkbox"/> Administer 375 mg per dose subcutaneously every 2 weeks <input type="checkbox"/> Other: Administer _____ mg per dose subcutaneously every 2 weeks For Xolair Vials only: <input type="checkbox"/> Include sterile water and supplies sufficient for medication days supply <input type="checkbox"/> No supplies requested (supplies will be sent with shipment unless indicated) <ul style="list-style-type: none"> One 10 mL vial sterile water for injection for every vial of Xolair dispensed Alcohol swabs Flexible bandages 1" x 3" 3 mL Luer Lock injection syringe NDL 18G x 1½" Safety Glide needle for reconstitution NDL 25G x 5/8" Safety Glide needle for subcutaneous injection 	Quantity: <input type="checkbox"/> 28-day supply <input type="checkbox"/> 84-day supply <input type="checkbox"/> ____-day supply Refills: <input type="checkbox"/> 1 year <input type="checkbox"/> Other: _____

I certify that the rationale for Xolair therapy for Allergic Asthma is necessary for this patient and I will be supervising the patient's treatment accordingly.

Nursing Medications

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Other: _____	Other: _____	Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> EpiPen	Other: _____	Use as directed.	Quantity: 1 Refills: _____
<input type="checkbox"/> EpiPen Jr.	Other: _____	Use as directed.	Quantity: 1 Refills: _____

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