

Fax Referral To: 1-800-323-2445

Phone: 1-800-237-2767 Email Referral To: Customer.ServiceFax@CVSHealth.com

Six Simple Steps to Submitting a Referral PATIENT INFORMATION (Complete or include demographic sheet) _____ DOB: __ _____ Gender: 🗌 Male 🔲 Female Patient Name: 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: _ _____ Last Four of SSN: Email: _____ Primary Language: ______ 2 PRESCRIBER INFORMATION Prescriber's Name: _ _____ State License #: ______ NPI #: _____ DEA #: _____ Group or Hospital: ___ _____ City, State, ZIP Cod __ City, State, ZIP Code: _____ Address: Contact's Phone: Phone: INSURANCE INFORMATION Please fax copy of prescription and insurance cards with this form, if available (front and back) 4 DIAGNOSIS AND CLINICAL INFORMATION Ship to: Patient Office Other: Needs by Date: Diagnosis (ICD-10): L28.1 Prurigo Nodularis
L40.4 Guttate Psoriasis L40.0 Psoriasis Vulgaris L40.1 Generalized Pustular Psoriasis L40.50 Arthropathic Psoriasis, Unspecified L40.54 Juvenile psoriatic arthritis L40.59 Other Psoriatic Arthropathy L40.8 Other Psoriasis L63.9 Alopecia areata, unspecified L40.9 Psoriasis, Unspecified L63.8 Other alopecia areata Other Code: _____ Description: __ L73.2 Hidradenitis Suppurativa **Patient Clinical Information:** Allergies: _____ Weight: _____In/cm TB Test Result: _____ Prior therapy, treatment dates, and reason(s) for discontinuation: _____ Treatment status: New to therapy Continuation of therapy; date of last treatment ___/__/ Needs by date: ___ **Nursing and Administration:** Specialty pharmacy to coordinate home health Infusion nurse visit as necessary? Tyes 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 QUANTITY/REFILLS STRENGTH DOSE & DIRECTIONS** ☐ Inject 40 mg SC every week ☐ Inject 40 mg SC every other week Adalimumab-28 days 40 mg/0.8 mL PEN ☐ Inject 80 mg SC every other week 84 days aacf (Unbranded Idacio) ☐ Inject 80 mg Day 1, followed by 40 mg every other week starting one Refills: _____ week after initial dose ☐ Inject 40 mg SC every week ☐ Inject 40 mg SC every other week ☐ Adalimumab-☐ Inject 80 mg SC every other week ☐ 40 mg/0.4 mL PEN ☐ Inject 80 mg SC on Day 1, followed by 40 mg every other week starting adaz ☐ 40 mg/0.4 mL PFS Quantity: (unbranded one week after initial dose version of (with needle guard) ☐ Inject 160 mg SC on Day 1 (single-dose or split over two consecutive 28 days Hyrimoz) days), 80 mg on Day 15, then 40 mg every week starting on Day 29 84 days Inject 160 mg SC on Day 1 (single-dose or split over two consecutive Refills: days), 80 mg on Day 15, then 80 mg every other week starting on Day 29 Strenath: Quantity: __ ☐ Dose: Other Refills: ☐ Patient is interested in patient support programs STAMP SIGNATURE NOT ALLOWED 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: _ CA. MA. NC & PR: Interchange is mandated unless Prescriber writes the words "No Substitution" ATTN: New York and Iowa providers, please submit electronic prescription

		Patient , Prescriber an			
			Patient		
Prescriber Name: _ Patient Clinical Info		Prescribe	er Phone:		
Allergies:					
Weight:		In/cm TB T	est Result:	Date:	
	ON INFORMATION				
MEDICATION	STRENGTH	DOSE &	directions	0	UANTITY/REFILLS
Adalimumab- fkjp (unbranded version of Hulio)	☐ 40 mg/0.8 mL PFS ☐ 40 mg/0.8 mL PEN	☐ Inject 40 mg SC every week☐ Inject 40 mg SC every other v☐ Inject 80 mg SC every other v☐ Inject 80 mg SC on Day 1, folloone week after initial dose☐ Inject 160 mg SC on Day 1 (sir days), 80 mg on Day 15, then 40☐ Inject 160 mg SC on Day 1 (sir days), 80 mg on Day 15, then 80	veek veek owed by 40 mg every other we ogle-dose or split over two cons mg every week starting on Day ogle-dose or split over two cons	ek starting Quececutive 29 Resecutive	uantity:] 28 days] 84 days efills:
Amjevita (adalimumab-atto)	☐ 40 mg/0.8 mL PFS ☐ 40 mg/0.8 mL PEN	☐ Inject 40 mg SC every week☐ Inject 40 mg SC every other v☐ Inject 80 mg SC every other v☐ Inject 80 mg Day 1, followed bweek after initial dose☐ Inject 160 mg SC on Day 1 (given consecutive days), 80 mg on Day other week dosing two weeks lat	veek veek by 40 mg every other week star ven in one day or split over two v 15. Begin 40 mg weekly or 80	Qu ting one	uantity:] 28 days] 84 days sfills:
Avsola	100 mg vial	☐ Induction Dose: Infuse IV at 5 0, 2, 6 and every 8 weeks therea: ☐ Maintenance Dose: Infuse IV (Dose =mg) every 8 weeks	mg/kg (Dose =mg) at we ter	#	uantity: of 100 mg vial(s) efills:
☐ Bimzelx	☐ 2 x 160 mg/mL PEN☐ 2 x 160 mg/mL PFS	Loading Dose: ☐ Inject 320 mg (2 x 160 mg/ml Maintenance Dose: ☐ Inject 320 mg (2 x 160 mg/ml Patients ≥ 120 kg (264lbs) may co ☐ Inject 320 mg (2 x 160 mg/ml	.) SC every 8 weeks onsider:	Qi Re <u>M</u> Qi 	pading Dose: Juantity: 28 Days Stills: 4 aintenance Dose: Juantity: 28 Days 56 Days Stills:
☐ Cimzia	Cimzia Starter Kit (6 prefilled syringes)	Psoriasis Loading Dose:		S Qu	uantity: 1 Kit efills: 0
☐ Cimzia	200 mg/1 mL prefilled syringe	Psoriasis Maintenance Dose: 400 mg (given as 2 subcutaneous injections of 200 mg each) every other week 200 mg every other week Psoriatic Arthritis Maintenance Dose: 200 mg every other week 400 mg (given as 2 subcutaneous injections of 200 mg each) every 4 weeks		Qı Re	uantity: Pfills:
Other	Strength:	Dose:		_	uantity: efills:
Patient is interested in pa		STAMP SIGNATURE NOT ALLOWED		es and kits provided a	as needed for administration
PRESCRIBER 1	SIGNATURE REQU	IRED (STAMP SIGNATU	RE NOT ALLOWED)		
/ May Not Substitute Prescriber's Signa	ature:	Not Substitute / No Substitution / DAW Date: pr writes the words "No Substitution"	May Substitute / Product Selection Substitution Permissible Prescriber's Signature:		

	Please Complete Patic	ent , Prescriber an	d Patient Clini	cal Information	
Patient Name:	Pa	atient DOB:		Patient Phone:	
		Prescribe	er Phone:		
Patient Clinical Informa					
Allergies:	lb/kg Height:	In /one TD T	ant Donults	Datas	
5 PRESCRIPTION	tb/kg Height:	IN/CM 1B I	est Result:	Date:	
			OOE O DIDECTION	10	OLIANTITY/DEELLO
MEDICATION	STRENGTH		OSE & DIRECTION	15	QUANTITY/REFILLS
☐ Cosentyx	☐ 75 mg/0.5 mL PFS ☐ 150 mg/mL PEN ☐ 150 mg/mL PFS ☐ 150 mg/mL PEN ☐ 150 mg/mL PFS ☐ 300 mg/2 mL PEN	Loading Dose: Inject 75 mg SC on Inject 150 mg SC or Inject 300 mg SC or Maintenance Dose: Inject 75 mg SC or Inject 75 mg SC or Inject 150 mg SC or Inject 150 mg SC or Inject 300 mg SC or Inject 300 mg SC or Inject 300 mg SC or	Neeks 0, 1, 2, 3 n Weeks 0, 1, 2, 3 Week 4, then every 4 ery 4 weeks n Week 4, then every ery 4 weeks n Week 4, then every very 4 weeks	4 weeks thereafter	Loading Dose: Quantity: 28 days Refills: 0 Maintenance Dose: Quantity: 28 days Refills:
☐ Dupixent	☐ PFS 300 mg/2 mL prefilled syringe ☐ Pen* 300 mg/2 mL prefilled pen *Comes in cartons of 2	Initial Prurigo Nodularis Inject 600 mg SC (2 SC every other week Maintenance Prurigo N Inject 300 mg SC every	s <u>Dose:</u> 2-300 mg injections) Iodularis Dose:	initially then 300 mg	Quantity: 28-day supply 84-day supply Other:Day supply Refills: 1 year Other:Refills
☐ Enbrel	50 mg/mL Mini 50 mg/mL PEN 50 mg/mL PFS 25 mg/0.5 mL PFS 25 mg/0.5 mL Vial	Loading Dose: Inject 50 mg SC twi 3 months, then mainter Maintenance Dose: Inject 50 mg SC one Inject mg Sc	nance dosing ce weekly	ys apart) for	Loading Dose: Quantity: 84 days Refills: 0 Maintenance Dose: Quantity: 28 days Refills:
☐ Hadlima	☐ 40 mg/0.4 mL PEN☐ 40 mg/0.8 mL PEN☐ 40 mg/0.4 mL PFS☐ 40 mg/0.8 mL PFS	☐ Inject 40 mg SC every week ☐ Inject 40 mg SC every other week ☐ Inject 80 mg SC every other week ☐ Inject 80 mg SC on Day 1, followed by 40 mg every other week starting one week after initial dose ☐ Inject 160 mg SC on Day 1 (single-dose or split over two consecutive days), 80 mg on Day 15, then 40 mg every week starting on Day 29 ☐ Inject 160 mg SC on Day 1 (single-dose or split over two consecutive days), 80 mg on Day 15, then 80 mg every other week starting on Day 29		Quantity: 28 days 84 days Refills:	
Other	Strength:	Dose:			Quantity: Refills:
Patient is interested in patient: PRESCRIBER SIG	support programs STAMPS GNATURE REQUIRED (SIGNATURE NOT ALLOWED			ded as needed for administration
"Dispense As Written" / Brar / May Not Substitute Prescriber's Signatur	nd Medically Necessary / Do Not Substi	itute / No Substitution / DAW	May Substitute / Produ Substitution Permissib Prescriber's Sign	uct Selection Permitted /	Date:submit electronic prescription

	Please Comple	ete Patient , Prescriber an	d Patient Clinical Informatio	<u>n</u>
		Patient DOB:	Patient Phone:	
	ne:	Prescribe	r Phone:	
Patient Clinical				
Allergies:	lb/kg Height	In /are TD T		
			est Result: Date: _	
	TION INFORMATION			
MEDICATION	STRENGTH		DIRECTIONS	QUANTITY/REFILLS
☐ Hulio	☐ 40 mg/0.8 mL PFS ☐ 40 mg/0.8 mL PEN	one week after initial dose Inject 160 mg SC on Day 1 (single days), 80 mg on Day 15, then 40 mg Inject 160 mg SC on Day 1 (single days), 80 mg on Day 15, then 80 mg	ek ed by 40 mg every other week starting e-dose or split over two consecutive	Quantity: 28 days 84 days Refills:
☐ Humira	☐ 40 mg/0.4 mL PFS ☐ 40 mg/0.4 mL Pen ☐ 80 mg/0.8 mL PFS ☐ 80 mg/0.8 mL Pen	subsequent doses Inject 160 mg SC on Day 1 (single days), 80 mg on Day 15, then 40 mg Inject 160 mg SC on Day 1 (single	ek O mg every other week on day 8 and e-dose or split over two consecutive	28 days 84 days Refills:
☐ Hyrimoz	40 mg/0.4 mL PEN 80 mg/0.8 mL PEN 40 mg/0.4 mL PFS (with needle guard) Psoriasis Starter Kit (1-80 mg and 2-40 mg PEN)	one week after initial dose Inject 160 mg SC on Day 1 (single days), 80 mg on Day 15, then 40 mg Inject 160 mg SC on Day 1 (single	ek ed by 40 mg every other week starting e-dose or split over two consecutive	28 days 84 days Refills:
☐ Idacio	☐ 40 mg/0.8 mL PEN ☐ 40 mg/0.8 mL PFS	☐ Inject 40 mg SC every week ☐ Inject 40 mg SC every other week ☐ Inject 80 mg SC every other week ☐ Inject 80 mg SC on Day 1, followed by 40 mg every other week starting one week after initial dose		28 days 84 days Refills:
□ Ilumya	100 mg/mL prefilled syringe	Psoriasis Induction Dose: Inject one pre-filled syringe (100 mg) SC at weeks 0 and 4, then maintenance dosing. Psoriasis Maintenance Dose: Inject one pre-filled syringe (100 mg) SC every 12 weeks.		Quantity: Refills:
☐ Inflectra		☐ Induction Dose: Infuse IV at 5 mg	g/kg	Quantity:
☐ Infliximab	100 mg vial	(Dose =mg) at weeks 0, 2, 6 and every 8 weeks thereaftermaintenance Dose: Infuse IV at 5 mg/kg (Dose =mg) every 8 weeks		# of 100 mg vial(s) Refills:
Other	Strength:	☐ Dose:		Quantity: Refills:
	d in patient support programs BER SIGNATURE REQ	STAMP SIGNATURE NOT ALLOWED UIRED (STAMP SIGNATURE)	, , , ,	ovided as needed for administration
"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute 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				

	Please Compl	ete Patient , Prescriber an	<u>d Patient Clinical Information</u>	
Patient Name: _			Patient Phone:	
		Prescribe	r Phone:	
Patient Clinical				
Allergies:	lb/kg Heigh	nt: In/cm TBTe	est Result: Date:	
	ION INFORMATION			
MEDICATION	STRENGTH	DOSE	& DIRECTIONS	QUANTITY/REFILL
Litfulo	50 mg capsule	☐ Take 50 mg orally once daily with	or without food	28 days 84 days Refills:
Olumiant	2 mg tablet 4 mg tablet	2 mg PO once daily 4 mg PO once daily		Quantity: Refills:
Orencia	125 mg/mL prefilled syringe	Inject 125 mg SC once weekly		Quantity: Refills:
☐ Otezla	Titration Starter Pack	Day 1: 10 mg PO in the morning. Day 2: 10 mg PO in the morning and 10 mg PO in the evening. Day 3: 10 mg PO in the morning and 20 mg PO in the evening. Day 4: 20 mg PO in the morning and 20 mg PO in the evening. Day 5: 20 mg PO in the morning and 30 mg PO in the evening. Day 6 and thereafter: 30 mg PO twice daily.		Quantity: 1 pack Refills: 0
Otezla	30 mg tablet	Maintenance Dose: 30 mg tablet	PO twice daily.	Quantity: Refills:
Remicade Renflexis	100 mg vial	☐ Induction Dose: Infuse IV at 5 mg/ (Dose =mg) at weeks 0, 2, 6 and ☐ Maintenance Dose: Infuse IV at 5		Quantity: # of 100 mg vial(s) Refills:
Rinvoq	15 mg	Take one 15 mg tablet PO daily		Quantity: Refills:
Siliq	Carton of two 210 mg/1.5 mL single-dose prefilled syringes	Inject one prefilled syringe (210 mg) SC at weeks 0, 1 and 2, followed by one prefilled syringe (210 mg) every 2 weeks. Prescribers must be certified in the SILIQ REMS Program to prescribe SILIQ. Please visit the following REMS website to register before prescribing SILIQ: SILIQ REMS Website (https://siliqrems.com/SiliqUI/home.u)		Quantity: Refills:
Simponi	50 mg/0.5 mL SmartJect Autoinjector 50 mg/0.5 mL prefilled syringe	Psoriatic Arthritis Dose: Inject 50 mg SC once a month.		Quantity: Refills:
☐ Simponi ARIA	50 mg/4 mL in a single- dose vial	Psoriatic Arthritis Dosing: Induction Dose: 2 mg/kg IV infusion over 30 minutes at weeks 0 and 4, then every 8 weeks thereafter Maintenance Dose: 2 mg/kg IV infusion over 30 minutes every 8 weeks		Quantity: # of 50 mg vial Refills:
Skyrizi	☐ 150 mg/mL single-dose Pen ☐ 150 mg/mL single-dose prefilled syringe	Psoriasis Induction Dose: Inject 150 mg SC at Weeks 0 and 4, then maintenance dosing. Psoriasis Maintenance Dose: Inject 150 mg SC every 12 weeks.		Quantity: Refills:
Sotyktu	6 mg tablet	Take one 6 mg tablet PO once daily		Quantity: Refills:
Other	Strength:	□ Dose:		Quantity: Refills:
	in patient support programs ER SIGNATURE REC	STAMP SIGNATURE NOT ALLOWED QUIRED (STAMP SIGNATUR	Ancillary supplies and kits provided a	as needed for administration
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CA, MA, NC & PR:	Interchange is mandated unless Pres	scriber writes the words "No Substitution"	ATTN: New York and Iowa providers, please subm	nit electronic prescription

	Please Complete	e Patient , Prescriber a	and Patient Clini	cal Information	<u>h</u>
		Patient DOB:		Patient Phone: _	
		Prescr	iber Phone:		
Patient Clinical I					
Allergies:	lb/kg Height: _	In/cm TE		Date:	
DDESCDID	TION INFORMATION	III/OIII 11	3 1651 Result	Date	
MEDICATION	STRENGTH	DOS	E & DIRECTIONS		QUANTITY/REFILLS
MEDICATION	JIKENGIII	PsO Peds patients (6 to 17yo):			QUARITI IZ RELIES
☐ Stelara	☐ 45 mg/0.5 mL prefilled syringe ☐ 90 mg/mL prefilled syringe	< 60 kg: Inject 0.75 mg/kg: thereafter. 60 kg to 100 kg: Inject 45 m 12 weeks thereafter. > 100 kg: Inject 90 mg SC at thereafter. > 100 kg: Inject 90 mg SC at thereafter. > 60 kg: Inject 0.75 mg/kg 12 weeks thereafter. > 60 kg: Inject 45 mg SC at thereafter. > 100 kg with co-existent n weeks 0 and 4, then every 12 vests a later, followed by 45 mesh 12 weeks later, followed by 90 mesh 2 mesh 12 mesh 12 mesh 13 m	ng SC at weeks 0 and 4, then eat weeks thereafter. Okg (220 lbs): Inject 45 and eat weeks. Okg (220 lbs): Inject 90 and 4, then every 12 weeks. Okg (230 lbs): Okg (every 12 weeks hen every very 12 weeks 90 mg SC at mg SC initially and mg SC initially and	Quantity: Refills:
☐ Taltz	☐ 80 mg Single Dose Autoinjector ☐ 80 mg Single Dose prefilled syringe	SC weeks 0 and 4, then every 12 weeks thereafter. Psoriasis Dosing: Starting Dose: Inject SC two 80 mg injections on Day 1, then begin first induction dose 2 weeks later. Induction Dose: Inject SC one 80 mg injection every 2 weeks (weeks 2-10). Final Induction Dose: Inject SC one 80 mg injection (week 12). Maintenance Dose: Inject SC one 80 mg injection every 4 weeks. Pediatric Psoriasis Dosing: For patients weighing less than 25 kg dose: 40 mg at Week 0, followed by 20 mg every 4 weeks. For patients weighing 25-50 kg dose: 80 mg at Week 0, followed by 40 mg every 4 weeks. For patients weighing greater than 50 kg dose: 160 mg (two 80 mg injections) at Week 0, followed by 80 mg every 4 weeks		Quantity: 3 Pens/Syringes 2 Pens/Syringes 1 Pen/Syringe Refills:	
☐ Taltz	80 mg Single Dose Autoinjector 80 mg Single Dose prefilled syringe	Psoriatic Arthritis Dosing: Starting Dose: Inject SC two 80 mg injections on Day 1. Maintenance Dose: Inject SC one 80 mg injection every 4 weeks.		Quantity: Refills:	
Other	Strength:	Dose:			Quantity: Refills:
	in patient support programs ER SIGNATURE REQU	STAMP SIGNATURE NOT ALLOWED IRED (STAMP SIGNAT		, ,,	vided as needed for administration
DAW / May Not Sub Prescriber's Si	en" / Brand Medically Necessary / Do ostitute ignature: interchange is mandated unless Prescribe	Date:	May Substitute / Product Substitution Permissible Prescriber's Signat ATTN: New York a	ture:	Date:e submit electronic prescription

	Please Comple	te Patient , Prescriber a	<u>nd Patient Clinical Informatio</u>	on .
Patient Name: _		Patient DOB:	Patient Phone:	
Prescriber Nam	:Prescriber Phone:			
<u>Patient Clinical I</u>				
Allergies:			Test Result: Date:	
			Test Result: Date:	
	TION INFORMATION			
MEDICATION	STRENGTH	DOSE	& DIRECTIONS	QUANTITY/REFILLS
☐ Tremfya	☐ 100 mg/mL prefilled syringe ☐ 100 mg/mL One-Press patient-controlled injector	Starting Dose: Inject 100 mg S dosing Maintenance Dose: Inject 100	C at weeks 0 and 4, then maintenance mg SC every 8 weeks	Quantity: Refills:
☐ Xeljanz	☐ 5 mg tablet☐ 11 mg XR tablet	☐ Take one 5 mg tablet PO twice☐ Take one 11 mg PO once daily	e daily	Quantity: Refills:
☐ Yuflyma	40 mg/0.4 mL PEN 40 mg/0.4 mL PFS 40 mg/0.4 mL PFS (with safety guard) 80 mg/0.8 mL PEN	one week after initial dose Inject 160 mg SC on Day 1 (sindays), 80 mg on Day 15, then 40 r Inject 160 mg SC on Day 1 (sindays)	eek wed by 40 mg every other week starting gle-dose or split over two consecutive	28 days 84 days Refills:
Other	Strength:	Dose:		Quantity: Refills:
	in patient support programs	STAMP SIGNATURE NOT ALLOWED		ovided as needed for administration
		UIRED (STAMP SIGNATU	_	
"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute Prescriber's Signature: Date: Prescriber's Signature: Date: Date:				

Dermatology Enrollment Form Nursing Orders

Ple	ease Comp	olete Patient , Prescriber and Patient Clinical Informati	on
Patient Name:		Patient DOB:Patient Phone	•
Prescriber Name:		Prescriber Phone:	
<u>Patient Clinical Informatio</u>	<u>on:</u>		
Allergies:			
		ht: In/cm TB Test Result: Date	
		ON **ITEMS BELOW THIS LINE WILL ONLY BE SENT FOR INFUSIONS DO	
MEDICATION/SUPPLIES	ROUTE	DOSE /STRENGTH/ DIRECTIONS	QUANTITY/REFILLS
Catheter: PIV PORT 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 & Heparin 10 units/mL or 100 units/mL 3-5 mL PORT: 10 mL sterile saline to access PORT w/ huber needle NS 10 mL & Heparin 100 units/mL 3-5 mL	Quantity: Refills:
Hydration:	IV	Pre:	Hydration max infusion rate mL/hr (Adult max rate 250 mL/hr unless otherwise indicated)
☐Epinephrine **nursing requires**	□ IM □ SC	☐ 1:1000, 0.3 mg/0.3 mL (greater than 30 kg/66lbs) ☐ 1:1000, 0.15 mg/0.3 mL (15-30 kg/33-66lbs) ☐ 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:
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 Ancillary supplies and kits EQUIRED (STAMP SIGNATURE NOT ALLOWED)	Drovided as needed for administration
"Dispense As Written" / Brand M DAW / May Not Substitute Prescriber's Signature:	edically Necessar	y / Do Not Substitute / No Substitution / Date: Date: Base of the words "No Substitution" May Substitute / Product Selection Permitted / Substitution Permissible Prescriber's Signature: ATTN: New York and Iowa providers, ple	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.

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Plan member privacy is important to us. Our employees are trained regarding the appropriate way to handle members' private health information.

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