Multiple Sclerosis IV Infusion Enrollment Form

CVS specialty™ **Fax Referral To:** 1-844-847-8585 **Phone:** 1-855-821-0356
Email Referral To: customerservicefax@caremark.com

Coram® CVS specialty infusion services

Six Simple Steps to Submitting a Referral

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

Patient Name: _____
Address: _____City, State, ZIP: _____
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.
Primary Phone: _____ Alternate Phone: _____DOB: _____
Gender: ☐ Male ☐ Female Email: _____
Last Four of SSN: _____Primary Language: _____

2 PRESCRIBER INFORMATION

Prescriber's Name: _____
State License #: _____ NPI #: _____ DEA #: _____
Group or Hospital: Abington Neurological Associates Address: 1151 Old York Road, Suite 200
City, State, ZIP: Abington, PA 19001
Phone: 215-957-9250 Fax 215-957-9254
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 ☐ Coram® Ambulatory Infusion Suite ☐ Other: _____
☐ Infusion Site: Name: _____ Address: _____
(Please include street address, suite #, city, state, ZIP)

Diagnosis (ICD-10):

☐ G35 Multiple Sclerosis (MS) ☐ Other Code: _____ Description _____
For additional ICD-10 information, please visit CVS Specialty Healthcare Professionals Website
https://www.cvsspecialty.com/wps/portal/specialty/healthcare-professionals/about-us
If MS, please indicate type:
☐ Primary progressive MS (PPMS)
☐ Relapsing-remitting MS (RRMS)
☐ Progressive-relapsing MS (PRMS)
☐ Secondary progressive MS (SPMS); If SPMS, does the patient have documented relapses? ☐ Yes ☐ No
☐ First clinical episode of MS; If so, does the patient have MRI features consistent with MS? ☐ Yes ☐ No
Height: _____in/cm Weight: _____lb/kg Allergies: _____

MS drug(s) not able to use:

Drug: _____ ☐ Inadequate response, trial duration _____
☐ Intolerance, specify: _____
☐ Contraindication, specify: _____
Drug: _____ ☐ Inadequate response, trial duration _____
☐ Intolerance, specify: _____
☐ Contraindication, specify: _____

Nursing:

Specialty pharmacy to coordinate home health infusion nurse visit necessary ☐ Yes ☐ No

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 below, 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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Please complete Patient and Prescriber information

Patient Name: _____ Patient DOB: _____

Prescriber Name: _____ Prescriber Phone: _____

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Lemtrada®	NA	Please complete an MS One to One®/Lemtrada enrollment form and indicate CVS Specialty™ as your preferred pharmacy provider. (For questions, please contact MS One to One at 1-855-676-6326).	Quantity: 0 Refills: 0
☐ Ocrevus™	300 mg/10 mL (30 mg/mL) single dose vial	☐ Induction Dose: Infuse 300 mg IV over approximately 2.5 hours. Follow with a second 300mg IV infusion over approximately 2.5 hours two weeks later. Infusions may be interrupted or slowed as needed. ☐ Maintenance Dose: Infuse 600 mg IV over approximately 3.5 hours every 6 months. Infusions may be interrupted or slowed as needed.	Quantity: ☐ 2 vials ☐ _____ Refills:_____
Diluent: ☐ Sodium Chloride	0.9%	Use as directed.	Quantity: ☐ 250 mL (induction) ☐ 500 mL (maintenance) Refills:_____
Premed Corticosteroid: ☐ Methylprednisolone ☐ Other: _____	☐ Other: _____	☐ 100mg administered IV approximately 30 minutes prior to each Ocrevus™ infusion. ☐ Other: _____	Quantity:_____ Refills:_____
Premed Antihistamine: ☐ Diphenhydramine ☐ Other: _____	☐ Other: _____	☐ Other: _____	Quantity:_____ Refills:_____
☐ Tysabri®	NA	Please complete an MS Touch®/Tysabri enrollment form and indicate CVS Specialty as your preferred pharmacy. (For questions, please contact TOUCH Prescribing Program at 1-800-456-2255).	Quantity: 0 Refills: 0
☐ Other: _____	☐ Other: _____	☐ Other: _____	Quantity:_____ Refills:_____

Complete Items below, required for Home Infusion/Coram AIS:

MEDICATION/SUPPLIES	ROUTE	DOSE/STRENGTH/DIRECTIONS	QUANTITY/REFILLS
Catheter ☐ PIV ☐ PORT ☐ PICC	☐ IV	Catheter Care/Flush – Only on drug admin days – SASH or PRN to maintain IV access and patency PIV – NS 5ml (Heparin 10 units/ml 3-5ml if multiple days) PORT/PICC – NS 10ml & Heparin 100units/ml 3-5ml, and/or 10ml sterile saline to access port a cath	Quantity:_____ Refills:_____
☐ Epinephrine **nursing requires**	☐ IM ☐ SC	☐ Adult 1:1000, 0.3mL (>30kg/>66lbs) ☐ Peds 1:2000, 0.3mL (15-30kg/33-66lbs) ☐ Infant 0.1mL/0.1mL, 0.1mL (7.5-15kg/16.5-33lbs) PRN severe allergic reaction – Call 911 May repeat in 5-15 minutes as needed	Quantity:_____ Refills:_____

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

6 PHYSICIAN SIGNATURE REQUIRED

PRODUCT SUBSTITUTION PERMITTED (Date)

X_____

DISPENSE AS WRITTEN (Date)

X_____

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