

Asthma Enrollment Form

Medications A-E

(Cinqair®, Dupixent®)



Fax Referral To: 207-899-0968
Address: 141 Preble St. Portland, ME 04101

Phone: 877-814-8447
NCPDP: 2008301

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: _____
 Address: _____ City, State, ZIP: _____
 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 Coram Ambulatory Infusion Site Other: _____

Diagnosis (ICD-10):

J45.4 Moderate Persistent Asthma J45.5 Severe Persistent Asthma
 M30.1 Eosinophilic Granulomatosis with Polyangiitis (EGPA) 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)

<https://www.cvsspecialty.com/wps/portal/specialty/healthcare-professionals/about-us>

Patient Clinical Information:

Allergies: _____ Weight: _____ lb/kg Height: _____ in/cm IgE Level: _____
 Eosinophil count: _____ Cells/µL 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 Insite autoguard or PIV insertion kit • Ultrasyte needle-free connector (one per vial shipped) • 30mL syringe (one per vial shipped) • 50mL 0.9% NaCl • 2 – 10mL 0.9% NaCl flush • Alcohol swabs	Quantity: _____ vials <input type="checkbox"/> 30-day supply <input type="checkbox"/> 90-day supply <input type="checkbox"/> _____-day supply Refills: <input type="checkbox"/> 1 year <input type="checkbox"/> Other: _____
<input type="checkbox"/> Dupixent (dupilumab)	<input type="checkbox"/> 200 mg/1.14mL PFS <input type="checkbox"/> 300 mg/2mL PFS *Come in cartons of 2 PFS	Initial Dose: <input type="checkbox"/> Inject 400mg SC (2-200mg injections in different injection sites) initially then 200mg SC every other week <input type="checkbox"/> Inject 600mg SC (2-300mg injections in different injection sites) initially then 200mg SC every other week Maintenance Dose: <input type="checkbox"/> Inject 200mg (one injection) SC every other week <input type="checkbox"/> Inject 300mg (one injection) SC every other week	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)

DISPENSE AS WRITTEN

(Date)

X _____

X _____

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.

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by telephone and destroy all copies of this communication and any attachments.

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Medications F-Z

Asthma Enrollment Form

(Fasenra®, Nucala®, Xolair®)

Please complete Patient and Prescriber information

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

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Fasenra (benralizumab)	30 mg/mL pre-filled syringe	<input type="checkbox"/> Administer 30mg/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 pre-filled syringe <input type="checkbox"/> 3 pre-filled syringes Refills: <input type="checkbox"/> 1 year <input type="checkbox"/> Other: _____
<input type="checkbox"/> Nucala (mepolizumab)	100 mg vial	<p>SEVERE ASTHMA</p> <input type="checkbox"/> Inject 100 mg subcutaneously once every 4 weeks into the upper arm, thigh or abdomen	Quantity: <input type="checkbox"/> 30-day supply <input type="checkbox"/> 90-day supply <input type="checkbox"/> ____-day supply Refills: <input type="checkbox"/> 1 year <input type="checkbox"/> Other: _____
		<p>EOSINOPHILIC GRANULOMATOSIS WITH POLYAGNIITIS (EGPA)</p> <input type="checkbox"/> Inject 300 mg as 3 separate 100mg subcutaneous injections once every 4 weeks into the upper arm, thigh or abdomen	
<input type="checkbox"/> Xolair (omalizumab)	<p>Vial</p> <input type="checkbox"/> 150 mg vial kit	<p>Every 4 weeks dosing:</p> <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	Quantity: <input type="checkbox"/> 30-day supply <input type="checkbox"/> 90-day supply <input type="checkbox"/> ____-day supply Refills: <input type="checkbox"/> 1 year <input type="checkbox"/> Other: _____
	<p>PFS</p> <input type="checkbox"/> 75mg/0.5ml pre-filled syringe <input type="checkbox"/> 150mg/1ml pre-filled syringe		
		<p>Every 2 weeks dosing:</p> <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	
		<p>For Xolair Vials only:</p> <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 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 	

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(Date)

X _____

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Nursing Medications Asthma Enrollment Form

(Epipen®, Epipen® Jr.)

Please complete Patient and Prescriber information

Patient Name: _____ Patient DOB: _____

Prescriber Name: _____ Prescriber Phone: _____

5 PRESCRIPTION INFORMATION

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

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(Date)

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(Date)

_____ _____

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