

# Multiple Sclerosis Enrollment Form



Fax Referral To: 1-877-232-5455

Address: 500 Ala Moana Blvd., Ste 1-A Honolulu, HI 96813

Phone: 1-800-896-1464

## Six Simple Steps to Submitting a Referral

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

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, ZIP Code: \_\_\_\_\_

Gender:  Male  Female

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: \_\_\_\_\_

If **Minor**, Parent/Caregiver/Guardian Name (Last, First): \_\_\_\_\_

Relationship to minor: \_\_\_\_\_

Email: \_\_\_\_\_ Last Four of SSN: \_\_\_\_\_ Primary Language: \_\_\_\_\_

### 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  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: \_\_\_\_\_

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: \_\_\_\_\_

Has pregnancy been excluded?  Yes  No  Not applicable (e.g., male, post-menopause)

**For Gilenya:** Please provide the patient's QTc interval: \_\_\_\_\_ ms  Unknown

Is the patient currently receiving therapy with Gilenya?  Yes  No

#### 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 injection training/ home health infusion nurse visit necessary  Yes  No

Site of Care:  MD office  Infusion Clinic  Outpatient Health  Home Health

Injection training not necessary. Date training occurred: \_\_\_\_\_

Reason:  MD office training patient  Pt already independent  Referred by MD to alternate trainer

# Multiple Sclerosis Enrollment Form

## Medications A-D

(Aubagio, Avonex, Bafiertam, Betaseron, Copaxone, Dalfampridine, Dimethyl Fumarate)

**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"/> Aubagio	<input type="checkbox"/> 7 mg <input type="checkbox"/> 14 mg	Take one tablet by mouth once a day.	<input type="checkbox"/> 30-day supply (1 bottle) <input type="checkbox"/> 90-day supply (3 bottles) Refills: _____
<input type="checkbox"/> Avonex	<input type="checkbox"/> 30 mcg prefilled syringe <input type="checkbox"/> 30 mcg pen (single doses)	Inject 30 mcg intramuscularly once a week	<input type="checkbox"/> 28-day supply (1 box) <input type="checkbox"/> 84-day supply (3 kits) Refills: _____
<input type="checkbox"/> Bafiertam	95 mg capsule	<input type="checkbox"/> Take one 95 mg capsule by mouth twice a day for 7 days. Starting on Day 8, take 190 mg (two 95 mg capsules) twice a day by mouth <input type="checkbox"/> Other: _____	<input type="checkbox"/> 30-day supply <input type="checkbox"/> 90-day supply <input type="checkbox"/> Other: _____ Refills: _____
<input type="checkbox"/> Betaseron	0.3 mg	<input type="checkbox"/> Inject 0.25 mg (1mL) SC every other day. <input type="checkbox"/> Dose Titration: • Weeks 1-2: Inject 0.0625 mg/0.25 mL SC QOD; • Weeks 3-4: Inject 0.125 mg/0.50 mL SC QOD; • Weeks 5-6: Inject 0.1875 mg/0.75 mL SC QOD; • Weeks 7+: Inject 0.25 mg/1 mL SC QOD <input type="checkbox"/> Other _____	<input type="checkbox"/> 28-day supply (1 kit of 14 vials) <input type="checkbox"/> 84-day supply (3 kits of 14 vials) Refills: _____
<input type="checkbox"/> Betaject Lite Autoinjector	N/A	Betaject Lite can be ordered through Betaplus #1-800-788-1467	Quantity: 0 Refills: 0
<input type="checkbox"/> Copaxone	20 mg prefilled syringe	Inject 20 mg SC daily.	<input type="checkbox"/> 30-day supply (1 kit) <input type="checkbox"/> 90-day supply (3 kits) Refills: _____
<input type="checkbox"/> Copaxone	40 mg prefilled syringe	Inject 40 mg SC three times a week.	<input type="checkbox"/> 28-day supply (12 syringes) <input type="checkbox"/> 84-day supply (36 syringes) Refills: _____
<input type="checkbox"/> Autoject 2 for glass syringe injection device	N/A	Autoject 2 can be ordered through Shared Solutions #1-800-887-8100	Quantity: 0 Refills: 0
<input type="checkbox"/> Dalfampridine	10 mg extended release tablet	Take one tablet (10 mg) twice daily (approximately 12 hours apart)	<input type="checkbox"/> 30-day supply <input type="checkbox"/> 90-day supply Refills: _____
<input type="checkbox"/> Dimethyl Fumarate	Starter Pack (14 capsules of 120 mg & 46 capsules of 240 mg)	Take one 120 mg capsule by mouth twice a day for 7 days, followed by one 240 mg capsule by mouth twice a day.	Quantity: 30-day supply Refills: _____
<input type="checkbox"/> Dimethyl Fumarate	120 mg capsule	<input type="checkbox"/> Administer 120 mg twice a day orally for seven days. <input type="checkbox"/> Other _____	Quantity: 7-day supply Refills: _____
<input type="checkbox"/> Dimethyl Fumarate	120 mg capsule	<input type="checkbox"/> Other _____	<input type="checkbox"/> 30-day supply <input type="checkbox"/> 60-day supply <input type="checkbox"/> Other: _____ Refills: _____
<input type="checkbox"/> Dimethyl Fumarate	240 mg capsule	<input type="checkbox"/> Administer 240 mg twice a day orally after day seven <input type="checkbox"/> Other _____	<input type="checkbox"/> 30-day supply <input type="checkbox"/> 90-day supply Refills: _____

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 <b>Prescriber's Signature:</b> _____ <b>Date:</b> _____	May Substitute / Product Selection Permitted / Substitution Permissible <b>Prescriber's Signature:</b> _____ <b>Date:</b> _____
<b>CA, MA, NC &amp; PR:</b> Interchange is mandated unless Prescriber writes the words "No Substitution" _____ <b>ATTN: New York and Iowa providers,</b> 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.

# Multiple Sclerosis Enrollment Form

## Medications E-L

(Extavia, Gilenya, Glatiramer Acetate, Glatopa, Kesimpta, Lemtrada)

**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"/> Extavia <input type="checkbox"/> Extavia Auto-Injector II	0.3 mg	<input type="checkbox"/> Inject 0.25 mg (1 mL) SC every other day. <input type="checkbox"/> Dose Titration: • Weeks 1-2: Inject 0.0625 mg/0.25 mL SC QOD • Weeks 3-4: Inject 0.125 mg/0.50 mL SC QOD • Weeks 5-6: Inject 0.1875 mg/0.75 mL SC QOD • Weeks 7+: Inject 0.25 mg/1 mL SC QOD <input type="checkbox"/> Other _____	<input type="checkbox"/> 30-day supply (1 kit) <input type="checkbox"/> 90-day supply (3 kits) Refills: _____
<input type="checkbox"/> Gilenya	0.5 mg	Take one capsule by mouth daily	<input type="checkbox"/> 30-day supply (1 bottle) <input type="checkbox"/> 90-day supply (3 bottles) Refills: _____
<input type="checkbox"/> Glatiramer Acetate	40 mg prefilled syringe	Inject 40 mg SC three times a week	<input type="checkbox"/> 28-day supply (12 syringes) <input type="checkbox"/> 84-day supply (36 syringes) Refills: _____
<input type="checkbox"/> WhisperJECT Autoinjector device (1st fill only)	N/A	Use as directed	Quantity: 1 Refills: 0
<input type="checkbox"/> Welcome Kit (1st fill only)	N/A	Use as directed	Quantity: 1 Refills: 0
<input type="checkbox"/> Glatopa	20 mg prefilled syringe	Inject 20 mg SC daily	<input type="checkbox"/> 30-day supply (1 kit) <input type="checkbox"/> 90-day supply (3 kits) Refills: _____
<input type="checkbox"/> Kesimpta	20 mg/0.4 mL single-dose prefilled Sensoready pen	Loading Dose: <input type="checkbox"/> Administer 20 mg subcutaneously at Week 0, 1, and 2  Maintenance Dose: <input type="checkbox"/> Administer 20 mg subcutaneously once a month starting Week 4	<input type="checkbox"/> 28-day supply <input type="checkbox"/> 84-day supply <input type="checkbox"/> Other: _____ Refills: _____
<input type="checkbox"/> Lemtrada	N/A	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

Patient is interested in patient support programs

**STAMP SIGNATURE NOT ALLOWED**

Ancillary supplies and kits provided as needed for administration

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"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute <b>Prescriber's Signature:</b> _____ <b>Date:</b> _____	May Substitute / Product Selection Permitted / Substitution Permissible <b>Prescriber's Signature:</b> _____ <b>Date:</b> _____
<b>CA, MA, NC &amp; PR:</b> Interchange is mandated unless Prescriber writes the words "No Substitution" _____ <b>ATTN: New York and Iowa providers,</b> 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.

# Multiple Sclerosis Enrollment Form

## Medications M

(Mavenclad)

**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"/> Mavenclad	10 mg tablet	Please see below for Week 1 and Week 5 dosing chart  Patient Weight: ___kg or ___lb  Treatment Course:  <input type="checkbox"/> Year 1  <input type="checkbox"/> Year 2	Week 1: 4-pack; Quantity: _____ 5-pack; Quantity: _____ 6-pack; Quantity: _____ 7-pack; Quantity: _____ 8-pack; Quantity: _____ 9-pack; Quantity: _____ 10-pack; Quantity: _____ Week 5: 4-pack; Quantity: _____ 5-pack; Quantity: _____ 6-pack; Quantity: _____ 7-pack; Quantity: _____ 8-pack; Quantity: _____ 9-pack; Quantity: _____ 10-pack; Quantity: _____ Refills: 0

**Number of MAVENCLAD (cladribine) 10 mg tablets per week**

Weight Range	Dose in mg (Number of 10 mg Tablets) per Cycle	
kg	First Cycle	Second Cycle
<input type="checkbox"/> 40 to less than 50	40 mg (4 tablets)	40 mg (4 tablets)
<input type="checkbox"/> 50 to less than 60	50 mg (5 tablets)	50 mg (5 tablets)
<input type="checkbox"/> 60 to less than 70	60 mg (6 tablets)	60 mg (6 tablets)
<input type="checkbox"/> 70 to less than 80	70 mg (7 tablets)	70 mg (7 tablets)
<input type="checkbox"/> 80 to less than 90	80 mg (8 tablets)	70 mg (7 tablets)
<input type="checkbox"/> 90 to less than 100	90 mg (9 tablets)	80 mg (8 tablets)
<input type="checkbox"/> 100 to less than 110	100 mg (10 tablets)	90 mg (9 tablets)
<input type="checkbox"/> 110 and above	100 mg (10 tablets)	100 mg (10 tablets)

Patient is interested in patient support programs

**STAMP SIGNATURE NOT ALLOWED**

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<b>CA, MA, NC &amp; PR:</b> Interchange is mandated unless Prescriber writes the words "No Substitution" _____ <b>ATTN: New York and Iowa providers,</b> please submit electronic prescription	

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# Multiple Sclerosis Enrollment Form

## Medications M-O

(Mayzent, Ocrevus)

**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"/> Mayzent Starter Pack (for 1 mg maintenance dose patients)	0.25 mg tablet	<input type="checkbox"/> Day 1: take 1 x 0.25 mg tablet by mouth once a day; Day 2: take 1 x 0.25 mg tablet by mouth once a day; Day 3: take 2 x 0.25 mg tablets by mouth once a day; Day 4: take 3 X 0.25 mg tablets once a day <input type="checkbox"/> Other: _____	Quantity: 4-day supply Refill: 0
<input type="checkbox"/> Mayzent Starter Pack (for 2 mg maintenance dose patients)	0.25 mg tablet	<input type="checkbox"/> Day 1: take 1 x 0.25 mg tablet by mouth once a day; Day 2: take 1 x 0.25 mg tablet by mouth once a day; Day 3: take 2 x 0.25 mg tablets by mouth once a day; Day 4: take 3 X 0.25 mg tablets once a day; Day 5: take 5 X 0.25 mg tablets once a day. <input type="checkbox"/> Other: _____	Quantity: 5-day supply Refill: 0
<input type="checkbox"/> Mayzent (maintenance prescription)	<input type="checkbox"/> 1 mg tablet <input type="checkbox"/> 2 mg tablet	Administer one tablet by mouth once a day.	<input type="checkbox"/> 30-day supply <input type="checkbox"/> 90-day supply Refills: _____
<input type="checkbox"/> Ocrevus	300 mg/10 mL (30 mg/mL) single dose vial	<input type="checkbox"/> <b>Induction:</b> Infuse 300 mg IV over approximately 2.5 hours. Follow with a second 300 mg IV infusion over approximately 2.5 hours two weeks later. Infusions may be interrupted or slowed as needed. <input type="checkbox"/> <b>Maintenance:</b> Infuse 600 mg IV over approximately 2 to 3.5 hours every 6 months. Infusions may be interrupted or slowed as needed. <b>Please use the following toll-free fax/phone numbers for Ocrevus enrollments.</b> <b>Fax: 1-855-592-6890; Phone: 1-866-526-4984</b>	<input type="checkbox"/> 2 vials <input type="checkbox"/> Other: _____ Refills: _____

Patient is interested in patient support programs

**STAMP SIGNATURE NOT ALLOWED**

Ancillary supplies and kits provided as needed for administration

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<b>CA, MA, NC &amp; PR:</b> Interchange is mandated unless Prescriber writes the words "No Substitution" _____ <b>ATTN: New York and Iowa providers,</b> please submit electronic prescription	

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# Multiple Sclerosis Enrollment Form

## Medications P-T

(Plegridy, Ponvory, Rebif, Ribject II, Tecfidera)

**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"/> Plegridy	<input type="checkbox"/> Pen Starter Pack (one 63 mcg pen & one 94 mcg pen) <input type="checkbox"/> Pre-Filled Syringe Starter Pack (one 63 mcg pre-filled syringe & one 94 mcg pre-filled syringe)	<input type="checkbox"/> Administer 63 mcg/0.5 mL SC on Day 1 followed by 94 mcg/0.5 mL SC on Day 15 <input type="checkbox"/> Administer 63 mcg/0.5 mL IM on Day 1 followed by 94 mcg/0.5 mL IM on Day 15	Quantity: 28-day supply Refills: _____
<input type="checkbox"/> Plegridy	<input type="checkbox"/> Pen Maintenance Pack (two 125 mcg pens) for SC administration <input type="checkbox"/> Pre-Filled Syringe Maintenance Pack (two 125 mcg pre-filled syringes) for SC administration <input type="checkbox"/> Pre-Filled Syringe Maintenance Pack (two 125 mcg pre-filled syringes) for IM administration	<input type="checkbox"/> Administer 125 mcg/0.5 mL SC every 14 days <input type="checkbox"/> Administer 125 mcg/0.5 mL IM every 14 days. <input type="checkbox"/> Other _____	<input type="checkbox"/> 28-day supply (1 pk) <input type="checkbox"/> 84-day supply (3 pks) Refills: _____
<input type="checkbox"/> Ponvory	Starter Pack	<b>Titration:</b> Day 1-2: Take 2 mg tablet by mouth once daily Day 3-4: Take 3 mg tablet by mouth once daily Day 5-6: Take 4 mg tablet by mouth once daily Day 7: Take 5 mg tablet by mouth once daily Day 8: Take 6 mg tablet by mouth once daily Day 9: Take 7 mg tablet by mouth once daily Day 10: Take 8 mg tablet by mouth once daily Day 11: Take 9 mg tablet by mouth once daily Day 12-14: Take 10 mg tablet by mouth once daily	Quantity: 14-day starter pack Refills: _____
<input type="checkbox"/> Ponvory	20 mg tablets	<b>Maintenance Dose</b> Day 15 and thereafter: Take 20 mg tablet by mouth once daily	<input type="checkbox"/> 30-day supply (30 tablets) <input type="checkbox"/> 90-day supply (90 tablets) Refills: _____
<input type="checkbox"/> Rebif	<input type="checkbox"/> Titration Pack (six 8.8 mcg & six 22 mcg prefilled syringes) <input type="checkbox"/> Rebidose Titration Pack (six 8.8 mcg prefilled autoinjectors & six 22 mcg prefilled autoinjectors)	Weeks 1-2: Inject 8.8 mcg SC three times a week Weeks 3-4: Inject 22 mcg SC three times a week	Quantity: 28-day supply (1 kit) Refills: _____
<input type="checkbox"/> Rebif <input type="checkbox"/> Ribject II	<input type="checkbox"/> 22 mcg prefilled syringe <input type="checkbox"/> 44 mcg prefilled syringe <input type="checkbox"/> Rebidose 22 mcg prefilled autoinjector <input type="checkbox"/> Rebidose 44 mcg prefilled autoinjector	<input type="checkbox"/> Inject 44 mcg SC three times a week. <input type="checkbox"/> Other _____	<input type="checkbox"/> 28-day supply (1 kit) <input type="checkbox"/> 84-day supply (3 kits) Refills: _____
<input type="checkbox"/> Tecfidera	Titration Starter Pack (14 capsules of 120 mg & 46 capsules of 240 mg)	Take one 120 mg capsule by mouth twice a day for 7 days, followed by one 240 mg capsule by mouth twice a day.	Quantity: 30-day supply Refills: _____
<input type="checkbox"/> Tecfidera	<input type="checkbox"/> 120 mg capsules <input type="checkbox"/> 240 mg capsules	<input type="checkbox"/> Take 240 mg by mouth twice a day. <input type="checkbox"/> Other _____	<input type="checkbox"/> 7-day supply <input type="checkbox"/> 30-day supply <input type="checkbox"/> 90-day supply Refills: _____

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

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<b>CA, MA, NC &amp; PR:</b> Interchange is mandated unless Prescriber writes the words "No Substitution" _____ <b>ATTN: New York and Iowa providers,</b> please submit electronic prescription	

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# Multiple Sclerosis Enrollment Form

## Medications T-Z

(Tysabri, VUMERITY, Zeposia)

**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"/> 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 Refill: 0
<input type="checkbox"/> VUMERITY	231 mg capsule	<input type="checkbox"/> Take one 231 mg capsule twice a day by mouth for 7 days. Starting on Day 8, take 462 mg (two 231 mg capsules) twice a day by mouth. <input type="checkbox"/> Other _____	<input type="checkbox"/> 30-day supply <input type="checkbox"/> 90-day supply Refills: _____
<input type="checkbox"/> Zeposia	Starter Kit (4 capsules of 0.23 mg, 3 capsules of 0.46 mg and one bottle containing 30 capsules of 0.92 mg)	Take 0.23 mg capsule once daily on days 1-4, followed by 0.46 mg capsule once daily on days 5-7, then take 0.92 mg capsule once daily starting on day 8)	Quantity: 37-day supply Refill: 0
<input type="checkbox"/> Zeposia	7-Day Starter Pack (4 capsules of 0.23 mg and 3 capsules of 0.46 mg)	Take 0.23 mg capsule once daily on days 1-4, followed by 0.46 mg capsule once daily on days 5-7	Quantity: 7-day supply Refill: 0
<input type="checkbox"/> Zeposia	0.92 mg capsules	Take 0.92 mg capsule once daily	<input type="checkbox"/> 30-day supply <input type="checkbox"/> 90-day supply Refills: _____

## Nursing Medications

### 5 PRESCRIPTION INFORMATION

**Complete items below, required for Home Infusion/Coram AIS:**

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

Patient is interested in patient support programs

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<b>CA, MA, NC &amp; PR:</b> Interchange is mandated unless Prescriber writes the words "No Substitution" _____ <b>ATTN: New York and Iowa providers,</b> please submit electronic prescription	

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**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.

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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