Hemophilia Enrollment Form

Fax Referral To: 1-888-280-1191 OR 787-759-4161
Phone: 1-888-280-1190 OR 787-759-4162
Email Referral To: Customer.ServiceFax@CVSHealth.com
Address: 280 Avenida Jesus T. Pinero Ste B Rio Piedras, PR 00927

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 ☐ Other: _____

Diagnosis (ICD-10):

☐ D66 Hereditary factor VIII deficiency
☐ D67 Hereditary factor IX deficiency
☐ D68.0 Von Willebrand's disease
☐ D68.311 Acquired hemophilia
☐ D68.318 Other hemorrhagic disorder due to intrinsic circulating anticoagulants, antibodies, or inhibitors
☐ D68.8 Other specified coagulation defects
☐ D68.9 Coagulation defect, unspecified
☐ D68.2 Hereditary deficiency of other clotting factors
☐ Other Code: _____Description: _____

Patient Clinical Information:

Allergies: _____ Height: _____in/cm Weight: _____lb/kg

Nursing:

Specialty pharmacy to coordinate injection or infusion training/ home health infusion nurse visit necessary ☐ Yes ☐ No
Site of Care: ☐ MD office ☐ Infusion Clinic ☐ Outpatient Health ☐ Home Health
Injection/Infusion training not necessary. Date training occurred: _____
Reason: ☐ MD office training patient ☐ Pt already independent ☐ Referred by MD to alternate trainer

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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
☐ Advate ☐ Adynovate ☐ Afstyla ☐ Alphanate ☐ AlphaNine ☐ Alprolix ☐ BeneFIX ☐ Coagadex ☐ Corifact ☐ Ceprotin ☐ Eloctate ☐ Feiba NF ☐ Hemofil-M ☐ Humate-P ☐ Idelvion ☐ Ixinity ☐ Jivi ☐ Koate-DVI ☐ Kogenate ☐ Kovaltry ☐ Novoeight ☐ Nuwiq ☐ Obizur ☐ Profilnine ☐ Rebinyn ☐ Recombinate ☐ Rixubis ☐ Thrombate III ☐ Tretten ☐ Vonvendi ☐ Wilate ☐ Xyntha	_____ IU/kg	☐ Prophylaxis: _____ ☐ Breakthrough Bleed: Infuse ____ units (+/- 10%) slow IV push every ____ hours / days (circle one) for a total of ____ doses as needed for bleeding episodes. Contact your physician's office if bleeding does not resolve. Minor: ☐ ____ IU q ____ hr PRN ☐ Other: _____ Major: ☐ ____ IU q ____ hr PRN ☐ Other: _____ ☐ Immune Tolerance: _____	Quantity: ☐ 1 mo ☐ 3 mo ☐ Other:_____ Refills: ☐ 1 year ☐ Other: _____
☐ Amicar	☐ Tablet 500 mg ☐ Tablet 1,000 mg ☐ Syrup 25%	☐ Other:_____	Quantity: ☐ 1 mo ☐ 3 mo ☐ Other:_____ Refills: ☐ 1 year ☐ Other: _____
☐ Esperoct	____ IU/kg	☐ Prophylaxis: ___ IU/kg every __ days or __ times per week ☐ Breakthrough Bleed: ___ IU/kg as needed for bleeding episodes. Contact your physician's office if bleeding does not resolve. ☐ Other: _____	Refills: ☐ 1 year ☐ Other: _____
☐ Hemlibra	☐ 30 mg/mL ☐ 60 mg/0.4 mL ☐ 105 mg/0.7 mL ☐ 150 mg/1 mL	☐ Initial dose: 3 mg/kg subcutaneously once weekly for 4 weeks ☐ Maintenance dose: ☐ 1.5 mg/kg subcutaneously every week ☐ 3 mg/kg subcutaneously every 2 weeks ☐ 6 mg/kg subcutaneously every 4 weeks Weight: _____ kg	Quantity: ☐ 1 mo ☐ 3 mo ☐ Other:_____ Refills: ☐ 1 year ☐ Other: _____
☐ NovoSeven RT	___ mcg/kg	Infuse _____ mcg/kg slow IV push every _____ hours, and/or _____ _____	Quantity: ☐ 1 mo ☐ 3 mo ☐ Other:_____ Refills: ☐ 1 year ☐ Other: _____
☐ SevenFact	☐ 1 mg ☐ 5 mg	For Mild/Moderate bleeds : ☐ 75 mcg/kg repeat q 3 hours until hemostasis achieved or ☐ Initial dose of 225 mcg/kg. May infuse 75 mcg/kg q 3 hours prn if hemostasis not achieved within 9 hours. For Severe bleeds : ☐ 225 mcg/kg, followed if necessary 6 hours later with 75 mcg/kg every 2 hours. ☐ Other_____ Round to nearest whole vial. Weight: _____ kg	Quantity: ☐ 1 mo ☐ 3 mo ☐ Other:_____ Refills: ☐ 1 year ☐ 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	May Substitute / Product Selection Permitted / Substitution Permissible
Prescriber's Signature: _____Date: _____	**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.

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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
☐ Stimate	150 mcg	☐ Weight <50 kg: Single spray in one nostril ☐ Weight >50 kg: Single spray in each nostril (2 sprays total) ☐ Other: _____	Quantity: ☐ 1 mo ☐ 3 mo ☐ Other:_____ Refills: ☐ 1 year ☐ Other: _____
☐ Normal Saline	Other:_____	Access Device: ☐ Port ☐ PICC ☐ PIV ☐ Butterfly ☐ Other: _____ ☐ _____ mL every _____	Quantity: ☐ 1 mo ☐ 3 mo ☐ Other:_____ Refills: ☐ 1 year ☐ Other: _____
☐ Heparin	☐ 10 IU/mL ☐ 100 IU/mL	Access Device: ☐ Port ☐ PICC ☐ PIV ☐ Butterfly ☐ Other: _____ ☐ _____ mL every _____	Quantity: ☐ 1 mo ☐ 3 mo ☐ Other:_____ Refills: ☐ 1 year ☐ Other: _____

MEDICATION/SUPPLIES	ROUTE	DOSE/STRENGTH/DIRECTIONS
Catheter ☐ PIV ☐ PORT ☐ 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) PORT/PICC – NS 10 mL & Heparin 100 units/mL 3-5 mL, and/or 10 mL sterile saline to access port a cath
☐ Diphenhydramine Oral	PO	☐ 12.25 mg/kg (0-30 kg) ☐ 25 mg ☐ 50 mg (Over 30 kg)
☐ Diphenhydramine 50 mg/mL vial	☐ Slow IV ☐ IM	☐ 1 mg/kg (under 15 kg) ☐ 12.5-50 mg (15-30 kg) ☐ 25 mg ☐ 50 mg (Over 30 kg) May repeat in 3-5 minutes as needed (Max dose-50 mg)
☐ Epinephrine **nursing requires**	☐ IM ☐ SC	☐ Adult 1:1000, 0.3 mL (>30 kg/>66 lbs) ☐ Peds 1:2000, 0.3 mL (15-30 kg/33-66 lbs) ☐ Infant 0.1 mL/0.1 mL, 0.1 mL (7.5-15 kg/16.5-33 lbs) PRN severe allergic reaction – Call 911 May repeat in 5-15 minutes as needed
☐ Other: _____	Other: _____	Other: _____
☐ Other: _____	Other: _____	Other: _____

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