Lysosomal Storage Disorders Enrollment Form

CVS specialty®

Fax Referral To: 1-855-297-1270 **Phone:** 1-888-280-1190
Address: 280 Avenida Jesus T. Pinero Ste B Rio Piedras, PR 00927 **NCPDP:** 4026325

Six Simple Steps to Submitting a Referral

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

Patient Name: _____DOB: _____ Gender: ☐ Male ☐ Female
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: _____
Email: _____ Last Four of SSN: _____ Primary Language: _____
Parent/Caregiver/Legal Guardian Name (Last, First): _____**Relationship to patient**: _____

2 PRESCRIBER INFORMATION

Prescriber's Name: _____ Group or Hospital: _____
State License #: _____ NPI #: _____DEA #: _____
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: _____

Diagnosis (ICD-10):

Date of Diagnosis: _____
☐ E74.02 Pompe Disease: ☐ Infantile Onset ☐ Late Onset
☐ E75.21 Fabry Disease: Exhibiting clinical signs/symptoms? ☐ Yes ☐ No
☐ E75.22 Gaucher Disease: ☐ Type 1 ☐ Type 2 ☐ Type 3
CYP2D6 Genotype: ☐ Ultra Rapid ☐ Extensive ☐ Intermediate ☐ Poor
☐ E75.24 Niemann-Pick disease, acid sphingomyelinase deficiency (ASMD)
☐ E75.5 Other Lipid Storage Disorders
☐ E76.0 Mucopolysaccharidosis I (MPS I)
☐ E76.1 Mucopolysaccharidosis II (MPS II, Hunter Syndrome)
☐ E76.219 Mucopolysaccharidosis IVA (MPS IVA, Moroquio A Syndrome)
☐ E76.29 Mucopolysaccharidosis VI (MPS VI, Maroteaux-Lamy Syndrome)
☐ Other Code: _____ Description _____

Patient Clinical Information:

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

Nursing:

Specialty Pharmacy to coordinate Nursing? ☐ Yes ☐ No Port? ☐ Yes ☐ No
Site of Care: ☐ Physician Office ☐ Infusion Clinic ☐ Outpatient Hospital ☐ Home Infusion ☐ Other: _____

Lysosomal Storage Disorders Enrollment Form

Please Complete Patient and Prescriber Information

Patient Name: _____Patient DOB: _____Patient Phone:_____

Prescriber Name: _____ Prescriber Phone: _____

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Aldurazyme	2.9 mg vial	Dose _____ mg _____ mg / kg Body Weight, IV Vol to infuse _____ mL Rate _____ mL Frequency _____ ☐ Ramping Required	Quantity: _____ Refills: ☐ 12 months ☐ __ months
☐ Cerdelga	84 mg capsule	Take 1 capsule _____ time(s) per day.	Quantity: _____ Refills: ☐ 12 months ☐ __ months
☐ Cerezyme	400 unit vial	Dose _____ Units _____ Units / kg Body Weight, IV Vol to infuse _____ mL Rate _____ mL Frequency _____ ☐ Ramping Required	Quantity: _____ Refills: ☐ 12 months ☐ __ months
☐ Elaprase	6 mg vial	Dose _____ mg _____ mg / kg Body Weight, IV Vol to infuse _____ mL Rate _____ mL Frequency _____ ☐ Ramping Required	Quantity: _____ Refills: ☐ 12 months ☐ __ months
☐ Elelyso	200 unit vial	Dose _____ Units _____ Units / kg Body Weight, IV Vol to infuse _____ mL Rate _____ mL Frequency _____ ☐ Ramping Required	Quantity: _____ Refills: ☐ 12 months ☐ __ months
☐ Fabrazyme	☐ 5 mg vial ☐ 35 mg vial	Dose _____ mg _____ mg / kg Body Weight, IV Vol to infuse _____ mL Rate _____ mL Frequency _____ ☐ Ramping Required	Quantity: _____ Refills: ☐ 12 months ☐ __ months
☐ Kanuma	NA	All referrals must be sent through the HUB, OneSource. Phone: 1-888-765-4747	Quantity: 0 Refills: 0
☐ Lumizyme	50 mg vial	Dose _____ mg _____ mg / kg Body Weight, IV Vol to infuse _____ mL Rate _____ mL Frequency _____ ☐ Ramping Required	Quantity: _____ Refills: ☐ 12 months ☐ __ months
☐ Miglustat	100 mg capsule	Take 1 capsule three times per day	Quantity: _____ Refills: ☐ 12 months ☐ __ months
☐ Naglazyme	NA	All referrals must be sent through the HUB, BioMarin RareConnections. Phone: 1-866-906-6100	Quantity: 0 Refills: 0
☐ Nexviazyme	100 mg vial	Dose _____ mg _____ mg / kg Body Weight, IV Vol to infuse _____ mL Rate _____ mL Frequency _____ ☐ Ramping Required	Quantity: _____ Refills: ☐ 12 months ☐ __ months
☐ Vpriv	400 unit vial	Dose _____ Units _____ Units / kg Body Weight, IV Vol to infuse _____ mL Rate _____ mL Frequency _____ ☐ Ramping Required	Quantity: _____ Refills: ☐ 12 months ☐ __ months
☐ Vimizim	NA	All referrals must be sent through the HUB, BioMarin RareConnections. Phone: 1-866-906-6100	Quantity: 0 Refills: 0
☐ Xenpozyme	20mg Vial	Dose _____ mg _____ mg / kg Body Weight, IV Vol to infuse _____ mL Rate _____ mL Frequency _____ ☐ Escalation Required (Please attach Rx for escalation dose)	Quantity: _____ Refills: ☐ 12 months ☐ __ months

☐ 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 **Prescriber's Signature: _____Date: _____**	May Substitute / Product Selection Permitted / Substitution Permissible **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.

Lysosomal Storage Disorders Enrollment Form
Nursing Medications

Please Complete Patient and Prescriber Information

Patient Name: _____Patient DOB: _____Patient Phone:_____

Prescriber Name: _____ Prescriber Phone: _____

5 PRESCRIPTION INFORMATION

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
☐ 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
☐ Diphenhydramine Oral	PO	☐ 12.25 mg/kg (0-30 kg) ☐ 25 mg ☐ 50 mg (Over 30 kg)
☐ Diphenhydramine 50mg/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)
☐ Other: _____	Other: _____	Other: _____
☐ Other: _____	Other: _____	Other: _____
☐ Other: _____	Other: _____	Other: _____
☐ Other: _____	Other: _____	Other: _____

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