Asthma Enrollment Form
Medications A-C
(Cinqair)

CVS specialty®

Fax Referral To: 1-800-323-2445 **Phone:** 1-800-237-2767
Email Referral To: Customer.ServiceFax@CVSHealth.com

Coram® CVS specialty infusion services

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):

☐ J45.4 Moderate Persistent Asthma ☐ J45.5 Severe Persistent Asthma
☐ D72.119 Hypereosinophilic syndrome (HES) ☐ M30.1 Eosinophilic Granulomatosis with Polyangiitis (EGPA)
☐ J33.0 Polyp of the nasal cavity ☐ J33.1 Polypoid sinus degeneration ☐ J33.8 Other polyp of sinus
☐ J33.9 Nasal Polyp, unspecified (indication for dupilumab and omalizumab) ☐ K20.0 Eosinophilic esophagitis (EoE)
☐ Other Code: _____ Description _____

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
☐ Cinqair (reslizumab)	100 mg/10 mL vial	Inject 3 mg/kg once every 4 weeks by IV infusion over 20 to 50 minutes ☐ Include sodium chloride and supplies sufficient for medication days supply • IV administration/infusion set (0.2micron filter) • IV Cath Insyte autoguard or PIV insertion kit • Ultrasyte needle-free connector (one per vial shipped) • 30 mL syringe (one per vial shipped) • 50 mL 0.9% NaCl • 2 – 10 mL 0.9% NaCl flush • Alcohol swabs	Quantity: _____ vials ☐ 30-day supply ☐ 90-day supply ☐ ___-day supply 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.

Asthma Enrollment Form
Medications D-S
(Dupixent, Fasenra, Nucala)

Please Complete Patient and Prescriber Information

Patient Name: _____ Patient DOB: _____

Prescriber Name: _____ Prescriber Phone: _____

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Dupixent (dupilumab)	**PFS** ☐ 100 mg/0.67 mL pre-filled syringe ☐ 200 mg/1.14 mL pre-filled syringe ☐ 300 mg/2 mL pre-filled syringe **PEN*** ☐ 200 mg/1.14 mL pre-filled pen ☐ 300 mg/2 mL pre-filled pen *Comes in cartons of 2	**Asthma: Pediatric 15 to <30 kg:** ☐ Inject 100 mg SC (one injection) every other week ☐ Inject 300 mg SC (one injection) every four weeks **Asthma: Pediatric ≥30 kg:** ☐ Inject 200 mg SC (one injection) every other week **Asthma: Adult Initial Dose:** ☐ Inject 400 mg SC (2-200 mg injections in different injection sites) initially then 200 mg SC every other week ☐ Inject 600 mg SC (2-300 mg injections in different injection sites) initially then 300 mg SC every other week **Asthma: Adult Maintenance Dose:** ☐ Inject 200 mg (one injection) SC every other week ☐ Inject 300 mg (one injection) SC every other week **Chronic Sinusitis with Nasal Polyposis** ☐ Inject 300 mg (one injection) SC every other week **Eosinophilic Esophagitis (EoE)** ☐ Inject 300 mg SC every week	Quantity: _____ Refills: _____
☐ Fasenra (benralizumab)	**PFS** ☐ 30 mg/mL pre-filled syringe **Auto-injector** ☐ 30 mg/mL Pen/Self-administered	☐ Administer 30 mg/mL by subcutaneous injection every 4 weeks for the first 3 doses, followed by injection once every 8 weeks thereafter ☐ Other: Administer _____	Quantity: ☐ 1 PFS/Pen ☐ 3 PFS/Pen Refills: ☐ 1 year ☐ Other: _____
☐ Nucala (mepolizumab)	**Vial** ☐ 100 mg vial **PEN** ☐ Auto-injector 100 mg/mL auto-injector **PFS** ☐ 100 mg/mL pre-filled syringe	**SEVERE ASTHMA** ☐ Inject 100 mg subcutaneously once every 4 weeks into the upper arm, thigh, or abdomen **EOSINOPHILIC GRANULOMATOSIS WITH POLYAGNIITIS (EGPA)** ☐ Inject 300 mg as 3 separate 100 mg subcutaneous injections once every 4 weeks into the upper arm, thigh, or abdomen **HYPEREOSINOPHILIC SYNDROME (HES)** ☐ Inject 300 mg as 3 separate 100 mg subcutaneous injections once every 4 weeks into the upper arm, thigh, or abdomen ☐ Include sterile water and supplies sufficient for medication days supply ☐ No supplies requested (supplies will be sent with shipment unless indicated) • One 10 mL vial sterile water for injection for every vial of Nucala dispensed • Alcohol swabs • 3 mL Luer Lock injection syringe • NDL 21G needle for reconstitution • 1 mL polypropylene syringe with 21G to 27G x ½" needle for subcutaneous injection	Quantity: ☐ 30-day supply ☐ 90-day supply ☐ ___-day supply 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 **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.

Asthma Enrollment Form
Medications T-Z
(Tezspire, Xolair)

Please Complete Patient and Prescriber Information

Patient Name: _____ Patient DOB: _____

Prescriber Name: _____ Prescriber Phone: _____

5 PRESCRIPTION INFORMATION

☐ Tezspire (Tezepelumab)	210 mg/1.91 mL (110 mg/mL) pre-filled syringe	210 mg injected subcutaneously every 4 weeks	Quantity: 1 Refills: 1 Year
☐ Xolair (omalizumab)	**Vial** ☐ 150 mg vial kit **PFS** ☐ 75 mg/0.5 mL pre-filled syringe ☐ 150 mg/1 mL pre-filled syringe	**Every 4 weeks dosing:** ☐ Administer 75 mg per dose subcutaneously every 4 weeks ☐ Administer 150 mg per dose subcutaneously every 4 weeks ☐ Administer 225 mg per dose subcutaneously every 4 weeks ☐ Administer 300 mg per dose subcutaneously every 4 weeks ☐ Other: Administer _____ mg per dose subcutaneously every 4 weeks **Every 2 weeks dosing:** ☐ Administer 225 mg per dose subcutaneously every 2 weeks ☐ Administer 300 mg per dose subcutaneously every 2 weeks ☐ Administer 375 mg per dose subcutaneously every 2 weeks ☐ Other: Administer _____ mg per dose subcutaneously every 2 weeks **For Xolair Vials only:** ☐ Include sterile water and supplies sufficient for medication days supply ☐ No supplies requested (supplies will be sent with shipment unless indicated) • One 10 mL vial 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 ⅝" Safety Glide needle for subcutaneous injection	Quantity: ☐ 30-day supply ☐ 90-day supply ☐ ___-day supply Refills: ☐ 1 year ☐ Other: _____

I certify that the rationale for Xolair therapy for Allergic Asthma is necessary for this patient and I will be supervising the patient's treatment accordingly.

Nursing Medications
(Epipen, Epipen Jr.)

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Other: _____	Other: _____	Other: _____	Quantity:_____ Refills:_____
☐ Epipen	Other: _____	Use as directed.	Quantity: 1 Refills: _____
☐ Epipen Jr.	Other: _____	Use as directed.	Quantity: 1 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 **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.