Lupus Enrollment Form

CVS specialty®

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

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: _____ 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):

☐ M32.1 Systemic lupus erythematosus (SLE)
☐ M32.11 Endocarditis in systemic lupus erythematosus
☐ M32.12 Pericarditis in systemic lupus erythematosus
☐ M32.13 Lung involvement in systemic lupus erythematosus
☐ M32.14 Glomerular disease in systemic lupus erythematosus
☐ M32.15 Tubulo-interstitial nephropathy in systemic lupus erythematosus
☐ M32.19 Other organ or system involvement in systemic lupus erythematosus
☐ M32.8 Other forms of systemic lupus erythematosus
☐ M32.9 Systemic lupus erythematosus, unspecified
☐ Other Code: _____ Description: _____

Patient Clinical Information:

Allergies: _____ Weight: _____lb/kg Height: _____in/cm
Positive ANA or anti-dsDNA test? ☐ Yes ☐ No Date of test: __/__/____

Nursing:

Specialty pharmacy to coordinate injection training/home health nurse visit as 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

Lupus Enrollment Form
Medication A-Z

Please Complete Patient and Prescriber Information

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

Patient Clinical Information:

Allergies: _____Weight: _____lb/kg Height:_____In/cm

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Benlysta SC	☐ 200 mg/mL single-dose prefilled autoinjector ☐ 200 mg/mL single-dose prefilled syringe	Inject 200 mg (one injection) SC once weekly	Quantity: 1 package (4 doses) Refills: _____
☐ Benlysta	☐ 120 mg 5 mL vial ☐ 400 mg 20 mL vial	☐ Induction Dose: 10 mg/kg IV (Dose = ____mg) at 2 week intervals for the first 3 doses and at 4-week intervals thereafter. Infuse IV over 1 hour. ☐ Maintenance Dose: 10 mg/kg (Dose = ____mg) every 4 weeks Infuse IV over 1 hour	Quantity: ___ vials Refills: _____
☐ Saphnelo	300 mg/2 mL (150 mg/mL)	☐ 300 mg IV over a 30-minute period, every 4 weeks ☐ Other: _____	Quantity: ___ vials Refills: _____
☐ Other: _____	☐ Other: _____	☐ Other: _____	Quantity: _____ 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	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.