

Fax Referral To: 1-877-232-5455

Address: 500 Ala Moana Blvd., Bldg 1 Honolulu, HI 96813

Phone: 1-808-254-2727 NCPDP: 1203417

		ix Simple Steps to Subr	mitting a Referral			
	RMATION (Complete or inclu		DOD:	0	1 Maria	.l.
Patient Name:		0:t. 0:t. 7ID	DOB:	Gender:	јиате 🗀 гета	ile
Professi Contact	Methods: Phone (to primar	City, State, ZIP	vt (to call # provide	ad balaw) 🗆 Email (t	o omoil providos	
Note: Corrier obere	ges may apply. If unable to cont	y # provided below) 🔲 Te	iolty Phormony will	ettempt to contact by	o eman provided	i below)
Email:		Last Four of \$	SSN:	Drimary Language:		
	egal Guardian Name (Last, First):					
PRESCRIBER IN		Rotati	ionamp to patient			
Prescriber's Name:				State Licen	SP #1	
NPI #	DEA #:	Group or Hospital				
Address:		City State				
Phone:	Fax	Contact Person:	, Zii Godo	Contact's Phone:	,	
INCLIDANCE IN	FORMATION Please fax copy	of prescription and insuran	nce cards (front and	contact of floric.	if available	
DIAGNOSIS (IC	D-10) AND PATIENT CLINIC	AL INFORMATION (Incl.)	lude carus (Horit and	ale)	i, ii avallable	
	toid Arthritis (RA)			113)		
	athic Psoriasis (PsA)					
	adiographic Axial Spondylarth		Altilitis (OF 3A)			
_	algia Rheumatica (PMR)		ic Arthritis ( IIA)			
	, unspecified eye	woo.oo oaverme lalopatri	io Ai tillitis (OIA)			
	Description					
Allergies:	B63611ptio11	□ NKDA \	 Weight:	lb  kg Heig	ıht <sup>.</sup>	l In $\square$ Cm
	New to therapy Continu	uation of therapy: Date of la	ast treatment /	ge.g _/		, 🗀 ٥
Samples provided	No Yes, if so, how many	v samples given?	TB Test Date	 /_	Nea	
	ment dates, and reason(s) for				19	
	INFORMATION Ship to:		her			
MEDICATION			SE & DIRECTIONS		QUANTITY	REFILLS
	☐ 162 mg/0.9 mL ACTPen	☐ Inject 162 mg SC every			28 days	
Actemra	☐ 162 mg/0.9 mL PFS	Inject 162 mg SC every			84 days	
Adalimumab		☐ Inject 40 mg SC every	week			
aacf	☐ 40 mg/0.8 mL PEN	☐ Inject 40 mg SC every			28 days	
(unbranded		☐ Inject 80 mg SC every			☐ 84 days	
version of Idacio)						
∐Adalimumab-	☐ 40 mg/0.4 mL PEN	□ Inia at 40 mm CO account				
adaz (unbranded	40 mg/0.4 mL PFS (with	☐ Inject 40 mg SC every☐ Inject 40 mg SC every			☐ 28 days	
version of	needle guard)	Inject 80 mg SC every			84 days	
Hvrimoz)		Inject 50 mg 50 every	Other week		□ 04 days	
Adalimumab-		☐ Inject 20 mg SC every	other week			
fkjp	20 mg/0.4 mL PFS	☐ Inject 40 mg SC every			☐ 28 days	
(unbranded	40 mg/0.8 mL PFS	☐ Inject 40 mg SC every			84 days	
version of Hulio)	☐ 40 mg/0.8 mL PEN	☐ Inject 80 mg SC every				
,		☐ Inject 10 mg SC every of				
	□ 10 mg/0 0 ml DEC	☐ Inject 20 mg SC every	other week			
☐Amjevita	☐ 10 mg/0.2 mL PFS ☐ 20 mg/0.4 mL PFS	Inject 40 mg SC every			_	
(adalimumab-	☐ 40 mg/0.8 mL PFS	1/0.4 mL PFS				
atto)	40 mg/0.8 mL PEN	Inject 80 mg SC every			☐ 84 days	
		☐ Inject 80 mg Day 1, foll		y other week		
		starting one week after ini	tial dose			
Other:						
PRESCRIBER SI	IGNATURE REQUIRED (STAI	MP SIGNATURE NOT AL	LOWED)			
	" / Brand Medically Necessary / Do Not	Substitute / No Substitution /		luct Selection Permitted /		
DAW / May Not Substi			Substitution Permissil			
Prescriber's Sig	nature:	Date:	Prescriber's Sig	nature:	D	ate:
OA MA NO C DD. Inte	probanga is mandated unless Dragoribar un		ATTN: No	w Vork and laws provider		

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.

Patient Name		mplete Patient, Prescriber Patient DOB				
Patient Name: Patient DOB: Patient Phone: Prescriber Phone:						
Patient Clinical I	nformation:					
Allergies:		NKDA V	Veight:	lb 🗌 kg Height:	🗌 ln 🗌 Cm	
Treatment status	$: \square$ New to therapy $\square$ Con	tinuation of therapy; Date of la	ist treatment//			
		any samples given?	□ TB Test Date/	/L Pos L Neg		
	atment dates, and reason(s)	for discontinuation :o:				
MEDICATION			ner: VIRECTIONS	QUANTITY	REFILLS	
MEDICATION	_	Loading Dose:	IRECTIONS	QUANTITY	REFILLS	
	Cimzia Starter Kit	☐ Inject 400 mg SC on weeks	s 0, 2 and 4	1 kit	0	
	200 mg/mL PFS	☐ Inject 200 mg SC every other week		28 days		
☐ Cimzia	200 mg/mL vial	☐ Inject 400 mg SC every 4 v	84 days			
		PsA Maintenance Dose (with p				
		☐ Inject 300 mg SC on week	-	28 days		
		thereafter		☐ 84 days		
		Loading Dose:				
		☐ Inject 75 mg SC on Weeks		<u>Loading Dose</u> : Quantity:	Loading Dose:	
		_ ·	150 mg SC on Weeks 0, 1, 2, 3		Refills: <u>0</u>	
	1x75 mg/mL PFS	☐ Inject 300 mg SC on Week Maintenance Dose:	S 0, 1, 2, 3	<u>28 days</u>		
	1x150 mg/mL PEN	☐ Inject 75 mg SC on Week 4	, then every 4 weeks there	eafter	Maintenance Dose:	
☐ Cosentyx	☐ 1x150 mg/mL PFS ☐ 2x150 mg/mL PEN	☐ Inject 75 mg SC every 4 we	eeks	Maintenance	Refills:	
	2x150 mg/mL PEN	☐ Inject 150 mg SC on Week	4, then every 4 weeks	<u>Dose</u> :		
	☐ 300 mg/2 mL PEN	thereafter		Quantity:		
	_	☐ Inject 150 mg SC every 4 w ☐ Inject 300 mg SC on Week		<u>28 days</u>		
		thereafter	4, then every 4 weeks			
		☐ Inject 300 mg SC every 4 v	veeks			
☐ Enbrel	50 mg/mL Mini 50 mg/mL PEN 50 mg/mL PFS 25 mg/0.5 mL PFS 25 mg/0.5 mL single dose vial 25 mg/0.5 mL lyophilized powder multi-dose vial for reconstitution	☐ Inject 50 mg SC once weel☐ Inject 0.8 mg/kg (Dose= maximum of 50 mg per week	mg) weekly, with a	☐ 28 days ☐ 84 days		
	☐ 40 mg/0.4 mL PEN	Inject 40 mg SC every wee				
□ 11a allta -	40 mg/0.8 mL PEN	Inject 40 mg SC every other week				
Hadlima	40 mg/0.4 mL PFS	☐ Inject 80 mg SC every othe ☐ Inject 80 mg SC on Day 1, f		☐ 28 days her ☐ 84 days		
	☐ 40 mg/0.8 mL PFS	week starting one week after i				
	☐ 20 mg/0.4 mL PFS	Inject 20 mg SC every other	er week			
☐ Hulio	40 mg/0.8 mL PFS	☐ Inject 40 mg SC every week ☐ Inject 40 mg SC every other week ☐ Inject 80 mg SC every other week		28 days		
_	40 mg/0.8 mL PEN			☐ 84 days		
		☐ Inject 80 mg SC every othe ☐ Inject 10 mg SC every othe				
	10 mg/0.1 mL PFS	☐ Inject 10 mg SC every othe				
☐ Humira	20 mg/0.2 mL PFS 40 mg/0.4 mL PEN	☐ Inject 40 mg SC every wee	28 days			
	80 mg/0.8 mL PEN	Inject 40 mg SC every other	☐ 84 days			
	☐ 40 mg/0.4 mL PFS	Inject 80 mg SC every other	th or			
	80 mg/0.8 mL PFS	Inject 80 mg SC on Day 1, f week starting one week after i		uier		
Other		Jon Standing One Wook arter				
	SIGNATURE REQUIRED (S	TAMP SIGNATURE NOT AI	LOWED)			
PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)  "Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / May Substitute / Product Selection Permitted /						
DAW / May Not Sub		mot Substitute / NO Substitution /	Substitution Permissible	odoni omilieu/		
Prescriber's Signature:Date:Date:Date:Date:Date:Date:Date:Date:Date:Date:Date:Date:Date:Date:Date:Date:Date: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						

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Potiont Name:			and Patient Clinical Information				
rauent ivame: Prescriber Name:	<del>-</del>	Patient DOB: Patient Phone: Prescriber Phone:					
Patient Clinical Ir			i rescriber r none				
Allergies:		NKDA Weig	Jht: ☐ lb ☐ kg	Height:	] In $\square$ Cm		
	$\square$ New to therapy $\square$ Continuation of	therapy; Date of last tr	eatment//	_			
Samples provided	$d  \square$ No $ \square$ Yes, if so how many sample	s given? 🔲 1	「B Test Date// Pos [	☐ Neg			
	atment dates, and reason(s) for disconti						
	NINFORMATION Ship to: Patient						
MEDICATION	STRENGTH	DOSE & DI	RECTIONS	QUANTITY	REFILLS		
Hyrimoz	☐ 10 mg/0.1 ml PFS ☐ 20 mg/0.2 ml PFS ☐ 40 mg/0.4 mL PEN ☐ 80 mg/0.8 mL PEN ☐ 40 mg/0.4 mL PFS (with needle guard)	☐ Inject 10 mg SC e ☐ Inject 20 mg SC e ☐ Inject 40 mg SC e ☐ Inject 40 mg SC e ☐ Inject 80 mg SC e	every other week every week every other week	☐ 28 days ☐ 84 days			
☐ Idacio	40 mg/0.8 mL PEN 40 mg/0.8 mL PFS	☐ Inject 40 mg SC every week ☐ Inject 40 mg SC every other week ☐ Inject 80 mg SC every other week		28 days 84 days			
□ Ilaris	150 mg/mL injection SDV	For patients weighing Injectmg (4 in a contract)	mg/kg) SC every 4 weeks	28 days 84 days			
☐ Kevzara	☐ 200 mg/1.14 mL PFS ☐ 150 mg/1.14 mL PFS ☐ 200 mg/1.14 mL PEN ☐ 150 mg/1.14 mL PEN	☐ Inject 150 mg S0	C once every two weeks C once every two weeks	28 days			
Olumiant	2 mg tablet	Take 2 mg PO once	daily	☐ 30 days ☐ 90 days			
☐ Orencia	☐ 50 mg/0.4 mL PFS ☐ 87.5 mg/0.7 mL PFS ☐ 125 mg PFS ☐ 125 mg PEN	Peds JIA or PsA (> 10 kg to < 25 kg:	SC once weekly	28 days			
☐ Otezla	28-day starter kit	Day 3: 10 mg in morn Day 4: 20 mg in morr	C once weekly  D in the morning.  D in g and 10 mg in evening.  D in g and 20 mg in evening.  D in g and 20 mg in evening.	1 kit	0		
	30 mg tablet Sample already provided/no titration needed	Day 5: 20 mg in morning and 30 mg in evening. Day 6 and thereafter: 30 mg PO twice daily  Take 30 mg PO twice daily		30 days			
Rinvoq	15 mg tablet	Take one 15 mg tablet PO once daily		☐ 30 days ☐ 90 days			
Simponi	☐ 50 mg/0.5 mL PEN ☐ 50 mg/0.5 mL PFS	Inject 50 mg SC every 4 weeks		28 days 84 days			
Other							
	RIBER SIGNATURE REQUIRED	(STAMD SIGNAT	TIPE NOT ALLOWED)				
"Dispense As \ DAW / May No	Written" / Brand Medically Necessary / Do Not Subs	stitute / No Substitution /	May Substitute / Product Selection Perr Substitution Permissible Prescriber's Signature:		)ate:		

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Patient Name	Please	Complete Patient , Prescriber Patient DOB:		nt Phone:		
Prescriber Name:		Patient DOB: Patient Phone: Prescriber Phone:				
Patient Clinical In						
Allergies:		NKDA Weig	NKDA Weight: lb  kg Height:		ı 🗌 Cm	
		ntinuation of therapy; Date of last t				
		many samples given?		os 🔲 Neg		
		) for discontinuation				
		o: Patient Office Other: _				
MEDICATION	STRENGTH	DOSE & DIRECTIONS Loading Dose:		QUANTITY	Y REFILLS	
Skyrizi	☐ 150 mg/mL PFS ☐ 150 mg/mL PEN	Inject 150 mg SC at week 0		☐ 28 days	s 0	
		Maintenance Dose:				
		Inject 150 mg SC at week 4, a	☐ 84 days	s		
		AS Loading Dose:				
		☐ Inject 160 mg (two 80 mg inje	☐ 28 days	s 0		
		AS Maintenance Dose:				
		☐ Inject 80 mg SC injection every 4 weeks			S	
				☐ 84 days		
	☐ 80 mg PEN	nr-axSpA:		28 days		
	80 mg PFS	Inject 80 mg SC every 4 week	☐ 84 days	S		
		PsA Loading Dose (w/o psoriasis				
☐ Taltz		☐ Inject 160 mg (two 80 mg inje	ctions) SC on week 0	☐ 28 days	s 0	
		PsA Maintananaa Pasa (w/a psa	riocio):	☐ 28 days	_	
		PsA Maintenance Dose (w/o psoriasis):  Inject 80 mg SC every 4 weeks			s	
		PsA Loading Dose (with psoriasis):			3	
		Inject 160 mg (two 80 mg injections) week 0, then 80 mg week 2			s 0	
			Inject for mg (two oo mg injections) week o, then oo mg week 2			
		☐ Inject 80 mg week 4, 6, 8, and 10		(3-pack) 28 days	s 1	
			(2-pack)			
		PsA Maintenance Dose (with psoriasis):			5	
		Inject 80 mg SC week 12 and every 4 weeks thereafter				
	100 mg/mL PFS	Loading Dose:		☐ 28 days		
		☐ Inject 100 mg SC on week 0			s 0	
☐ Tremfya	100 mg/mL PEN	Maintenance Dose:				
		☐ Inject 100 mg SC week 4, then every 8 weeks thereafter			6	
	□ E ma Tablet					
☐ Xeljanz ☐ 5 mg Tablet ☐ 11 mg XR Tablet		☐ Take one 5 mg tablet PO twice daily☐ Take one 11 mg tablet PO once daily			s	
	40 mg/0.4 mL PEN	Li rano one irring tablet i o once daily				
	40 mg/0.4 mL PFS	☐ Inject 40 mg SC every week		☐ 28 days		
☐ Yuflyma	(with safety guard)	☐ Inject 40 mg SC every other week ☐ Inject 80 mg SC every other week			s	
	40 mg/0.4 mL PFS				5 -	
	☐ 80 mg/0.8 mL PEN					
Other						
				112		
	n patient support programs	STAMP SIGNATURE NOT STAMP SIGNATURE NOT ALLO		nd kits provided as needed for administr	ration	
	-			landar Davidus III		
•		lecessary / Do Not Substitute /	May Substitute / Product Se	lection Permitted /		
Prescriber's Sig	/ DAW / May Not Substitut	Substitution Permissible Prescriber's Signature:		Date	۵۰	
	<u>-                                    </u>			Date	<u>" ———</u>	
		ed unless Prescriber writes the word ase submit electronic prescription	ds " <b>No Substitution</b> "			

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