Rheumatology Oral/Subcutaneous Enrollment Form

CVS specialty Fax Referral To: 1-855-297-1270 Phone: 1 Address: 280 Avenida Jesus T. Pinero Ste B Rio Piedras, PR 00927

Phone: 1-888-280-1190

NC	Ρ	D	P:	402	263	25

		ix Simple Steps to Subr	nitting a Referral			
PATIENT INFOR	MATION (Complete or inclu					
Patient Name:City, State,			DOB:	Gender: 🗌] Male 🔲 Fem	ale
Address:		City, State, ZIP	Code:			
Preferred Contact	Methods: 🗌 Phone (to primar	y # provided below) 🗌 Te	ext (to cell # provide	ed below) 🗌 Email (to email provide	d below)
Note: Carrier charge	es may apply. If unable to cont	act via text or email, Speci	alty Pharmacy will a	attempt to contact by	/ phone.	
Primary Phone:			Alternate Phone: _			
	egal Guardian Name (Last, First)	Relati	onship to patient: _			
2 PRESCRIBER IN	FORMATION					
Prescriber's Name:				State Licer	nse #:	
NPI #:	DEA #:	Group or Hospital	:			
Address:	Fax	City, State,	ZIP Code:			
Phone:	Fax	_ Contact Person:		Contact's Phone	:	
SINSURANCE INI	FORMATION Please fax copy	of prescription and insural	nce cards (front and	l back) with this forn	n, if available	
4 DIAGNOSIS (IC	D-10) AND PATIENT CLINIC	AL INFORMATION (Incl	ude copy of clinica	ıls)		
M06.9 Rheumat	toid Arthritis (RA)	M45.9 Ankylosing Spondy	/litis (AS)			
L40.50 Arthropa	athic Psoriasis (PsA) 🛛 🗌	L40.54 Juvenile Psoriatic	Arthritis (JPsA)			
M45.A0 Non-Ra	adiographic Axial Spondylarth	ritis (nr-axSpA)				
M35.3 Polymyal	lgia Rheumatica (PMR) 🛛 🗌	M08.00 Juvenile Idiopath	ic Arthritis (JIA)			
	, unspecified eye					
Other Code:	Description				_	
Allergies:	<u> </u>	NKDA V	Veight:	🗌 lb 🗌 kg 🛛 Heię	ght: [ln 🗌 Cm
Treatment status:	New to therapy Continue No Yes, if so, how many	ation of therapy; Date of la	ast treatment/_	_/	_	
Samples provided [🔄 No 🔲 Yes, if so, how many	/ samples given?	TB Test Date _	_/_/ Pos [] Neg	
Prior therapy, treat	ment dates, and reason(s) for	discontinuation				
5 PRESCRIPTION	INFORMATION Ship to:	🗌 Patient 🗌 Office 🗌 Ot	her:			
MEDICATION	STRENGTH	DOS	SE & DIRECTIONS		QUANTITY	REFILLS
	🗌 162 mg/0.9 mL ACTPen	Inject 162 mg SC every	other week		28 days	
Actemra	162 mg/0.9 mL PFS	Inject 162 mg SC every			🗌 84 days	
Adalimumab-						
aacf	40 mg/0.8 mL PEN	Inject 40 mg SC every			28 days	
(unbranded		Inject 40 mg SC every			84 days	
version of Idacio)		Inject 80 mg SC every	other week			
Adalimumab-						
adaz	40 mg/0.4 mL PEN 40 mg/0.4 mL PFS (with	Inject 40 mg SC every	week			
(unbranded		Inject 40 mg SC every	other week		28 days	
version of	needle guard)	Inject 80 mg SC every	other week		84 days	
Hyrimoz)						
🗌 Adalimumab-	20 mg/0.4 mL PFS	🗌 Inject 20 mg SC every	other week			
fkjp	40 mg/0.8 mL PFS	Inject 40 mg SC every			🗌 28 days	
(unbranded	40 mg/0.8 mL PEN	Inject 40 mg SC every other week				
version of Hulio)		Inject 80 mg SC every other week				
		Inject 10 mg SC every o				
	10 mg/0.2 mL PFS	🔲 Inject 20 mg SC every				
Amjevita 20 mg/0.4 mL PFS Inject 40 mg SC every other week (adalimumab- 10 mg/0.8 mL PFS Inject 40 mg SC every week 28 days						
atto)						
Inject 80 mg Day 1, followed by 40 mg every other week						
		starting one week after ini	tial dose			
Other:						
OPRESCRIBER SI	GNATURE REQUIRED (STAI		I OWFD)		1	1
	/ Brand Medically Necessary / Do Not	Substitute / No Substitution /		uct Selection Permitted /		
DAW / May Not Substi Prescriber's Sign		Date:		Substitution Permissible Prescriber's Signature:Date:		
Prescriber's Sign	Iatul 6	Date:	Prescriber's Sig	na.ure.		Vale:
CA, MA, NC & PR: Inte	rchange is mandated unless Prescriber wr	ites the words " No Substitution "	ATTN: Ne	w York and Iowa provide	rs, please submit elect	ronic 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.

Plasse Complete Patient, Normania Patient Name: Patient DB::				neous Enrollment Form					
Partent Clinical Information: Partent Clinical Information: Partent Status: Prestrement status: Prestremen	Dationt Nome	<u>Please C</u>	omplete Patient, Prescriber	and Patient Clinical Informa	tion Decree				
Partent Clinical Information: Partent Clinical Information: Partent Status: Prestrement status: Prestremen	Patient Name: Patient DOB: Patient DOB: Patient Phone: Patient Phone:								
Altergies:	Patient Clinical Information:								
Samples provided No Yes, if so how many samples given?	Allergies:								
Samples provided No Yes, if so how many samples given?	Treatment statu	s: 🗌 New to therapy 🗌 Co	ntinuation of therapy; Date of la	ast treatment//					
Prescret Provide Number Num	Samples provide	ed 🗌 No 🗌 Yes, if so how i	many samples given?	□ TB Test Date/] Pos 🗌 Neg				
MEDICATION STRENGTH DOSE & DIRECTIONS QUANTITY REFILES	Prior therapy, tre	eatment dates, and reason(s	s) for discontinuation						
□ Cinzia □ Cinzia Starter Kit □ Loading Dose: □ Cinzia □ Adding Dose: □ 200 mg/mL PFS □ Adding Dose: □ Adding Dose: □ Inject 300 mg SC overy other week □ 28 days □									
Image: Statement Inject 300 mg SC on weeks 0, 2 and 4 1 kit 0 Image: Statement Image: Statement Image: Statement Image: Statement Image: Statement Image: Statement Image: Statement <td< th=""><td>MEDICATION</td><td>STRENGTH</td><td></td><td>DIRECTIONS</td><td>QUANTITY</td><td>REFILLS</td></td<>	MEDICATION	STRENGTH		DIRECTIONS	QUANTITY	REFILLS			
Cimzia ¹ 200 mg/mL PFS ¹ Niject 300 mg SC every other week ¹ Niject 300 mg SC on Weeks 0, 1, 2, 3 ¹ Niject 300 mg SC on Weeks 0, 1, 2, 3 ¹ Niject 300 mg SC on Weeks 0, 1, 2, 3 ¹ Niject 300 mg SC on Weeks 0, 1, 2, 3 ¹ Niject 300 mg SC on Weeks 0, 1, 2, 3 ¹ Niject 300 mg SC on Weeks 0, 1, 2, 3 ¹ Niject 300 mg SC on Weeks 0, 1, 2, 3 ¹ Niject 75 mg SC on Weeks 0, 1, 2, 3 ¹ Niject 75 mg SC on Weeks 0, 1, 2, 3 ¹ Niject 75 mg SC on Weeks 0, 1, 2, 3 ¹ Niject 75 mg SC on Weeks 0, 1, 2, 3 ¹ Niject 75 mg SC on Weeks 0, 1, 2, 3 ¹ Niject 75 mg SC on Weeks 0, 1, 2, 3 ¹ Niject 75 mg SC on Weeks 0, 1, 2, 3 ¹ Niject 75 mg SC on Weeks 0, 1, 2, 3 ¹ Niject 75 mg SC on Weeks 0, 1, 2, 3 ¹ Niject 75 mg SC on Week 4, then every 4 weeks ¹ Niject 75 mg SC on Week 4, then every 4 weeks ¹ Niject 75 mg SC on Week 4, then every 4 weeks ¹ Niject 50 mg SC on Week 4, then every 4 weeks ¹ Niject 50 mg SC on Week 4, then every 4 weeks ¹ Niject 50 mg SC on Week 4, then every 4 weeks ¹ Niject 50 mg SC on Week 4, then every 4 weeks ¹ Niject 50 mg SC on Week 4, then every 4 weeks ¹ Niject 50 mg SC on Week 4, then every 4 weeks ¹ Niject 50 mg SC on Week 4, then every 4 weeks ¹ Niject 50 mg SC on Week 4, then every 4 weeks ¹ Niject 50 mg SC every 0 her week ¹ Nij		Cimzia Starter Kit	5		41.5				
□ Cimzia □ Riget 200 mg/mL PFS □ Riget 200 mg SC every other week □ 28 days □ 28 days □ Cimzia □ Riget 200 mg SC every other week □ 28 days □ 28 days □ 28 days □ Cimzia □ Riget 200 mg SC on Week 4, then every 4 weeks □ 28 days □ 28 days □ Lossing Dose: □ Riget 200 mg SC on Week 0, 1, 2, 3 □ Lossing Dose: □ Lossing Dose: □ Histo mg/mL PFS □ Riget 75 mg SC on Week 4, then every 4 weeks thereafter Maintenance Dose: Maintenance Dose: □ Histo mg/mL PFS □ Riget 75 mg SC on Week 4, then every 4 weeks thereafter Inget 75 mg SC on Week 4, then every 4 weeks thereafter Maintenance Dose: □ Histo mg/mL PFS □ Riget 75 mg SC on Week 4, then every 4 weeks □ Riget 75 mg SC on Week 4, then every 4 weeks □ Riget 75 mg SC on Week 4, then every 4 weeks □ So mg/mL PFN □ Riget 75 mg SC on Week 4, then every 4 weeks □ Riget 76 mg SC on Week 4, then every 4 weeks □ Riget 76 mg SC on Week 4, then every 4 weeks □ Riget 75 mg SC on Miset A, then every 4 weeks □ Riget 76 mg SC on Miset A, then every 4 weeks □ Riget 76 mg SC on Week 4, then every 4 weeks □ Riget 76 mg SC on Miset A, then every 4 weeks □ Riget 76 mg SC on Miset A, then every 4 weeks □ Riget 76 mg SC on Miset A, then every 4 weeks □ Riget 76 mg SC on Miset A, then ever				is 0, 2 and 4	1 kit	0			
□ CUM28 □ COUM9/mL Visit □ Inject 400 mg SC every 4 weeks □ 84 days □ Cosentyx □ ItrS5 mg/mL PFS □ Inject 500 mg SC on Woeks 0, 1, 2, 3 □ Loading Dose: □ Cosentyx □ ItrS5 mg/mL PFS □ Inject 500 mg SC on Woeks 0, 1, 2, 3 □ Loading Dose: □ Cosentyx □ ItrS5 mg/mL PFN □ Inject 500 mg SC on Woeks 0, 1, 2, 3 □ Loading Dose: □ Cosentyx □ ItrS5 mg/mL PFN □ Inject 500 mg SC on Woeks 0, 1, 2, 3 □ Loading Dose: □ Inject 500 mg SC on Woeks 0, 1, 2, 3 □ Loading Dose: □ Loading Dose: □ Loading Dose: □ Inject 500 mg SC on Woeks 0, 1, 2, 3 □ Loading Dose: □ Loading Dose: □ Loading Dose: □ Sto mg/mL PFN □ Inject 500 mg SC on Woek 4, then every 4 weeks □ Dose: □ Dose: □ Inject 500 mg SC on Woek 4, then every 4 weeks □ Dose: □ Dose: □ Dose: □ Inject 500 mg SC on Woek 4, then every 4 weeks □ Dose: □ Dose: □ Dose: □ Inject 500 mg SC once weekly □ Dose: □ Dose: □ Dose: □ Dose: □ Post □ So mg/L AmL PFN □ Inject 40 mg SC every 4 weeks □ Dose: □ Dose: □ Dose: □ Dose: □ Dose: □ Dose: □ Dose: <td< th=""><td></td><td></td><td></td><td></td><td></td></td<>									
P=A Maintenance Dose (with psoriasis):	🗌 Cimzia	🗌 200 mg/mL vial							
Image: 300 mg SC on week 4, then every 4 weeks 28 days									
Image: Consention Im									
Image: TS mg SC on Weeks 0, 1, 2, 3 Loading Dose: Loading Dose: Loading Dose: Loading Dose: Refils: 0 Image: TS mg SC on Weeks 0, 1, 2, 3 Image: TS mg SC on Weeks 0, 1, 2, 3 Maintenance Dose: Main					📙 84 days				
Image: Some system Image: Some Weeks 0, 1, 2, 3 Image: Some Some Weeks 0, 1, 2, 3 Image: Some Some Weeks 0, 1, 2, 3 Image: Some Some Weeks 0, 1, 2, 3 Maintenance Dose: Image: Some Weeks 4, then every 4 weeks thereafter Image: TS mg SC on Week 4, then every 4 weeks Image: Some Some Weeks 4, then every 4 weeks Image: Some Some Week 4, then every 4 weeks Image: Some Some Some Some Week 4, then every 4 weeks Image: Some Some Some Some Some Some Some Some									
Image: Second									
 Cosentyx 					• •	Refills: <u>0</u>			
Cosentyx Inits0 mg/mL PS Inits0 mg/mL PFS Inject 75 mg SC on Week 4, then every 4 weeks thereafter Inject 150 mg SC on Week 4, then every 4 weeks Maintenance Dose: Quantity: 2 xt50 mg/mL PFS Inject 150 mg SC on Week 4, then every 4 weeks thereafter Maintenance Dose: Quantity: 300 mg/2 mL PFS Inject 300 mg SC on Week 4, then every 4 weeks thereafter Participation 1 inject 300 mg SC on Week 4, then every 4 weeks thereafter Inject 300 mg SC on Week 4, then every 4 weeks thereafter Participation 0 50 mg/mL PFS Inject 300 mg SC on Week 4, then every 4 weeks Participation Participation 0 50 mg/mL PFS Inject 300 mg SC once weekly Participation Participation 0 50 mg/mL PFS Inject 0.8 mg/kg (Dose=mg) weekly, with a maximum of 50 mg per week Participation Participation 0 40 mg/0.4 mL PFS Inject 40 mg SC every other week Participation Participation Participation 0 40 mg/0.4 mL PFS Inject 40 mg SC every other week Participation Participation Participation Participation 0 40 mg/0.4 mL PFS Inject 40 mg SC every other week Participation Participation Participation Participation Participation Participation Participation Participation Participation<				(\$ 0, 1, 2, 3	<u>28 days</u>				
Cosentyx Initio Unity (m. PFS) Inject 75 mg SC every 4 weeks Maintenance Refills:				4, then every 4 weeks thereafter		Maintenance Dose:			
² xt60 mg/mL PFs ¹ hight 150 mg 300 week 4, then every 4 weeks ² Quarity: ² 300 mg/2 mL PFN ¹ hight 150 mg 300 mg SC every 4 weeks ² Quarity: ¹ big t 150 mg 300 mg SC on Week 4, then every 4 weeks ¹ light 150 mg 300 mg SC every 4 weeks ¹ big t 300 mg /CL Mini ⁵ 0 mg/mL PFS ² 28 mg/0.5 mL PFS ² 5 mg/0.5 mL PFS ² 5 mg/0.5 mL PFS ² 28 days ² 5 mg/0.5 mL PFS ² 5 mg/0.5 mL PFS ¹ liget 40 mg SC every week ⁴ Hadlima ⁴ 0 mg/0.4 mL PEN ⁴ Hadlima ⁴ 0 mg/0.4 mL PFS	Cosentyx		Inject 75 mg SC every 4 w	eeks	Maintenance	Refills:			
^{Inderestrier} ^{Inde}				4, then every 4 weeks					
Inject 300 mg SC on Week 4, then every 4 weeks thereafter □ hject 300 mg SC every 4 weeks □ hject 300 mg SC every 4 weeks □ S0 mg/mL PEN □ S0 mg/0.5 mL single □ S mg/0.5 mL □ S0 mg/0.5 mL Nyophilized powder multi-dose vial for reconstitution □ Hadlima □ 40 mg/0.4 mL PEN □ hject 40 mg SC every other week □ 40 mg/0.8 mL PEN □ hject 40 mg SC every other week □ Hulio □ 20 mg/0.4 mL PFS □ hject 40 mg SC every other week □ Hulio □ 20 mg/0.8 mL PFS □ hject 40 mg SC every other week □ 28 days □ Hulio □ 20 mg/0.8 mL PFS □ hject 40 mg SC every other week □ 28 days □ Hulio □ 0 mg/0.8 mL PFS □ hject 40 mg SC every other week □ 28 days □ hject 40 mg SC every other week □ 28 days □ hject 40 mg SC every oth									
itereafter Inject 300 mg SC every 4 weeks Image: S0 mg/mL Mini S0 mg/mL PEN S0 mg/mL PEN S0 mg/m2 PFS 28 days S0 mg/m2 PFS 25 mg/0.5 m L PFS Imige: S0 mg/kg (Dose=mg) weekly, with a B4 days Upophilzed powder maximum of 50 mg per week B4 days B4 days Upophilzed powder Inject 40 mg SC every other week B4 days Imige: S0 mg/n2 PEN Hadlima 40 mg/0.4 mL PEN Inject 40 mg SC every other week B4 days Imige: S0 mg SC every other week Hadlima 20 mg/0.4 mL PEN Inject 40 mg SC every other week B4 days Imige: S0 mg SC every other week Hulio 20 mg/0.4 mL PFS Inject 40 mg SC every other week B4 days Imige: S0 mg SC every other week B4 days Hulio 20 mg/0.4 mL PFS Inject 40 mg SC every other week B4 days Imige: S0 mg SC every other week B4 days Imige: S0 mg SC every other week B4 days Imige: S0 mg SC every other week B4 days Imige: S0 mg SC every other week B4 days Imige: S0 mg SC every other week B4 days Imige: S0 mg SC every other week B4 days Imige: S0 mg SC every other week B4 days Imige: S0 mg SC every other week B4 days Imige: S0		-			<u>28 days</u>				
□ Inject 300 mg SC every 4 weeks Image: S0 mg/mL Mini □ S0 mg/mL Mini S0 mg/mL PFS Image: S0 mg/mL PFS Image: S0 mg/mL PFS □ S0 mg/mL ST Image: S0 mg/kg (Dose =mg) weekly, with a Image: S0 mg/mL PFS Image: S0 mg/kg (Dose =mg) weekly, with a Image: S0 mg/kg (Dose =mg) weekly, with a □ S5 mg/0.5 mL Image: S0 mg/kg (Dose =mg) weekly, with a Image: S0 mg/kg (Dose =mg) weekly, with a Image: S0 mg/kg (Dose =mg) weekly, with a □ Hadlima Image: A0 mg/0.4 mL PFS Image: S0 mg SC every week Image: S0 mg SC every week Image: S0 mg SC every other week □ Hadlima Image: A0 mg/0.4 mL PFS Image: A0 mg SC every other week Image: A0 mg/0.4 mL PFS Image: A0 mg SC every other week □ Hulio Image: A0 mg/0.4 mL PFS Image: A0 mg SC every other week Image: A0 mg/0.4 mL PFS Image: A0 mg SC every other week □ Hulio Image: A0 mg/0.4 mL PFS Image: A0 mg SC every other week Image: A0 mg/0.4 mL PFS Image: A0 mg/0.4 mL PFS Image: A0 mg SC every other week Image: A0 mg/0.4 mL PFS Image: A0 mg/0.4 mL PFS </th <td></td> <td></td> <td colspan="2"></td> <td></td> <td></td>									
So mg/mL PFN So mg/mL PFS Inject 50 mg SC once weekly 28 days Description Smg/0.5 mL PFS Inject 0.8 mg/kg (Dose=mg) weekly, with a maximum of 50 mg per week 84 days Image: Smg/0.5 mL kyophilized powder multi-dose vial for reconstitution Inject 40 mg SC every week 28 days Image: Hadlima 40 mg/0.4 mL PEN Inject 40 mg SC every other week 28 days Image: Hadlima 40 mg/0.4 mL PEN Inject 80 mg SC every other week 28 days Image: Hadlima 20 mg/0.4 mL PEN Inject 80 mg SC every other week 28 days Image: Hadlima 20 mg/0.4 mL PFS Inject 20 mg SC every other week 28 days Image: Hulio 20 mg/0.4 mL PFS Inject 40 mg SC every other week 28 days Image: Hulio 20 mg/0.4 mL PFS Inject 40 mg SC every other week 28 days Image: Hulio 20 mg/0.4 mL PFS Inject 40 mg SC every other week 28 days Image: Hulio 20 mg/0.4 mL PFS Inject 40 mg SC every other week 28 days Image: Hulio 10 mg/0.4 mL PFS Inject 40 mg SC every other week 28 days Image: Hulio 10 mg/0.4 mL PFS Inject 40 mg SC every other week 28 days Imject 10				weeks					
Hadlima	🗌 Enbrel	 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 	☐ Inject 0.8 mg/kg (Dose=mg) weekly, with a						
Hadlima			Inject 40 mg SC every wee	ek					
Haduma 40 mg/0.4 mL PFS Inject 80 mg SC every other week 28 days 40 mg/0.8 mL PFS Inject 80 mg SC every other week 84 days			Inject 40 mg SC every othe	er week					
40 mg/0.8 mL PFS Inject 80 mg SC on Day 1, followed by 40mg every other 84 days week starting one week after initial dose 28 days Hulio 20 mg/0.4 mL PFS Inject 20 mg SC every other week 40 mg/0.8 mL PFS Inject 40 mg SC every other week 28 days 40 mg/0.8 mL PFN Inject 10 mg SC every other week 84 days 10 mg/0.1 mL PFS Inject 10 mg SC every other week 84 days 20 mg/0.2 mL PFS Inject 10 mg SC every other week 28 days 10 mg/0.1 mL PFS Inject 40 mg SC every other week 28 days 20 mg/0.2 mL PFS Inject 40 mg SC every other week 28 days 40 mg/0.4 mL PEN Inject 40 mg SC every other week 28 days 40 mg/0.4 mL PFS Inject 40 mg SC every other week 84 days 40 mg/0.4 mL PFS Inject 80 mg SC on Day 1, followed by 40 mg every other 84 days 90 mg/0.8 mL PFS Inject 80 mg SC on Day 1, followed by 40 mg every other 84 days 90 mg/0.8 mL PFS Inject 80 mg SC on Day 1, followed by 40 mg every other 98 days 90 mg/0.8 mL PFS Inject 80 mg SC on Day 1, followed by 40 mg every other 98 days 90 mg/0.8 mL PFS Inject 80 mg SC on Day 1, followed by 40 mg every other	🔄 Hadlima		Inject 80 mg SC on Day 1, followed by 40mg every other		=				
Image: Describer's Signature:					🛄 84 days				
Hulio 20 mg/0.4 mL PFS Inject 40 mg SC every week 28 days 40 mg/0.8 mL PFN Inject 40 mg SC every other week 84 days									
Image: domg/0.8 mL PEN Image: domg SC every other week Image: domg SC every other week Image: domg/0.1 mL PFS Image: domg SC every other week Image: domg SC every other week Image: domg/0.2 mL PFS Image: domg SC every other week Image: domg SC every other week Image: domg/0.2 mL PFS Image: domg SC every other week Image: domg SC every other week Image: domg/0.2 mL PFS Image: domg SC every other week Image: domg SC every other week Image: domg/0.4 mL PEN Image: domg SC every other week Image: domg SC every other week Image: domg/0.8 mL PEN Image: domg SC every other week Image: domg SC every other week Image: domg/0.8 mL PEN Image: domg SC every other week Image: domg SC every other week Image: domg/0.8 mL PFS Image: domg SC every other week Image: domg SC every other week Image: domg/0.8 mL PFS Image: domg SC every other week Image: domg SC every other week Image: domg/0.8 mL PFS Image: domg SC every other week Image: domg SC every other week Image: domg/0.8 mL PFS Image: domg SC every other week Image: domg SC every other week Image: domg/0.8 mL PFS Image: domg SC every other week Image: domg SC every other week Image: domg/0.8 mL PFS Image: domg SC			 Inject 40 mg SC every week Inject 40 mg SC every other week 		28 days				
Image: Section of the section of th					🗌 84 days				
Image: Normal Describer's Signature: Image: Normal Describer's Signature: Image: Normal Describer's Signature: Image: Normal Description Image: Normal Describer's Signature: Image: Normal Description Image: Normal Description Image: Normal Description Image: Normal Description Image: Normal Description Image: Normal Description Image: Normal Description Image: Normal Description Image: Normal Description Image: Normal Description Image: Normal Description Image: Normal Description Image: Normal Description Image: Normal Description Image: Normal Description Image: Normal Description Image: Normal Description Image: Normal Description Image: Normal Description Image: Normal Description Image: Normal Description Image: Normal Description Image: Normal Description Image: Normal Description Image: Normal Description Image: Normal Description Image: Normal Description Image: Normal Description Image: Normal Description Image: Normal Description Image: Normal Description Image: Normal Description Image: Normal Description Image: Normal Description Image: Normal Description Image: Normal Description Image: Normal Description Image: Normal Description Image: Normal Description									
Image: Describer's Signature:									
Humira 40 mg/0.4 mL PEN Inject 40 mg SC every other week 84 days 40 mg/0.8 mL PEN Inject 80 mg SC every other week 84 days 40 mg/0.4 mL PFS Inject 80 mg SC on Day 1, followed by 40 mg every other week 0 Other 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: Date: Date: Date:		-	Inject 40 mg SC every week		28 davs				
B0 mg/0.8 mL PEN Inject 80 mg SC every other week	🗌 Humira	-							
B0 mg/0.8 mL PFS Inject 80 mg SC on Day 1, followed by 40 mg every other week store initial dose Other									
Other									
**Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / May Substitute / Product Selection Permitted / **Daw / May Not Substitute Date: Date: Prescriber's Signature:Date: Date: Date:		-	week starting one week after	initial dose					
"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / May Substitute / Product Selection Permitted / DAW / May Not Substitute Date: Date: Prescriber's Signature: Date: Date:	_								
DAW / May Not Substitute Prescriber's Signature:Date:Da									
	DAW / May Not Su	bstitute		Substitution Permissible	ermitted /	Date:			
			iber writes the words "No Substitution"						

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.

			aneous Enrollment Form and Patient Clinical Information	n			
Patient Name:				e:			
	atient Name: Patient DOB: Patient DOB: Patient Phone: Patient Phone:						
Patient Clinical In							
Allergies:		🗌 NKDA Weig	ht: 🗌 lb 🗌 kg	Height:] ln 🗌 Cm		
Treatment status:	New to therapy Continuation of	therapy; Date of last tre	eatment//				
Samples provided	l 🗌 No 🗌 Yes, if so how many sample	s given? T	B Test Date// Pos 🗌	Neg			
Prior therapy, trea	tment dates, and reason(s) for disconti	nuation					
	NINFORMATION Ship to: 🗌 Patient	Office Other:					
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 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 other week every other week	28 days			
🗌 Ilaris	150 mg/mL injection SDV	For patients weighir Injectmg (4 r (*max 300 mg per d	ng/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 		C once every two weeks C once every two weeks	28 days 84 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	10 kg to < 25 kg: \square Inject 50 mg SC of 25 kg to < 50 kg: \square Inject 87.5 mg S \ge 50 kg: \square Inject 125 mg SC	C once weekly once weekly	28 days 84 days			
		Adult RA or PsA Do					
🗌 Otezla	28-day starter kit	Day 3: 10 mg in morni Day 4: 20 mg in morn Day 5: 20 mg in morn	in the morning. ing and 10 mg in evening. ing and 20 mg in evening. ing and 20 mg in evening. ing and 30 mg in evening. 30 mg PO twice daily	1 kit	0		
	30 mg tablet Sample already provided/no titration needed	Take 30 mg PO twice daily		30 days 90 days			
🗌 Rinvoq	15 mg tablet	Take one 15 mg tabl	Take one 15 mg tablet PO once daily				
Simponi	50 mg/0.5 mL PEN 50 mg/0.5 mL PFS	Inject 50 mg SC eve	ry 4 weeks	28 days 84 days			
6 PRESCR	IBER SIGNATURE REQUIRED	(STAMP SIGNAT	URE NOT ALLOWED)				
"Dispense As V DAW / May No	Written" / Brand Medically Necessary / Do Not Subs		May Substitute / Product Selection Perm Substitution Permissible Prescriber's Signature:		ate:		

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.

Rheumatology Oral/Subcutaneous Enrollment Form								
	Please		and Patient Clinical Information					
		Patient DOB:	Patient Phone:					
Prescriber Name:			_ Prescriber Phone:					
Patient Clinical In Allergies:	formation:		ht: 🗌 lb 🗌 kg Height:_		1 cm			
Allergies Treatment status:		INDA Weig	ni Lib Likg Height eatment / /		J CIII			
Samples provided	\square No \square Yes if so how r	many samples given? \Box	eatment// Pos Neg					
Prior therapy, trea	tment dates, and reason(s)) for discontinuation						
		: Patient Office Other:						
MEDICATION	STRENGTH	DOSE & DIRECTIONS		QUANTITY	REFILLS			
		Loading Dose:						
🗌 Skyrizi	150 mg/mL PFS 150 mg/mL PEN	Inject 150 mg SC at week 0		28 days	0			
		Maintenance Dose:						
		Inject 150 mg SC at week 4, an	nd every 12 weeks thereafter	🗌 84 days				
		AS Loading Dose:	28 days	о				
			Subirs) SC ON WEEK O	20 uays	0			
		AS Maintenance Dose:						
		Inject 80 mg SC injection every	v 4 weeks	28 days				
				84 days				
	🗌 80 mg PEN	nr-axSpA:		28 days				
		🗌 Inject 80 mg SC every 4 weeks	🗌 84 days					
	80 mg PFS	PsA Loading Dose (w/o psoriasis)						
🗌 Taltz		🗌 Inject 160 mg (two 80 mg injec	ctions) SC on week 0	28 days	0			
		PsA Maintenance Dose (w/o psor		28 days				
		Inject 80 mg SC every 4 weeks		84 days				
		PsA Loading Dose (with psoriasis)	r: ctions) week 0, then 80 mg week 2	28 days	о			
			(3-pack)	U				
		☐ Inject 80 mg week 4, 6, 8, and	10	28 days	1			
				(2-pack)				
		PsA Maintenance Dose (with psor		28 days				
		Inject 80 mg SC week 12 and e	every 4 weeks thereafter	(1-pack)				
	☐ 100 mg/mL PFS ☐ 100 mg/mL PEN	Loading Dose:						
— —		Inject 100 mg SC on week 0		28 days	0			
Tremfya		Maintenance Dose:						
		Inject 100 mg SC week 4, then	56 days					
	5 mg Tablet	Take one 5 mg tablet PO twice	30 days					
🗌 Xeljanz	11 mg XR Tablet	Take one 11 mg tablet PO once		\square 90 days				
	40 mg/0.4 mL PEN							
	40 mg/0.4 mL PFS	Inject 40 mg SC every week		28 days				
🗌 Yuflyma	(with safety guard)	Inject 40 mg SC every other w	\square 84 days					
	🗌 40 mg/0.4 mL PFS	Inject 80 mg SC every other we	eek					
	🗌 80 mg/0.8 mL PEN							
Other								
	patient support programs	STAMP SIGNATURE NOT A	ALLOWED Ancillary supplies and kits provided as	s needed for administratio	n			
		STAMP SIGNATURE NOT ALLOW	, , , , , , , , , , , , , , , , , , , ,					
	"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / May Substitute / Product Selection Permitted /							
	/ DAW / May Not Substitut		Substitution Permissible					
Prescriber's Sig	-	Date: Prescriber's Signature:		Date:				
	D : Interchance is mandate	d unless Prescriber writes the word	e "No Substitution"					
	-	ase submit electronic prescription						

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by telephone and destroy all copies of this communication and any attachments. Plan member privacy is important to us. Our employees are trained regarding the appropriate way to handle members' private health information. 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.

This document contains references to brand-name prescription drugs that are trademarks or registered trademarks of pharmaceutical manufacturers not affiliated with CVS Pharmacy, Inc. or one of its affiliates.