Rheumatology Oral/Subcutaneous Enrollment Form

CVS specialty[®]

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

PATIENT INFOR	MATION (Complete or includ	Six Simple Steps to Subm de demographic sheet)	hitting a Referral		
Patient Name:			_ DOB:	_Gender: 🗌 Male 🔲 Fer	nale
Address:		City, State, ZIP (Code:		
Preferred Contact N	Vethods: 🗌 Phone (to primary	y # provided below) 🗌 Te:	xt (to cell # provided below	/) 🔲 Email (to email provid	ed below)
	es may apply. If unable to cont				
Primary Phone:					
Email:			SSN: Primary		
	gal Guardian Name (Last, First):	Relation	onship to patient:		
2 PRESCRIBER IN					
Prescriber's Name:				_ State License #:	
NPI #:	DEA #:	Group or Hospital:	, •		
Address:	Fax	City, State,	ZIP Code:		
Phone:	Fax	_ Contact Person:	Cont	act's Phone:	
	FORMATION Please fax copy			vith this form, if available	
	D-10) AND PATIENT CLINIC				
M06.9 Rheumat	toid Arthritis (RA)	M45.9 Ankylosing Spondy	litis (AS)		
	athic Psoriasis (PsA)		Arthritis (JPsA)		
	diographic Axial Spondylarthr				
	gia Rheumatica (PMR)	M08.00 Juvenile Idiopathi	c Arthritis (JIA)		
H44.139 Uveitis,					
	Description		Veight: lb	- <u></u>	
Allergies:		LI NKDA V	Veight: L] lb	L kg Height:	📋 ln 🛄 Cm
Treatment status:	☐ New to therapy ☐ Continu ☐ No ☐ Yes, if so, how many	ation of therapy; Date of la	st treatment/_/		
			B lest Date/_/_		
	ment dates, and reason(s) for a				
	INFORMATION Ship to:				
MEDICATION			SE & DIRECTIONS	QUANTIT	Y REFILLS
Actemra	☐ 162 mg/0.9 mL ACTPen ☐ 162 mg/0.9 mL PFS	Inject 162 mg SC every		28 days 84 days	
🗌 Adalimumab-		Inject 40 mg SC every v	wook		
aacf	40 mg/0.8 mL PEN	Inject 40 mg SC every of		28 days	
(unbranded		Inject 80 mg SC every of		🗌 84 days	
version of Idacio)					
Adalimumab-	40 mg/0.4 mL PEN				
adaz	40 mg/0.4 mL PFS (with	Inject 40 mg SC every v			
(unbranded	needle guard)	Inject 40 mg SC every o		28 days 84 days	
version of Hyrimoz)		Inject 80 mg SC every o	Juner week		
Adalimumab-		Inject 20 mg SC every o	atharwaak		
fkjp	20 mg/0.4 mL PFS	Inject 20 mg SC every v		28 days	
(unbranded	40 mg/0.8 mL PFS	Inject 40 mg SC every of		84 days	
version of Hulio)	🗌 40 mg/0.8 mL PEN	Inject 80 mg SC every of			
		Inject 10 mg SC every o			
		Inject 20 mg SC every of			
Amjevita	☐ 10 mg/0.2 mL PFS ☐ 20 mg/0.4 mL PFS	Inject 40 mg SC every o			
(adalimumab-	40 mg/0.8 mL PFS	Inject 40 mg SC every v	week	28 days	
atto)	40 mg/0.8 mL PFS	Inject 80 mg SC every o		🗌 84 days	
			owed by 40 mg every other w	veek	
		starting one week after init	ial dose		
Other:					
	GNATURE REQUIRED (STA		I OWFD)	I	I
"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute DAW / May Not Substitute					
Prescriber's Sign		Date:	Substitution Permissible Prescriber's Signature:		_Date:
CA, MA, NC & PR: Inter	rchange is mandated unless Prescriber wri	ites the words " No Substitution "	ATTN: New York and	d Iowa providers, please submit elec	ctronic 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		
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Altergies:	Prescriber Name:						
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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	
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□ 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 rowspan="2">🗌 Cimzia</td><td></td><td colspan="2"></td><td></td><td></td></td<>	🗌 Cimzia						
P=A Maintenance Dose (with psoriasis):		🗌 200 mg/mL vial			= '		
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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							
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DAW / May Not Substitute Prescriber's Signature:Date:Da							
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			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:	Please Completer			e:	
Prescriber Name:			_ Prescriber 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 m (*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 1: Take 10 mg PO in the morning. Day 2: 10 mg in morning and 10 mg in evening. Day 3: 10 mg in morning and 20 mg in evening. Day 4: 20 mg in morning and 20 mg in evening. Day 5: 20 mg in morning and 30 mg in evening. Day 6 and thereafter: 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 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	
6 PRESCR	IBER SIGNATURE REQUIRED	(STAMP SIGNAT	URE NOT ALLOWED)		
"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute Substitute Substitute / No Substitution / Substitution Permissible				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.

		eumatology Oral/Subcuta			
	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
🗌 Skyrizi		Loading Dose:			
	150 mg/mL PFS	Inject 150 mg SC at week 0		28 days	0
	150 mg/mL PEN	Maintenance Dose:			
		Inject 150 mg SC at week 4, an	nd every 12 weeks thereafter	🗌 84 days	
		AS Loading Dose:	stiene) SC en week 0	28 days	о
			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	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):		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	every 8 weeks thereafter	56 days	
	5 mg Tablet	Take one 5 mg tablet PO twice daily		30 days	
🗌 Xeljanz	11 mg XR Tablet	Take one 11 mg tablet PO once		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	, , , , , , , , , , , , , , , , , , , ,		
		lecessary / Do Not Substitute /	May Substitute / Product Selection Permi	itted /	
	/ 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			

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