

Fax Referral To: 1-877-232-5455

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

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

		Six Simple Steps to Subr	nitting a Referral			
	RMATION (Complete or include		DOD:	Candom	l Mala 🔲 Fame	a la
Patient Name:		Oit Chata ZID	DOB:	Gender: [_	j Male 🔲 Fema	ile.
Professi Contact	Methods: Phone (to primar	City, State, ZIP	vyt (to coll # provide	ad balaw) 🗆 Email (t	o omoil providor	
Note: Corrier chara	ges may apply. If unable to cont	y # provided below) 🔲 Te	iolty Phormony will	ettomat to contact by	o eman provided	i below)
	уез тау арріу. п ипавіе то сопт 					
Email:		Last Four of \$	SSN:	Drimary Language:		
	egal Guardian Name (Last, First):					
PRESCRIBER IN		Rotati	onship to patient			
Prescriber's Name				State Licen	150 #·	
NPI #	 DEA #:	Group or Hospital				
Address:		City State				
Phone:	Fax	Contact Person:	211 Codo	Contact's Phone	,	
INSUPANCE IN	FORMATION Please fax copy	of prescription and insural	nce cards (front and	contact of floric. d hack) with this form	if available	
DIAGNOSIS (IC	CD-10) AND PATIENT CLINIC	AL INFORMATION (Incl.)	ude carus (Horit ari	ale)	i, ii available	
	atoid Arthritis (RA)			113)		
	pathic Psoriasis (PsA)					
	adiographic Axial Spondylarthi		Artifitis (OF 3A)			
_	algia Rheumatica (PMR)		ic Arthritis (JIA)			
	s, unspecified eye	woo.oo daverme lalopatri	io Ai tillitio (olA)			
	Description					
Allergies:		□ NKDA \	Neight:	lb kg Heig	ıht:] In \square Cm
	New to therapy Continu	uation of therapy: Date of la	est treatment /		,	, <u> </u>
Samples provided	No Yes, if so, how many	v samples given?	TB Test Date	 /_	Nea	
	tment dates, and reason(s) for				,	
	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 avenue				
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 40 mg SC every			84 days	
Hvrimoz)		inject do mg 30 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 mm/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	other week			
(adalimumab- do mg/0.8 mL PFS				28 days		
atto) T 40 mg/0.8 ml PEN Linject 80 mg SC every other week Li 84 days						
		☐ Inject 80 mg Day 1, foll		ry 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 Subst		Data	Substitution Permissi		_	
Prescriber's Sig	nature:	Date:	Prescriber's Sig	nature:	D	oate:
OA MA NOC DD. Inte	archango is mandatad unlass Drassribar uri		ATTN: N-	w Vork and lawa provider		

Patient Name:	Please Comple		and Patient Clinical Informa Patient	<u>tion</u> : Phone:	
Prescriber Name			Prescriber Phone:		
Patient Clinical I	Information:	□ NIZDA N	Veight:		
Allergies: Treatment status	s: New to therapy Continua	tion of therapy: Date of la	st treatment / /	kg Height	
Samples provide	d \square No \square Yes, if so how many s	amples given?	☐ TB Test Date//	Pos 🗌 Neg	
	atment dates, and reason(s) for di				
5 PRESCRIPTION MEDICATION	ON INFORMATION Ship to: STRENGTH			CHANTITY	DEFILLS
MEDICATION	SIRENGIA	PsA/nr-axSpA/AS:	& DIRECTIONS	QUANTITY 28 days	REFILLS
	2 x 160 mg/mL PEN	Inject 160 mg SC ever	y 4 weeks ry 4 weeks at weeks 0, 4, 8, and 1	☐ 84 days	3
Bimzelx	2 x 160 mg/mL PFS 160 mg/mL PEN		eek 16 and then every 8 weeks	56 days	0
	160 mg/mL PFS	☐ Inject 320 mg SC at w	eek 16 and then every 4 weeks	28 days	0
		☐ Inject 320 mg SC ever ☐ Inject 320 mg SC eve		28 days 84 days	
	Cimzia Starter Kit	☐ Inject 400 mg SC on v	veeks 0, 2 and 4	1 kit	0
☐ Cimzia	200 mg/mL PFS (carton of 1) 200 mg/mL PFS (carton of 2) 200 mg/mL vial kit (carton of 2-HCP administration	☐ Inject 50 mg SC every ☐ Inject 100 mg SC on w ☐ Inject 100 mg SC ever ☐ Inject 200 mg SC on w ☐ Inject 200 mg SC ever ☐ Inject 400 mg SC ever ☐ Inject 400 mg SC ever	veeks 0, 2 and 4 ry other week veeks 0, 2 and 4 ry other week	☐ 28 days ☐ 84 days	
		self-administration for do	·		
☐ Cosentyx	1x75 mg/mL PFS 1x150 mg/mL PEN 1x150 mg/mL PFS 2x150 mg/mL PEN 2x150 mg/mL PFS 300 mg/2 mL PEN	☐ Inject 75 mg SC on Winject 150 mg SC on Winject 300 mg SC on Winject 300 mg SC on Winject 75 mg SC on Winject 75 mg SC every ☐ Inject 150 mg SC on Withereafter ☐ Inject 150 mg SC every ☐ Inject	Veeks 0, 1, 2, 3 Veeks 0, 1, 2, 3 Veek 4, then every 4 weeks therea Veek 4, then every 4 weeks Veek 4, then every 4 weeks Veek 4, then every 4 weeks	Loading Dose: Quantity: 28 days fter Maintenance Dose: Quantity: 28 days	Loading Dose: Refills: 0 Maintenance Dose: Refills:
☐ 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 weekly ☐ Inject 0.8 mg/kg (Dose=mg) weekly, with a maximum of 50 mg per week		28 days 84 days	
Other	CIONATURE DECUMED (CT.)		I OWED)		
	SIGNATURE REQUIRED (STAM		-		
DAW / May Not Sub	en" / Brand Medically Necessary / Do Not Superitute ignature:		May Substitute / Product Selection Pe Substitution Permissible Prescriber's Signature:		Date:
CA, MA, NC & PR:	nterchange is mandated unless Prescriber write	es the words "No Substitution"	ATTN: New York and low	ra providers, please submit e	electronic prescription

			nd Patient Clinical Information		
Patient Name: _		Patient DOB:	Patient Phone: _		
Prescriber Nam			Prescriber Phone:		
Patient Clinica					-
Allergies:	us: New to therapy Continua	LJ NKDA Weigh	nt: 🔲 lb 🗌 kg 🕒 F	łeight: [ln
Treatment statu	us: New to therapy Continua	tion of therapy; Date of last tre	atment//		
			B Test Date// Pos 🗌 N	√leg	
	reatment dates, and reason(s) for di				
	ON INFORMATION Ship to: T				
MEDICATION	N STRENGTH	DOSE & DIRECTI		QUANTITY	REFILLS
	☐ 40 mg/0.4 mL PEN	Inject 40 mg SC every w			
	☐ 40 mg/0.8 mL PEN	Inject 40 mg SC every ot	her week	28 days	
☐ Hadlima	☐ 40 mg/0.4 mL PFS	Inject 80 mg SC every of	her week	☐ 84 days	
	☐ 40 mg/0.8 mL PFS		, followed by 40mg every other week		
		starting one week after initia			+
	☐ 20 mg/0.4 mL PFS	☐ Inject 20 mg SC every ot	ner week		
☐ Hulio	☐ 40 mg/0.8 mL PFS	☐ Inject 40 mg SC every w		28 days	
	☐ 40 mg/0.8 mL PEN	☐ Inject 40 mg SC every of		☐ 84 days	
		☐ Inject 80 mg SC every ot☐ Inject 10 mg SC every ot☐			
	☐ 10 mg/0.1 mL PFS	☐ Inject 10 mg SC every of			
	20 mg/0.2 mL PFS	☐ Inject 40 mg SC every w		28 days	
☐ Humira	☐ 40 mg/0.4 mL PEN	☐ Inject 40 mg SC every of		84 days	
	☐ 80 mg/0.8 mL PEN	☐ Inject 40 mg SC every of		□ 04 days	
	☐ 40 mg/0.4 mL PFS	☐ Inject 80 mg SC on Day 1			
	☐ 80 mg/0.8 mL PFS	starting one week after initia			
	☐ 10 mg/0.1 ml PFS				+
	20 mg/0.2 ml PFS	Inject 10 mg SC every ot			
	☐ 40 mg/0.4 mL PEN	Inject 20 mg SC every o		28 days	
☐ Hyrimoz	☐ 80 mg/0.8 mL PEN	Inject 40 mg SC every w		84 days	
	40 mg/0.4 mL PFS (with	Inject 40 mg SC every o		_ ,	
	needle guard)	☐ Inject 80 mg SC every o	:her week		
		☐ Inject 40 mg SC every w	eek	28 days	
☐ Idacio	40 mg/0.8 mL PEN	Inject 40 mg SC every other week		84 days	
	☐ 40 mg/0.8 mL PFS	☐ Inject 80 mg SC every ot	her week		
		For patients weighing ≥ 7.5 l			
☐ Ilaris	150 mg/mL injection SDV	Injectmg (4 mg/kg) SC every 4 weeks		28 days	
		(*max 300 mg per dose)		☐ 84 days	
	200 mg/1.14 mL PFS	_			
☐ Kevzara	☐ 150 mg/1.14 mL PFS	Inject 200 mg SC once e		28 days	
Revzulu	200 mg/1.14 mL PEN	☐ Inject 150 mg SC once e	ery two weeks	☐ 84 days	
	☐ 150 mg/1.14 mL PEN				
	2 mg tablet	Take 2 mg PO once daily		30 days	
☐ Olumiant				90 days	
<u> </u>		Peds JIA or PsA (>2 years	old) Dosina:		-
		10 kg to < 25 kg:			
	☐ 50 mg/0.4 mL PFS	☐ Inject 50 mg SC once we	eklv		
	☐ 87.5 mg/0.7 mL PFS	25 kg to < 50 kg:	,	28 days	
	☐ 125 mg PFS	☐ Inject 87.5 mg SC once	weekly	84 days	
Orencia	☐ 125 mg PEN	≥50 kg:	_ ,		
		Inject 125 mg SC once weekly			
		Adult RA or PsA Dosing:			
		☐ Inject 125 mg SC once w	eekly		
					+
U Other					
6 PRESC	RIBER SIGNATURE REQU	RED (STAMP SIGNAT	JRE NOT ALLOWED)		
	As Written" / Brand Medically Necessary / Do		May Substitute / Product Selection Permitted		
	Not Substitute	TO SUBSTITUTE / INO SUBSTITUTION /	Substitution Permissible		
	er's Signature:	Date:	Prescriber's Signature:	ı	Date:
			y		-
CA, MA, NC	& PR: Interchange is mandated unless Prescribe	r writes the words "No Substitution"	ATTN: New York and Iowa prov	iders, please submit elec	tronic prescription

	Patient DOB:	Da	tiont Dhaire		
		га	tient Phone:		
		_ Prescriber Phone:			
ation:				П. Г	7 _
	L NKDA Weigi	nt:	g Height:	LI LN L	_l Cm
w to therapy \square Continuatio	on of therapy; Date of last tre	eatment//	Dan 🗆 Nasi		
O Lyes, it so, how many sai	mples given? L	B Test Date//	Pos ∐ Neg		
		010			
STRENGTH				QUANTITY	REFILLS
Titration Starter Pack for 80 mg BID dosage	Day 1: Take 10 mg PO in the morning. Day 2: Take 10 mg PO in the morning and 10 mg PO in the evening. Day 3: Take 10 mg PO in the morning and 20 mg PO in the evening. Day 4: Take 20 mg PO in the morning and 20 mg PO in the evening. Day 5: Take 20 mg PO in the morning and 30 mg PO in the evening. Day 6 and thereafter: Take 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	
15 mg tablet	Take one 15 mg tablet PO o	30 days 90 days			
☐ 1 mg/ 1 mL	4 mg (4 mL oral solution	Quantity(ml)			
☐ 40 mg/0.4 mL PEN	☐ Inject 40mg SC every wo ☐ Inject 40mg SC every ot ☐ Inject 80mg SC every ot	eek her week her week	ek starting one	28 days 84 days	
50 mg/0.5 mL PEN 50 mg/0.5 mL PFS		28 days			
☐ 150 mg/mL PFS ☐ 150 mg/mL PEN	Inject 150 mg SC at wee Maintenance Dose:		after	28 days	0
	AS Loading Dose: Inject 160 mg (two 80 m AS Maintenance Dose:	g injections) SC on week 0		28 days 28 days 84 days	0
7 80 mg PFN	nr-axSpA:	<u> </u>		28 days 84 days	O O O T
☐ 80 mg PFS	☐ Inject 160 mg (two 80 m	g injections) SC on week 0		28 days	0
	Inject 80 mg SC every 4 weeks PsA Loading Dose (with psoriasis):		84 days		
	Inject 160 mg (two 80 mg injections) week 0, then 80 mg week 2 Inject 80 mg week 4, 6, 8, and 10		28 days		
			r	28 days (1-pack)	
SIGNATURE REQUIR	│ ED (STAMP SIGNAT	URE NOT ALLOWED	<u> </u>		<u> </u>
tute nature:	Date:	Substitution Permissible Prescriber's Signature:			
	A SIGNATURE REQUIR SIGNATURE	NKDA Weight NKDA Weight NKDA Weight NKDA Weight NKDA Note NKDA Note Note	NKDA Weight:	NKDA Weight:	invito therapy Continuation of therapy Date of last treatment

	Please Complete Pa	atient , Prescriber and P	atient Clinical Information				
Patient Name:	Patient DOB: Patient Phone:						
Prescriber Name:							
Patient Clinical Informat	<u>ion:</u>						
Allergies:		NKDA Weight:	🗌 lb 🗌 kg 💢 Hei	ght:	🗌 ln 🗌 Cm		
Treatment status: 🔲 New	v to therapy \square Continuation of th	erapy; Date of last treatme	ent//				
Samples provided 🗌 No	Yes, if so, how many samples	given? TB Te	st Date// Pos 🗌 Ne	g			
	lates, and reason(s) f <u>or</u> discontin <u>u</u>						
	RMATION Ship to: \square Patient \square	Office Other:					
MEDICATION	STRENGTH	DOSE & DIREC	TIONS	QUANTITY	REFILLS		
		Loading Dose:		28 days	0		
☐ Tremfya	☐ 100 mg/mL PFS	☐ Inject 100 mg SC on w					
	100 mg/mL PEN	Maintenance Dose:		☐ 56 days			
			k 4, then every 8 weeks thereafter				
Tyenne (tocilizumab-	162 mg/0.9 mL PEN	Inject 162 mg SC every	28 days				
aazg)	☐ 162 mg/0.9 mL PFS	☐ Inject 162 mg SC every		☐ 84 days			
☐ Xeljanz	5 mg Tablet	Take one 5 mg tablet I	30 days				
	11 mg XR Tablet	☐ Take one 11 mg tablet	90 days				
	☐ 40 mg/0.4 mL PEN						
	40 mg/0.4 mL PFS (with	☐ Inject 40 mg SC every	28 days				
☐ Yuflyma	safety guard) 3 40 mg/0.4 mL PFS	☐ Inject 40 mg SC every	☐ 84 days				
	☐ 40 mg/0.4 mL PFS	☐ Inject 80 mg SC every					
	comg/c.cmeren						
Other							
Patient is interested in patient su	pport programs	STAMP SIGNATURE NOT ALLOW	ED Ancillary supplies and kits prov	ided as needed for ac	dministration		
<u>_</u>							
PRESCRIBER SIGNAT	URE REQUIRED (STAMP SIGNA	ATURE NOT ALLOWED)					
"Dispense As Written" /	Brand Medically Necessary / Do	Not Substitute / Ma	ay Substitute / Product Selection F	Permitted /			
•			bstitution Permissible	Cirilliaca /			
No Substitution / DAW / May Not Substitute Prescriber's Signature:					Date:		
	change is mandated unless Presc		Substitution"				
ATTN: New York and Io	owa providers, please submit elec	ctronic prescription					

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