Dermatology Enrollment Form

Fax Referral To: 1-888-280-1191 OR 787-759-4161
Phone: 1-888-280-1190 OR 787-759-4162
Email Referral To: Customer.ServiceFax@CVSHealth.com
Address: 280 Avenida Jesus T. Pinero Ste B Rio Piedras, PR 00927

Six Simple Steps to Submitting a Referral

1 PATIENT INFORMATION *(Complete or include demographic sheet)*

Patient Name: _____ DOB: _____
Address: _____City, State, ZIP Code: _____
Gender: ☐ Male ☐ Female
Preferred Contact Methods: ☐ Phone (to primary # provided below) ☐ Text (to cell # provided below) ☐ Email (to email provided below)
Note: Carrier charges may apply. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.
Primary Phone: _____ Alternate Phone: _____
If **Minor**, Parent/Caregiver/Guardian Name (Last, First): _____
Relationship to minor: _____
Email: _____ Last Four of SSN: _____ Primary Language: _____

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):

☐ L40.0 Psoriasis Vulgaris ☐ L40.1 Generalized Pustular Psoriasis ☐ L40.4 Guttate Psoriasis
☐ L40.50 Arthropathic Psoriasis, Unspecified ☐ L40.59 Other Psoriatic Arthropathy ☐ L40.8 Other Psoriasis
☐ L40.9 Psoriasis, Unspecified ☐ L73.2 Hidradenitis Suppurativa
☐ Other Code: _____ Description
_____

Patient Clinical Information:

Allergies:_____
Weight:_____lb/kg Height:_____
_____In/cm TB Test Result:_____
Date:_____

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

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Dermatology Enrollment Form
Medications A-C
(Avsola, Cimzia)

Please Complete Patient , Prescriber and Patient Clinical Information

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

Patient Clinical Information:

Allergies:_____
Weight:_____lb/kg Height:_____In/cm TB Test Result:_____ Date:_____

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Avsola	100 mg vial	☐ Induction Dose: Infuse IV at 5 mg/kg (Dose = ____mg) at weeks 0, 2, 6 and every 8 weeks thereafter ☐ Maintenance Dose: Infuse IV at 5 mg/kg (Dose = ___mg) every 8 weeks ☐ Other:_____	Quantity: _____ # of 100 mg vial(s) Refills: _____
☐ Cimzia	Cimzia Starter Kit (6 prefilled syringes)	Psoriasis Loading Dose: ☐ 400 mg (given as 2 subcutaneous injections of 200 mg each) every other week ☐ Patients (with body weight ≤ 90 kg): 400 mg (given as 2 subcutaneous injections of 200 mg each) initially and at weeks 2 and 4, followed by 200 mg every other week Psoriatic Arthritis Loading Dose: ☐ 400 mg (given as 2 subcutaneous injections of 200 mg each) initially and at week 2 and 4, followed by 200 mg every other week ☐ Other:_____	Quantity: 1 Kit Refills: 0
☐ Cimzia	☐ 200mg/1 mL prefilled syringe ☐ 200mg vial	Psoriasis Maintenance Dose: ☐ 400 mg (given as 2 subcutaneous injections of 200 mg each) every other week ☐ 200 mg every other week Psoriatic Arthritis Maintenance Dose: ☐ 200 mg every other week ☐ 400 mg (given as 2 subcutaneous injections of 200 mg each) every 4 weeks ☐ 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 **Prescriber's Signature: _____Date: _____**	May Substitute / Product Selection Permitted / Substitution Permissible **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	

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Dermatology Enrollment Form
Medications C-G
(Cosentyx, Enbrel)

Please Complete Patient , Prescriber and Patient Clinical Information

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

Patient Clinical Information:

Allergies:_____
Weight:_____lb/kg Height:_____In/cm TB Test Result:_____ Date:_____

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Cosentyx 150 mg	☐ Sensoready Pen (1x150 mg/mL) ☐ Prefilled Syringe (1x150 mg/mL)	Adult: ☐ Loading Dose: Inject 150 mg subcutaneously on Weeks 0, 1, 2, 3 ☐ Maintenance Dose: Inject 150 mg subcutaneously on Week 4, then every 4 weeks thereafter ☐ Other:_____	Quantity: _____ Refills: _____
☐ Cosentyx 300 mg	☐ Sensoready Pen (2x150 mg/mL) ☐ Prefilled Syringe (2x150 mg/mL)	Adult: ☐ Loading Dose: Inject 300 mg subcutaneously on Weeks 0, 1, 2, 3 ☐ Maintenance Dose: Inject 300 mg subcutaneously on Week 4, then every 4 weeks thereafter ☐ Other:_____	Quantity: _____ Refills: _____
☐ Cosentyx 75 mg (wt ≥ 15 kg and < 50 kg)	Prefilled Syringe (1x75 mg/0.5 mL)	Pediatric: ☐ Loading Dose: Inject 75 mg subcutaneously on Weeks 0, 1, 2, 3 ☐ Maintenance Dose: Inject 75 mg subcutaneously on Week 4, then every 4 weeks thereafter ☐ Other:_____	Quantity: _____ Refills: _____
☐ Cosentyx 150 mg (wt ≥ 50 kg)	☐ Sensoready Pen (1x150 mg/mL) ☐ Prefilled Syringe (1x150 mg/mL)	Pediatric: ☐ Loading Dose: Inject 150 mg subcutaneously on Weeks 0, 1, 2, 3 ☐ Maintenance Dose: Inject 150 mg subcutaneously on Week 4, then every 4 weeks thereafter ☐ Other:_____	Quantity: _____ Refills: _____
☐ Enbrel	☐ 50 mg/mL Sureclick Autoinjector ☐ 50 mg/mL prefilled syringe ☐ 50 mg/mL Enbrel Mini prefilled cartridge for use with the AutoTouch reusable autoinjector only (Prescriber MUST supply). CVS does not order the autoinjector. ☐ 25 mg/0.5 mL prefilled syringe ☐ 25 mg/0.5 mL solution in a single-dose vial	☐ Psoriasis Induction Dose: Inject 50 mg SC TWICE a week (3 to 4 days apart) for 3 months, then maintenance dosing. ☐ Psoriasis Maintenance Dose: Inject 50 mg SC ONCE a week. ☐ Psoriatic Arthritis Dose: Inject 50 mg SC ONCE a week. ☐ 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 **Prescriber's Signature: _____Date: _____**	May Substitute / Product Selection Permitted / Substitution Permissible **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

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Dermatology Enrollment Form
Medications H
(Humira)

Please Complete Patient , Prescriber and Patient Clinical Information

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

Patient Clinical Information:

Allergies:_____
Weight:_____lb/kg Height:_____In/cm TB Test Result:_____ Date:_____

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Humira	☐ Psoriasis 40 mg/0.4 mL Starter Package **Citrate Free** ☐ Psoriasis 80 mg/0.8 mL and 40 mg/0.4 mL Starter Package **Citrate Free**	☐ Psoriasis Induction Dose: 80 mg SC initial dose, followed by 40 mg SC on day 8, then 40 mg every other week.	Quantity: 1 package Refills: 0
☐ Humira	☐ 40 mg/0.4 mL Pen **Citrate Free** ☐ 40 mg/0.4 prefilled syringe **Citrate Free**	☐ Psoriasis Maintenance Dose: Inject one 40 mg pen/syringe SC every other week. ☐ Psoriatic Arthritis Dose: Inject one 40 mg pen/syringe SC every other week. ☐ Other:_____	Quantity: _____ Refills: _____
☐ Humira	**30 kg (66 lbs) to less than 60 kg (132 lbs); ≥ 12 years:** ☐ Adolescent Hidradenitis Suppurativa 80 mg/0.8 mL and 40 mg/0.4 mL Starter Package **Citrate Free**	Adolescent Hidradenitis Suppurativa Initial Dose: ☐ Inject SC 80mg Day 1, then 40mg every other week on day 8 and subsequent doses ☐ Other:_____	Quantity: 1 kit (3 Pens) Refills: 0
☐ Humira	**60 kg (132 lbs) and greater; ≥ 12 years:** ☐ Adult Hidradenitis Suppurativa 80 mg/0.8 mL Starter Package **Citrate Free**	Hidradenitis Suppurativa Initial Dose: ☐ Inject SC 160mg Day 1, then 80mg two weeks later (Day 15), then 40mg every week (Day 29) and subsequent doses ☐ Inject SC 80mg Day 1, 80mg Day 2, then 80mg two weeks later (Day 15), then 40mg every week (Day 29) and subsequent doses ☐ Inject SC 160mg Day 1, then 80mg two weeks later (Day 15), then 80mg every other week (Day 29) and subsequent doses ☐ Inject SC 80mg Day 1, 80mg Day 2, then 80mg two weeks later (Day 15), then 80mg every other week (Day 29) and subsequent doses ☐ Other:_____	Quantity: 1 kit (3 Pens) Refills: 0
☐ Humira	**30 kg (66 lbs) to less than 60 kg (132 lbs); ≥ 12 years:** ☐ 40 mg/0.4 mL Pen **Citrate Free** ☐ 40 mg/0.4 mL prefilled syringe **Citrate Free**	Adolescent Hidradenitis Suppurativa Maintenance Dose: ☐ Inject SC 40mg every other week ☐ Other:_____	Quantity: _____ Refills: _____
☐ Humira	**60 kg (132 lbs) and greater; ≥ 12 years:** ☐ 40 mg/0.4 mL Pen **Citrate Free** ☐ 40 mg/0.4 prefilled syringe **Citrate Free** ☐ 80 mg/0.8 mL Pen **Citrate Free**	Hidradenitis Suppurativa Maintenance Dose: ☐ Inject SC 40mg every week ☐ Inject SC 80 mg every other week	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)

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Dermatology Enrollment Form
Medications I-S

(Ilumya, Inflectra, Infliximab, Orencia, Otezla, Remicade, Renflexis, Rinvoq, Siliq, Simponi, Simponi ARIA)

Please Complete Patient , Prescriber and Patient Clinical Information

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

Patient Clinical Information:

Allergies:_____
Weight:_____lb/kg Height:_____In/cm TB Test Result:_____ Date:_____

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Ilumya	100 mg/mL prefilled syringe	☐ Psoriasis Induction Dose: Inject one pre-filled syringe (100 mg) SC at weeks 0 and 4, then maintenance dosing. ☐ Psoriasis Maintenance Dose: Inject one pre-filled syringe (100 mg) SC every 12 weeks. ☐ Other: _____	Quantity: _____ Refills: _____
☐ Inflectra ☐ Infliximab	100 mg vial	☐ Induction Dose: Infuse IV at 5 mg/kg (Dose = ____mg) at weeks 0, 2, 6 and every 8 weeks thereafter ☐ Maintenance Dose: Infuse IV at 5 mg/kg (Dose = ___mg) every 8 weeks ☐ Other: _____	Quantity: _____ # of 100 mg vial(s) Refills: _____
☐ Orencia	125 mg/mL prefilled syringe	Inject 125 mg SC once weekly	Quantity: _____ Refills: _____
☐ Otezla	Titration Starter Pack	Day 1: 10 mg PO in the morning. Day 2: 10 mg PO in the morning and 10 mg PO in the evening. Day 3: 10 mg PO in the morning and 20 mg PO in the evening. Day 4: 20 mg PO in the morning and 20 mg PO in the evening. Day 5: 20 mg PO in the morning and 30 mg PO in the evening. Day 6 and thereafter: 30 mg PO twice daily.	Quantity: 1 pack Refills: 0
☐ Otezla	30 mg tablet	☐ Maintenance Dose: 30 mg tablet PO twice daily. ☐ Other: _____	Quantity: _____ Refills: _____
☐ Remicade ☐ Renflexis	100 mg vial	☐ Induction Dose: Infuse IV at 5 mg/kg (Dose = ____mg) at weeks 0, 2, 6 and every 8 weeks thereafter ☐ Maintenance Dose: Infuse IV at 5 mg/kg (Dose = ___mg) every 8 weeks ☐ Other: _____	Quantity: _____ # of 100 mg vial(s) Refills: _____
☐ Rinvoq	15 mg	Take one 15 mg tablet PO daily	Quantity: _____ Refills: _____
☐ Siliq	☐ Carton of two 210 mg/1.5 mL single-dose prefilled syringes	Inject one prefilled syringe (210 mg) SC at weeks 0, 1 and 2, followed by one prefilled syringe (210 mg) every 2 weeks. Prescribers must be certified in the SILIQ REMS Program to prescribe SILIQ. Please visit the following REMS website to register before prescribing SILIQ: SILIQ REMS Website (https://siliqrems.com/SiliqUI/home.u)	Quantity: _____ Refills: _____
☐ Simponi	☐ 50 mg/0.5 mL SmartJect Autoinjector ☐ 50 mg/0.5 mL prefilled syringe	☐ Psoriatic Arthritis Dose: Inject 50 mg SC once a month. ☐ Other: _____	Quantity: _____ Refills: _____
☐ Simponi ARIA	50 mg/4 mL in a single-dose vial	Psoriatic Arthritis Dosing: Induction Dose: 2 mg/kg IV infusion over 30 minutes at weeks 0 and 4, then every 8 weeks thereafter Maintenance Dose: 2 mg/kg IV infusion over 30 minutes every 8 weeks	Quantity: _____ # of 50 mg vial Refills: _____

☐ Patient is interested in patient support programs **STAMP SIGNATURE NOT ALLOWED** Ancillary supplies and kits provided as needed for administration

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Dermatology Enrollment Form
Medications S-Z
(Skyrizi, Stelara, Taltz, Tremfya, Xeljanz)

Please Complete Patient , Prescriber and Patient Clinical Information

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

Patient Clinical Information:

Allergies:_____
Weight:_____lb/kg Height:_____In/cm TB Test Result:_____ Date:_____

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Skyrizi	☐ 150 mg/mL single-dose Pen ☐ 150 mg/mL single-dose prefilled syringe	☐ Psoriasis Induction Dose: Inject 150 mg SC at Weeks 0 and 4, then maintenance dosing. ☐ Psoriasis Maintenance Dose: Inject 150mg SC every 12 weeks. ☐ Other: _____	Quantity: _____ Refills: _____
☐ Stelara	☐ 45 mg/0.5 mL prefilled syringe ☐ 90 mg/mL prefilled syringe	☐ For patients weighing ≤100 kg (220 lbs): Inject 45 mg SC initially and 4 weeks later, followed by 45 mg every 12 weeks. ☐ For patients weighing >100 kg (220 lbs): Inject 90 mg SC initially and 4 weeks later, followed by 90 mg every 12 weeks. ☐ Other: _____	Quantity: _____ Refills: _____
☐ Taltz	☐ 80 mg Single Dose Autoinjector ☐ 80 mg Single Dose prefilled syringe	Psoriasis Dosing: ☐ Starting Dose: Inject SC two 80 mg injections on Day 1, then begin first induction dose 2 weeks later. ☐ Induction Dose: Inject SC one 80 mg injection every 2 weeks (weeks 2-10). ☐ Final Induction Dose: Inject SC one 80 mg injection (week 12). ☐ Maintenance Dose: Inject SC one 80 mg injection every 4 weeks. Pediatric Psoriasis Dosing: For patients weighing less than 25 kg dose: ☐ 40 mg at Week 0, followed by 20 mg every 4 weeks. For patients weighing 25-50 kg dose: ☐ 80 mg at Week 0, followed by 40 mg every 4 weeks. For patients weighing greater than 50 kg dose: ☐ 160 mg (two 80 mg injections) at Week 0, followed by 80 mg every 4 weeks.	Quantity: ☐ 3 Pens/Syringes ☐ 2 Pens/Syringes ☐ 1 Pens/Syringes Refills: _____
☐ Taltz	☐ 80 mg Single Dose Autoinjector ☐ 80 mg Single Dose prefilled syringe	Psoriatic Arthritis Dosing: ☐ Starting Dose: Inject SC two 80 mg injections on Day 1. ☐ Maintenance Dose: Inject SC one 80 mg injection every 4 weeks.	Quantity: _____ Refills: _____
☐ Tremfya	☐ 100 mg/mL prefilled syringe ☐ 100 mg/mL One-Press patient-controlled injector	☐ Starting Dose: Inject 100 mg SC at weeks 0 and 4, then maintenance dosing ☐ Maintenance Dose: Inject 100 mg SC every 8 weeks	Quantity: _____ Refills: _____
☐ Xeljanz	☐ 5 mg Tablet ☐ 11 mg XR Tablet	☐ Take one 5 mg tablet PO twice daily ☐ Take one 11 mg PO once daily ☐ Other: _____	Quantity: _____ Refills: _____

☐ Patient is interested in patient support programs **STAMP SIGNATURE NOT ALLOWED** Ancillary supplies and kits provided as needed for administration

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Dermatology Enrollment Form
Nursing Medications

Please Complete Patient , Prescriber and Patient Clinical Information

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

Patient Clinical Information:

Allergies:_____
Weight:_____lb/kg Height:_____In/cm TB Test Result:_____ Date:_____

5 PRESCRIPTION INFORMATION

Complete Items below, required for Home Infusion/Coram AIS:

MEDICATION/SUPPLIES	ROUTE	DOSE/STRENGTH/DIRECTIONS	QUANTITY/REFILLS
Catheter ☐ PIV ☐ PORT ☐ PICC	IV	Catheter Care/Flush – Only on drug admin days – SASH or PRN to maintain IV access and patency PIV – NS 5 mL (Heparin 10 units/mL 3-5 mL if multiple days) PORT/PICC – NS 10 mL & Heparin 100 units/mL 3-5mL, and/or 10 mL sterile saline to access port a cath	Quantity: _____ Refills: _____
☐ Epinephrine **nursing requires**	☐ IM ☐ SC	☐ Adult 1:1000, 0.3 mL (>30 kg/>66 lbs) ☐ Peds 1:2000, 0.3 mL (15-30 kg/33-66 lbs) ☐ Infant 0.1mL/0.1 mL, 0.1 mL (7.5-15 kg/16.5-33 lbs) PRN severe allergic reaction – Call 911 May repeat in 5-15 minutes as needed	Quantity: _____ Refills: _____
Premed Antihistamine: ☐ Diphenhydramine ☐ Other: _____	☐ Other: _____	☐ Other: _____	Dose will be rounded to the nearest vial size
☐ Flush Orders	☐ Peripheral Access ☐ Central Venus Access	☐ 0.9% Sodium Chloride flush with _____ mL IV before and after medication and IVP for Maintenance ☐ Heparin _____ units per mL Flush with _____ units as final flush and as directed	Send quantity sufficient for medication days supply

☐ Patient is interested in patient support programs **STAMP SIGNATURE NOT ALLOWED** Ancillary supplies and kits provided as needed for administration

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