

Rheumatology Enrollment Form Medications A (Actemra®)



Fax Referral To: 1-888-280-1191 OR 787-759-4161
 Phone: 1-888-280-1190 OR 787-759-4162
 Email Referral To: customerservicefax@caremark.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: _____ Address: _____ City, State, ZIP: _____
 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: _____ DOB: _____ Gender: Male Female
 Email: _____ Last Four of SSN: _____ Primary Language: _____

2 PRESCRIBER INFORMATION

Prescriber's Name: _____ State License #: _____
 NPI #: _____ DEA #: _____ Group or Hospital: _____
 Address: _____ City, State, ZIP: _____
 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):

- | | |
|---|---|
| <input type="checkbox"/> M06.9 Rheumatoid Arthritis, Unspecified | <input type="checkbox"/> M45.9 Ankylosing Spondylitis of Unspecified Sites in Spine |
| <input type="checkbox"/> L40.50 Arthropathic Psoriasis, Unspecified | <input type="checkbox"/> L40.59 Other Psoriatic Arthropathy |
| <input type="checkbox"/> M08.00 Unspecified Juvenile Rheumatoid Arthritis of Unspecified Site | <input type="checkbox"/> Other Code: _____ Description: _____ |

For additional ICD-10 information, please visit [CVS Specialty Healthcare Professionals Website](https://www.cvsspecialty.com/wps/portal/specialty/healthcare-professionals/about-us)
<https://www.cvsspecialty.com/wps/portal/specialty/healthcare-professionals/about-us>

Patient Clinical Information:

Allergies: _____ Weight: _____ lb/kg Height: _____ in/cm TB Test Result: _____ Date: _____

Nursing:

Specialty pharmacy to coordinate injection training/ home health infusion nurse visit 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

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Actemra	<input type="checkbox"/> 80 mg/4 mL <input type="checkbox"/> 200 mg/10 mL <input type="checkbox"/> 400 mg/20 mL	<input type="checkbox"/> <u>Induction Dose:</u> Infuse 4 mg/kg every 4 weeks. <input type="checkbox"/> <u>Maintenance Dose:</u> Infuse 8 mg/kg every 4 weeks. <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Actemra	162mg/0.9 mL prefilled syringe	<input type="checkbox"/> <u>For patients weighing <100kg:</u> Inject 162mg SC every other week, followed by an increase to every week based on clinical response <input type="checkbox"/> <u>For patients weighing ≥ 100kg:</u> Inject 162mg SC every week.	Quantity: _____ Refills: _____

I hereby freely and voluntarily have selected CVS Caremark and/or CarePlus CVS/pharmacy to dispense the medication herein prescribed by my physician.

Patient Signature: _____

Patient is interested in patient support programs

STAMP SIGNATURE NOT ALLOWED

Ancillary supplies and kits provided as needed for administration

6 PHYSICIAN SIGNATURE REQUIRED

PRODUCT SUBSTITUTION PERMITTED

(Date)

DISPENSE AS WRITTEN

(Date)

X _____ X _____

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 below, 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.

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Medications A-C

Rheumatology Enrollment Form

(Avsola™, Cimzia®, Cosentyx®)

Please complete Patient and Prescriber information

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

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Avsola	100 mg vial	<input type="checkbox"/> Rheumatoid Arthritis <u>Induction Dose</u> : In conjunction with <u>methotrexate</u> Infuse IV at 3 mg/kg (Dose = _____ mg) at weeks 0, week 2, week 6 and every 8 weeks thereafter. <input type="checkbox"/> Rheumatoid Arthritis <u>Maintenance Dose</u> : Infuse 3 mg/kg every 8 weeks. <input type="checkbox"/> Psoriatic Arthritis <u>Induction Dose</u> : Infuse IV at 5 mg/kg (Dose = _____ mg) at weeks 0, week 2, week 6 and every 8 weeks thereafter. <input type="checkbox"/> Psoriatic Arthritis <u>Maintenance Dose</u> : Infuse 5 mg/kg every 8 weeks. <input type="checkbox"/> Ankylosing Spondylitis <u>Induction Dose</u> : Infuse IV at 5 mg/kg (Dose = _____ mg) at weeks 0, week 2, week 6 and every 6 weeks thereafter. <input type="checkbox"/> Ankylosing Spondylitis <u>Maintenance Dose</u> : Infuse 5 mg/kg every 6 weeks. <input type="checkbox"/> Other: _____	Quantity: _____ # of 100 mg vial Refills: _____
<input type="checkbox"/> Cimzia	Cimzia Starter Kit (6 prefilled syringes)	<u>Induction Dose</u> : 400 mg initially and at week 2 and 4, (given as 2 SC of 200 mg each) followed by 200 mg every other week;	Quantity: 1 Kit Refills: 0
<input type="checkbox"/> Cimzia	<input type="checkbox"/> 200mg/1 mL prefilled syringe <input type="checkbox"/> 200mg vial	<input type="checkbox"/> <u>Maintenance Dose</u> : Inject 200mg SC every OTHER week. <input type="checkbox"/> <u>Maintenance Dose</u> : Inject 400mg SC every four weeks. <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Cosentyx	<input type="checkbox"/> Sensoready® pen 150 mg/mL injection <input type="checkbox"/> Prefilled syringe 150 mg/mL injection	<u>Psoriatic Arthritis with Coexistent Moderate to Severe Plaque Psoriasis</u> <input type="checkbox"/> <u>Loading Dose</u> : Inject 300 mg (two injections) SC at weeks 0, 1, 2, 3 and 4. <input type="checkbox"/> <u>Maintenance Dose</u> : Inject 300 mg (two injections) SC every 4 weeks. <u>Other Psoriatic Arthritis or Ankylosing Spondylitis</u> <input type="checkbox"/> <u>With Loading Dose</u> : Inject 150 mg (one injection) SC at weeks 0, 1, 2, 3 and 4, and then every 4 weeks thereafter. <input type="checkbox"/> <u>Without Loading Dose</u> : Inject 150 mg (one injection) SC every 4 weeks. <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____

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 Patient Signature: _____
 Patient is interested in patient support programs

STAMP SIGNATURE NOT ALLOWED

Ancillary supplies and kits provided as needed for administration

6 PHYSICIAN SIGNATURE REQUIRED

PRODUCT SUBSTITUTION PERMITTED

(Date)

DISPENSE AS WRITTEN

(Date)

X _____

X _____

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Medications E-I

Rheumatology Enrollment Form

(Enbrel®, Humira®, Ilaris®, Inflectra®)

Please complete Patient and Prescriber information

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

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Enbrel	<input type="checkbox"/> 25mg/0.5 mL prefilled syringe <input type="checkbox"/> 25mg vial <input type="checkbox"/> 50mg/mL Sureclick™ Autoinjector <input type="checkbox"/> 50mg/mL prefilled syringe <input type="checkbox"/> 50 mg/mL Enbrel Mini™ prefilled cartridge for use with the AutoTouch™ reusable autoinjector only (Prescriber MUST supply). CVS does <u>not</u> order the autoinjector.	<input type="checkbox"/> Inject 25mg SC TWICE a week (72 – 96 hours apart). <input type="checkbox"/> Inject 50mg SC ONCE a week. <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Humira	<input type="checkbox"/> 40 mg/0.4 mL Pen Citrate Free <input type="checkbox"/> 40 mg/0.4 mL Prefilled Syringe Citrate Free	<input type="checkbox"/> Inject 40mg SC every OTHER week. <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Ilaris	150 mg/mL injection solution	For patients weighing ≥ 7.5 kg: Inject 4 mg/kg (with a maximum of 300 mg) SC every 4 weeks. Each single-dose vial of ILARIS (canakinumab) Injection delivers 150 mg/mL sterile, preservative-free, clear to slightly opalescent, colorless to a slight brownish to yellow solution.	Quantity: _____ Refills: _____
<input type="checkbox"/> Inflectra	100 mg vial	<input type="checkbox"/> Rheumatoid Arthritis <u>Induction Dose</u> : In conjunction with <u>methotrexate</u> Infuse IV at 3 mg/kg (Dose = _____mg) at weeks 0, week 2, week 6 and every 8 weeks thereafter. <input type="checkbox"/> Rheumatoid Arthritis <u>Maintenance Dose</u> : Infuse 3 mg/kg every 8 weeks. <input type="checkbox"/> Psoriatic Arthritis <u>Induction Dose</u> : Infuse IV at 5 mg/kg (Dose = _____mg) at weeks 0, week 2, week 6 and every 8 weeks thereafter. <input type="checkbox"/> Psoriatic Arthritis <u>Maintenance Dose</u> : Infuse 5 mg/kg every 8 weeks. <input type="checkbox"/> Ankylosing Spondylitis <u>Induction Dose</u> : Infuse IV at 5 mg/kg (Dose = _____mg) at weeks 0, week 2, week 6 and every 6 weeks thereafter. <input type="checkbox"/> Ankylosing Spondylitis <u>Maintenance Dose</u> : Infuse 5 mg/kg every 6 weeks. <input type="checkbox"/> Other: _____	Quantity: _____ # of 100 mg vial Refills: _____

I hereby freely and voluntarily have selected CVS Caremark and/or CarePlus CVS/pharmacy to dispense the medication herein prescribed by my physician.

Patient Signature: _____
 Patient is interested in patient support programs

STAMP SIGNATURE NOT ALLOWED

Ancillary supplies and kits provided as needed for administration

6 PHYSICIAN SIGNATURE REQUIRED

PRODUCT SUBSTITUTION PERMITTED (Date) _____ DISPENSE AS WRITTEN (Date) _____

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Medications K-O

Rheumatology Enrollment Form

(Kevzara®, Olumiant®, Orencia®, Otezla®)

Please complete Patient and Prescriber information

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

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Kevzara	<input type="checkbox"/> 200 mg/1.14 mL prefilled syringe (pk of 2) <input type="checkbox"/> 150 mg/1.14 mL prefilled syringe (pk of 2) <input type="checkbox"/> 200 mg/1.14 mL prefilled pen (pk of 2) <input type="checkbox"/> 150 mg/1.14 mL prefilled pen (pk of 2)	<input type="checkbox"/> Inject 200 mg SC once every two weeks. <input type="checkbox"/> Inject 150 mg SC once every two weeks.	Quantity: _____ Refills: _____
<input type="checkbox"/> Olumiant	<input type="checkbox"/> 2 mg tablet <input type="checkbox"/> 1 mg tablet	<input type="checkbox"/> Take 2 mg PO once daily <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Orencia	<input type="checkbox"/> 125mg prefilled syringe <input type="checkbox"/> ClickJect Autoinjector 125 mg/mL pack of 4	<input type="checkbox"/> Inject 125mg SC every week <input type="checkbox"/> <u>After Single IV Loading Dose</u> : Inject 125mg SC within a day and 125mg SC every week thereafter. <input type="checkbox"/> <u>Patients Unable to Receive an IV Loading Dose</u> : Inject 125 mg SC every week. <input type="checkbox"/> <u>Patients Transitioning from IV Infusion Therapy</u> : Inject 125 mg SC instead of the next scheduled IV dose, followed by 125mg SC injections every week thereafter.	Quantity: _____ Refills: _____
<input type="checkbox"/> Orencia	250 mg vial	<input type="checkbox"/> Infuse ___ mg at weeks 0, 2 and 4, then every 4 weeks thereafter. <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> 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
<input type="checkbox"/> Otezla	30 mg tablet	<input type="checkbox"/> <u>Maintenance Dose</u> : 30 mg PO twice daily. <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____

I hereby freely and voluntarily have selected CVS Caremark and/or CarePlus CVS/pharmacy to dispense the medication herein prescribed by my physician.

Patient Signature: _____

Patient is interested in patient support programs

STAMP SIGNATURE NOT ALLOWED

Ancillary supplies and kits provided as needed for administration

6 PHYSICIAN SIGNATURE REQUIRED

PRODUCT SUBSTITUTION PERMITTED

(Date)

DISPENSE AS WRITTEN

(Date)

X _____ X _____

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Medications R-S Rheumatology Enrollment Form

(Remicade®, Renflexis®, Rinvoq®, Rituxan®, Simponi®)

Please complete Patient and Prescriber information

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

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Remicade	100 mg vial	<input type="checkbox"/> Rheumatoid Arthritis <u>Induction Dose</u> : In conjunction with <u>methotrexate</u> Infuse IV at 3 mg/kg (Dose = _____ mg) at weeks 0, week 2, week 6 and every 8 weeks thereafter. <input type="checkbox"/> Rheumatoid Arthritis <u>Maintenance Dose</u> : Infuse 3 mg/kg every 8 weeks. <input type="checkbox"/> Psoriatic Arthritis <u>Induction Dose</u> : Infuse IV at 5 mg/kg (Dose = _____ mg) at weeks 0, week 2, week 6 and every 8 weeks thereafter. <input type="checkbox"/> Psoriatic Arthritis <u>Maintenance Dose</u> : Infuse 5 mg/kg every 8 weeks. <input type="checkbox"/> Ankylosing Spondylitis <u>Induction Dose</u> : Infuse IV at 5 mg/kg (Dose = _____ mg) at weeks 0, week 2, week 6 and every 6 weeks thereafter. <input type="checkbox"/> Ankylosing Spondylitis <u>Maintenance Dose</u> : Infuse 5 mg/kg every 6 weeks. <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Renflexis	100 mg vial	<input type="checkbox"/> Rheumatoid Arthritis <u>Induction Dose</u> : In conjunction with <u>methotrexate</u> Infuse IV at 3 mg/kg (Dose = _____ mg) at weeks 0, week 2, week 6 and every 8 weeks thereafter. <input type="checkbox"/> Rheumatoid Arthritis <u>Maintenance Dose</u> : Infuse 3 mg/kg every 8 weeks. <input type="checkbox"/> Psoriatic Arthritis <u>Induction Dose</u> : Infuse IV at 5 mg/kg (Dose = _____ mg) at weeks 0, week 2, week 6 and every 8 weeks thereafter. <input type="checkbox"/> Psoriatic Arthritis <u>Maintenance Dose</u> : Infuse 5 mg/kg every 8 weeks. <input type="checkbox"/> Ankylosing Spondylitis <u>Induction Dose</u> : Infuse IV at 5 mg/kg (Dose = _____ mg) at weeks 0, week 2, week 6 and every 6 weeks thereafter. <input type="checkbox"/> Ankylosing Spondylitis <u>Maintenance Dose</u> : Infuse 5 mg/kg every 6 weeks. <input type="checkbox"/> Other: _____	Quantity: _____ # of 100 mg vial Refills: _____
<input type="checkbox"/> Rinvoq	15 mg	<input type="checkbox"/> Take one 15 mg tablet PO once daily. <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Rituxan	<input type="checkbox"/> 100 mg/10 mL vial <input type="checkbox"/> 500 mg/50 mL vial	<input type="checkbox"/> Infuse two doses of 1000 mg separated by 2 weeks. <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Simponi	<input type="checkbox"/> 50mg/0.5mL prefilled SmartJect® Autoinjector <input type="checkbox"/> 50mg/0.5mL prefilled syringe	<input type="checkbox"/> Inject 50mg SC once a month. <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____

I hereby freely and voluntarily have selected CVS Caremark and/or CarePlus CVS/pharmacy to dispense the medication herein prescribed by my physician.

Patient Signature: _____

Patient is interested in patient support programs

STAMP SIGNATURE NOT ALLOWED

Ancillary supplies and kits provided as needed for administration

6 PHYSICIAN SIGNATURE REQUIRED

PRODUCT SUBSTITUTION PERMITTED

(Date)

DISPENSE AS WRITTEN

(Date)

X _____

X _____

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Medications S-Z

Rheumatology Enrollment Form

(Simponi ARIA®, Stelara®, Taltz®, Tremfya®, Xeljanz®)

Please complete Patient and Prescriber information

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

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Simponi ARIA	50 mg/4 mL in a single use vial	Infuse 2 mg/kg over 30 minutes at weeks 0 and 4, then every 8 weeks thereafter.	Quantity: _____ # of 50 mg vial Refills: _____
<input type="checkbox"/> Stelara	<input type="checkbox"/> 45mg/0.5mL prefilled syringe <input type="checkbox"/> 90mg/mL prefilled syringe	<input type="checkbox"/> For patients weighing ≤100 kg (220 lbs): Inject 45 mg SC initially and 4 weeks later, followed by 45 mg every 12 weeks. <input type="checkbox"/> For patients weighing >100 kg (220 lbs): Inject 90 mg SC initially and 4 weeks later, followed by 90 mg every 12 weeks. <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Taltz	<input type="checkbox"/> 80 mg Single Dose Autoinjector <input type="checkbox"/> 80 mg Single Dose Prefilled Syringe	Psoriatic Arthritis with Coexistent Moderate to Severe Plaque Psoriasis Dosing: <input type="checkbox"/> <u>Starting Dose</u> : Inject SC two 80 mg injections on Day 1, then begin the induction dose 2 weeks later. <input type="checkbox"/> <u>Induction Dose</u> : Inject SC one 80 mg injection every 2 weeks (weeks 2, 4, 6, 8, 10, and 12). <input type="checkbox"/> <u>Maintenance Dose</u> : Inject SC one 80 mg injection every 4 weeks.	<input type="checkbox"/> 3 Pens/Syringes <input type="checkbox"/> 2 Pens/Syringes <input type="checkbox"/> 1 Pens/Syringes Refills: _____
<input type="checkbox"/> Taltz	<input type="checkbox"/> 80 mg Single Dose Autoinjector <input type="checkbox"/> 80 mg Single Dose Prefilled Syringe	Psoriatic Arthritis Dosing and Ankylosing Spondylitis Dosing: <input type="checkbox"/> <u>Starting Dose</u> : Inject SC two 80 mg injections on Day 1. <input type="checkbox"/> <u>Maintenance Dose</u> : Inject SC one 80 mg injection every 4 weeks. Non-radiographic Axial Spondyloarthritis Dosing: <input type="checkbox"/> <u>Dose</u> : Inject SC one 80 mg injection every 4 weeks	Quantity: _____ <input type="checkbox"/> 2 Pens/Syringes <input type="checkbox"/> 1 Pens/Syringes Refills: _____
<input type="checkbox"/> Tremfya	100 mg/mL prefilled syringe	Psoriatic Arthritis Dosing: <input type="checkbox"/> 100mg administered by SC at Week 0, Week 4 and every 8 weeks thereafter	Quantity: _____ Refills: _____
<input type="checkbox"/> Xeljanz	<input type="checkbox"/> 5 mg Tablet <input type="checkbox"/> 11 mg XR Tablet	<input type="checkbox"/> Take one 5 mg tablet PO twice daily <input type="checkbox"/> Take one 11 mg PO once daily <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____

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

MEDICATION/SUPPLIES	ROUTE	DOSE/STRENGTH/DIRECTIONS	QUANTITY/REFILLS
Catheter <input type="checkbox"/> PIV <input type="checkbox"/> PORT <input type="checkbox"/> PICC	<input type="checkbox"/> IV	Catheter Care/Flush – Only on drug admin days – SASH or PRN to maintain IV access and patency PIV – NS 5ml (Heparin 10 units/ml 3-5ml if multiple days) PORT/PICC – NS 10ml & Heparin 100units/ml 3-5ml, and/or 10ml sterile saline to access port a cath	Quantity: _____ Refills: _____
<input type="checkbox"/> Epinephrine **nursing requires**	<input type="checkbox"/> IM <input type="checkbox"/>	<input type="checkbox"/> Adult 1:1000, 0.3mL (>30kg/>66lbs) <input type="checkbox"/> Peds 1:2000, 0.3mL (15-30kg/33-66lbs) <input type="checkbox"/> Infant 0.1mL/0.1mL, 0.1mL (7.5-15kg/16.5-33lbs) PRN severe allergic reaction – Call 911 May repeat in 5-15 minutes as needed	Quantity: _____ Refills: _____

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Patient Signature: _____

Patient is interested in patient support programs

STAMP SIGNATURE NOT ALLOWED

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PRODUCT SUBSTITUTION PERMITTED

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(Date)

X _____

X _____

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