

Rheumatology Oral/Subcutaneous Enrollment Form



Fax Referral To: 1-855-297-1270

Phone: 1-888-280-1190

Address: 6020 Ave Roberto Sanchez Vilella Carolina, PR 00982

NCPDP: 4026325

Six Simple Steps to Submitting a Referral

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

Patient Name: _____ DOB: _____ Gender: Male Female
 Address: _____ City, State, ZIP Code: _____
 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: _____
 Email: _____ Last Four of SSN: _____ Primary Language: _____
 Parent/Caregiver/Legal Guardian Name (Last, First): _____ Relationship to patient: _____

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 (front and back) with this form, if available*

4 DIAGNOSIS (ICD-10) AND PATIENT CLINICAL INFORMATION *(Include copy of clinicals)*

- M06.9 Rheumatoid Arthritis (RA) M45.9 Ankylosing Spondylitis (AS)
 L40.50 Arthropathic Psoriasis (PsA) L40.54 Juvenile Psoriatic Arthritis (JPsA)
 M45.A0 Non-Radiographic Axial Spondylarthritis (nr-axSpA)
 M35.3 Polymyalgia Rheumatica (PMR) M08.00 Juvenile Idiopathic Arthritis (JIA)
 H44.139 Uveitis, unspecified eye
 Other Code: _____ Description: _____

Allergies: _____ NKDA Weight: _____ lb kg Height: _____ In Cm
 Treatment status: New to therapy Continuation of therapy; Date of last treatment ___/___/___
 Samples provided No Yes, if so, how many samples given? _____ TB Test Date ___/___/___ Pos Neg
 Prior therapy, treatment dates, and reason(s) for discontinuation _____

5 PRESCRIPTION INFORMATION Ship to: Patient Office Other: _____

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY	REFILLS
<input type="checkbox"/> Actemra	<input type="checkbox"/> 162 mg/0.9 mL ACTPen <input type="checkbox"/> 162 mg/0.9 mL PFS	<input type="checkbox"/> Inject 162 mg SC every other week <input type="checkbox"/> Inject 162 mg SC every week	<input type="checkbox"/> 28 days <input type="checkbox"/> 84 days	_____
<input type="checkbox"/> Adalimumab-aacf (unbranded version of Idacio)	<input type="checkbox"/> 40 mg/0.8 mL PEN	<input type="checkbox"/> Inject 40 mg SC every week <input type="checkbox"/> Inject 40 mg SC every other week <input type="checkbox"/> Inject 80 mg SC every other week	<input type="checkbox"/> 28 days <input type="checkbox"/> 84 days	_____
<input type="checkbox"/> Adalimumab-adaz (unbranded version of Hyrimoz)	<input type="checkbox"/> 40 mg/0.4 mL PEN <input type="checkbox"/> 40 mg/0.4 mL PFS (with needle guard)	<input type="checkbox"/> Inject 40 mg SC every week <input type="checkbox"/> Inject 40 mg SC every other week <input type="checkbox"/> Inject 80 mg SC every other week	<input type="checkbox"/> 28 days <input type="checkbox"/> 84 days	_____
<input type="checkbox"/> Adalimumab-fkjp (unbranded version of Hulio)	<input type="checkbox"/> 20 mg/0.4 mL PFS <input type="checkbox"/> 40 mg/0.8 mL PFS <input type="checkbox"/> 40 mg/0.8 mL PEN	<input type="checkbox"/> Inject 20 mg SC every other week <input type="checkbox"/> Inject 40 mg SC every week <input type="checkbox"/> Inject 40 mg SC every other week <input type="checkbox"/> Inject 80 mg SC every other week	<input type="checkbox"/> 28 days <input type="checkbox"/> 84 days	_____
<input type="checkbox"/> Amjevita (adalimumab-atto)	<input type="checkbox"/> 10 mg/0.2 mL PFS <input type="checkbox"/> 20 mg/0.4 mL PFS <input type="checkbox"/> 40 mg/0.8 mL PFS <input type="checkbox"/> 40 mg/0.8 mL PEN	<input type="checkbox"/> Inject 10 mg SC every other week <input type="checkbox"/> Inject 20 mg SC every other week <input type="checkbox"/> Inject 40 mg SC every other week <input type="checkbox"/> Inject 40 mg SC every week <input type="checkbox"/> Inject 80 mg SC every other week <input type="checkbox"/> Inject 80 mg Day 1, followed by 40 mg every other week starting one week after initial dose	<input type="checkbox"/> 28 days <input type="checkbox"/> 84 days	_____
<input type="checkbox"/> Other:	_____	_____	_____	_____

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"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	

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.

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

Prescriber Name: _____ Prescriber Phone: _____

Patient Clinical Information:

Allergies: _____ NKDA Weight: _____ lb kg Height: _____ In Cm

Treatment status: New to therapy Continuation of therapy; Date of last treatment ___/___/___

Samples provided No Yes, if so how many samples given? _____ TB Test Date ___/___/___ Pos Neg

Prior therapy, treatment dates, and reason(s) for discontinuation _____

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MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY	REFILLS
<input type="checkbox"/> Bimzelx	<input type="checkbox"/> 2 x 160 mg/mL PEN <input type="checkbox"/> 2 x 160 mg/mL PFS <input type="checkbox"/> 160 mg/mL PEN <input type="checkbox"/> 160 mg/mL PFS	PsA/nr-axSpA/AS: <input type="checkbox"/> Inject 160 mg SC every 4 weeks	<input type="checkbox"/> 28 days <input type="checkbox"/> 84 days	_____
		PsA with Psoriasis: <input type="checkbox"/> Inject 320 mg SC every 4 weeks at weeks 0, 4, 8, and 12	<input type="checkbox"/> 28 days	3
		<input type="checkbox"/> Inject 320 mg SC at week 16 and then every 8 weeks	<input type="checkbox"/> 56 days	0
		<input type="checkbox"/> Inject 320 mg SC at week 16 and then every 4 weeks	<input type="checkbox"/> 28 days	0
		<input type="checkbox"/> Inject 320 mg SC every 8 weeks <input type="checkbox"/> Inject 320 mg SC every 4 weeks	<input type="checkbox"/> 28 days <input type="checkbox"/> 84 days	_____
<input type="checkbox"/> Cimzia	<input type="checkbox"/> Cimzia Starter Kit <input type="checkbox"/> 200 mg/mL PFS (carton of 1) <input type="checkbox"/> 200 mg/mL PFS (carton of 2) <input type="checkbox"/> 200 mg/mL vial kit (carton of 2-HCP administration)	<input type="checkbox"/> Inject 400 mg SC on weeks 0, 2 and 4	1 kit	0
		<input type="checkbox"/> Inject 50 mg SC every other week <input type="checkbox"/> Inject 100 mg SC on weeks 0, 2 and 4 <input type="checkbox"/> Inject 100 mg SC every other week <input type="checkbox"/> Inject 200 mg SC on weeks 0, 2 and 4 <input type="checkbox"/> Inject 200 mg SC every other week <input type="checkbox"/> Inject 400 mg SC every 4 weeks *There is no dosage form for Cimzia that allows for patient self-administration for doses below 200 mg. Doses less than 200 mg require administration by a HCP using the vial kit*	<input type="checkbox"/> 28 days <input type="checkbox"/> 84 days	_____
<input type="checkbox"/> Cosentyx	<input type="checkbox"/> 1x75 mg/mL PFS <input type="checkbox"/> 1x150 mg/mL PEN <input type="checkbox"/> 1x150 mg/mL PFS <input type="checkbox"/> 2x150 mg/mL PEN <input type="checkbox"/> 2x150 mg/mL PFS <input type="checkbox"/> 300 mg/2 mL PEN	Loading Dose: <input type="checkbox"/> Inject 75 mg SC on Weeks 0, 1, 2, 3 <input type="checkbox"/> Inject 150 mg SC on Weeks 0, 1, 2, 3 <input type="checkbox"/> Inject 300 mg SC on Weeks 0, 1, 2, 3 Maintenance Dose: <input type="checkbox"/> Inject 75 mg SC on Week 4, then every 4 weeks thereafter <input type="checkbox"/> Inject 75 mg SC every 4 weeks <input type="checkbox"/> Inject 150 mg SC on Week 4, then every 4 weeks thereafter <input type="checkbox"/> Inject 150 mg SC every 4 weeks <input type="checkbox"/> Inject 300 mg SC on Week 4, then every 4 weeks thereafter <input type="checkbox"/> Inject 300 mg SC every 4 weeks	Loading Dose: Quantity: <u>28 days</u>	Loading Dose: Refills: <u>0</u>
			Maintenance Dose: Quantity: <u>28 days</u>	Maintenance Dose: Refills: _____
<input type="checkbox"/> Enbrel	<input type="checkbox"/> 50 mg/mL Mini <input type="checkbox"/> 50 mg/mL PEN <input type="checkbox"/> 50 mg/mL PFS <input type="checkbox"/> 25 mg/0.5 mL PFS <input type="checkbox"/> 25 mg/0.5 mL single dose vial <input type="checkbox"/> 25 mg/0.5 mL lyophilized powder multi-dose vial for reconstitution	<input type="checkbox"/> Inject 50 mg SC once weekly <input type="checkbox"/> Inject 0.8 mg/kg (Dose= _____ mg) weekly, with a maximum of 50 mg per week	<input type="checkbox"/> 28 days <input type="checkbox"/> 84 days	_____
		<input type="checkbox"/> Other	_____	_____

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

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Patient Clinical Information:

Allergies: _____ NKDA Weight: _____ lb kg Height: _____ In Cm

Treatment status: New to therapy Continuation of therapy; Date of last treatment ___/___/___

Samples provided No Yes, if so how many samples given? _____ TB Test Date ___/___/___ Pos Neg

Prior therapy, treatment dates, and reason(s) for discontinuation _____

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MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY	REFILLS
<input type="checkbox"/> Hadlima	<input type="checkbox"/> 40 mg/0.4 mL PEN <input type="checkbox"/> 40 mg/0.8 mL PEN <input type="checkbox"/> 40 mg/0.4 mL PFS <input type="checkbox"/> 40 mg/0.8 mL PFS	<input type="checkbox"/> Inject 40 mg SC every week <input type="checkbox"/> Inject 40 mg SC every other week <input type="checkbox"/> Inject 80 mg SC every other week <input type="checkbox"/> Inject 80 mg SC on Day 1, followed by 40mg every other week starting one week after initial dose	<input type="checkbox"/> 28 days <input type="checkbox"/> 84 days	_____
<input type="checkbox"/> Hulio	<input type="checkbox"/> 20 mg/0.4 mL PFS <input type="checkbox"/> 40 mg/0.8 mL PFS <input type="checkbox"/> 40 mg/0.8 mL PEN	<input type="checkbox"/> Inject 20 mg SC every other week <input type="checkbox"/> Inject 40 mg SC every week <input type="checkbox"/> Inject 40 mg SC every other week <input type="checkbox"/> Inject 80 mg SC every other week	<input type="checkbox"/> 28 days <input type="checkbox"/> 84 days	_____
<input type="checkbox"/> Humira	<input type="checkbox"/> 10 mg/0.1 mL PFS <input type="checkbox"/> 20 mg/0.2 mL PFS <input type="checkbox"/> 40 mg/0.4 mL PEN <input type="checkbox"/> 80 mg/0.8 mL PEN <input type="checkbox"/> 40 mg/0.4 mL PFS <input type="checkbox"/> 80 mg/0.8 mL PFS	<input type="checkbox"/> Inject 10 mg SC every other week <input type="checkbox"/> Inject 20 mg SC every other week <input type="checkbox"/> Inject 40 mg SC every week <input type="checkbox"/> Inject 40 mg SC every other week <input type="checkbox"/> Inject 80 mg SC every other week <input type="checkbox"/> Inject 80 mg SC on Day 1, followed by 40 mg every other week starting one week after initial dose	<input type="checkbox"/> 28 days <input type="checkbox"/> 84 days	_____
<input type="checkbox"/> Hyrimoz	<input type="checkbox"/> 10 mg/0.1 ml PFS <input type="checkbox"/> 20 mg/0.2 ml PFS <input type="checkbox"/> 40 mg/0.4 mL PEN <input type="checkbox"/> 80 mg/0.8 mL PEN <input type="checkbox"/> 40 mg/0.4 mL PFS (with needle guard)	<input type="checkbox"/> Inject 10 mg SC every other week <input type="checkbox"/> Inject 20 mg SC every other week <input type="checkbox"/> Inject 40 mg SC every week <input type="checkbox"/> Inject 40 mg SC every other week <input type="checkbox"/> Inject 80 mg SC every other week	<input type="checkbox"/> 28 days <input type="checkbox"/> 84 days	_____
<input type="checkbox"/> Idacio	<input type="checkbox"/> 40 mg/0.8 mL PEN <input type="checkbox"/> 40 mg/0.8 mL PFS	<input type="checkbox"/> Inject 40 mg SC every week <input type="checkbox"/> Inject 40 mg SC every other week <input type="checkbox"/> Inject 80 mg SC every other week	<input type="checkbox"/> 28 days <input type="checkbox"/> 84 days	_____
<input type="checkbox"/> Ilaris	150 mg/mL injection SDV	For patients weighing \geq 7.5 kg: Inject _____ mg (4 mg/kg) SC every 4 weeks (*max 300 mg per dose)	<input type="checkbox"/> 28 days <input type="checkbox"/> 84 days	_____
<input type="checkbox"/> Kevzara	<input type="checkbox"/> 200 mg/1.14 mL PFS <input type="checkbox"/> 150 mg/1.14 mL PFS <input type="checkbox"/> 200 mg/1.14 mL PEN <input type="checkbox"/> 150 mg/1.14 mL PEN	<input type="checkbox"/> Inject 200 mg SC once every two weeks <input type="checkbox"/> Inject 150 mg SC once every two weeks	<input type="checkbox"/> 28 days <input type="checkbox"/> 84 days	_____
<input type="checkbox"/> Olumiant	2 mg tablet	Take 2 mg PO once daily	<input type="checkbox"/> 30 days <input type="checkbox"/> 90 days	_____
<input type="checkbox"/> Orencia	<input type="checkbox"/> 50 mg/0.4 mL PFS <input type="checkbox"/> 87.5 mg/0.7 mL PFS <input type="checkbox"/> 125 mg PFS <input type="checkbox"/> 125 mg PEN	Peds JIA or PsA (>2 years old) Dosing: 10 kg to < 25 kg: <input type="checkbox"/> Inject 50 mg SC once weekly 25 kg to < 50 kg: <input type="checkbox"/> Inject 87.5 mg SC once weekly >50 kg: <input type="checkbox"/> Inject 125 mg SC once weekly Adult RA or PsA Dosing: <input type="checkbox"/> Inject 125 mg SC once weekly	<input type="checkbox"/> 28 days <input type="checkbox"/> 84 days	_____
<input type="checkbox"/> Other	_____	_____	_____	_____

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MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY	REFILLS
<input type="checkbox"/> Otezla	<input type="checkbox"/> Titration Starter Pack for 30 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
	<input type="checkbox"/> 30 mg tablet <input type="checkbox"/> Sample already provided/ no titration needed	Take 30 mg PO twice daily	<input type="checkbox"/> 30 days <input type="checkbox"/> 90 days	_____
<input type="checkbox"/> Rinvoq	<input type="checkbox"/> 15 mg tablet	Take one 15 mg tablet PO once daily	<input type="checkbox"/> 30 days <input type="checkbox"/> 90 days	_____
<input type="checkbox"/> Rinvoq LQ	<input type="checkbox"/> 1 mg/ 1 mL	<input type="checkbox"/> 3 mg (3 mL oral solution) PO twice daily <input type="checkbox"/> 4 mg (4 mL oral solution) PO twice daily <input type="checkbox"/> 6 mg (6 mL oral solution) PO twice daily	Quantity (mL)	_____
<input type="checkbox"/> Simlandi (adalimumab-ryvk)	<input type="checkbox"/> 40 mg/0.4 mL PEN	<input type="checkbox"/> Inject 40mg SC every week	<input type="checkbox"/> 28 days <input type="checkbox"/> 84 days	_____
		<input type="checkbox"/> Inject 40mg SC every other week <input type="checkbox"/> Inject 80mg SC every other week <input type="checkbox"/> Inject 80 mg Day 1, followed by 40 mg every other week starting one week after initial dose		
<input type="checkbox"/> Simponi	<input type="checkbox"/> 50 mg/0.5 mL PEN	Inject 50 mg SC every 4 weeks	<input type="checkbox"/> 28 days <input type="checkbox"/> 84 days	_____
	<input type="checkbox"/> 50 mg/0.5 mL PFS			
<input type="checkbox"/> Skyrizi	<input type="checkbox"/> 150 mg/mL PFS <input type="checkbox"/> 150 mg/mL PEN	Loading Dose: <input type="checkbox"/> Inject 150 mg SC at week 0	<input type="checkbox"/> 28 days <input type="checkbox"/> 84 days	0 _____
		Maintenance Dose: <input type="checkbox"/> Inject 150 mg SC at week 4, and every 12 weeks thereafter		
<input type="checkbox"/> Taltz	<input type="checkbox"/> 80 mg PEN <input type="checkbox"/> 80 mg PFS	AS Loading Dose: <input type="checkbox"/> Inject 160 mg (two 80 mg injections) SC on week 0	<input type="checkbox"/> 28 days <input type="checkbox"/> 84 days	0 _____
		AS Maintenance Dose: <input type="checkbox"/> Inject 80 mg SC injection every 4 weeks		
		nr-axSpA: <input type="checkbox"/> Inject 80 mg SC every 4 weeks	<input type="checkbox"/> 28 days <input type="checkbox"/> 84 days	_____
		PsA Loading Dose (w/o psoriasis): <input type="checkbox"/> Inject 160 mg (two 80 mg injections) SC on week 0		
		PsA Maintenance Dose (w/o psoriasis): <input type="checkbox"/> Inject 80 mg SC every 4 weeks	<input type="checkbox"/> 28 days <input type="checkbox"/> 84 days	_____
		PsA Loading Dose (with psoriasis): <input type="checkbox"/> Inject 160 mg (two 80 mg injections) week 0, then 80 mg week 2		
		<input type="checkbox"/> Inject 80 mg week 4, 6, 8, and 10	<input type="checkbox"/> 28 days <input type="checkbox"/> 84 days	0 1 _____
PsA Maintenance Dose (with psoriasis): <input type="checkbox"/> Inject 80 mg SC week 12 and every 4 weeks thereafter	<input type="checkbox"/> 28 days <input type="checkbox"/> 84 days	_____		
<input type="checkbox"/> Other	_____	_____	_____	_____

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MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY	REFILLS
<input type="checkbox"/> Tremfya	<input type="checkbox"/> 100 mg/mL PFS	Loading Dose: <input type="checkbox"/> Inject 100 mg SC on week 0	<input type="checkbox"/> 28 days	0
	<input type="checkbox"/> 100 mg/mL PEN	Maintenance Dose: <input type="checkbox"/> Inject 100 mg SC week 4, then every 8 weeks thereafter	<input type="checkbox"/> 56 days	_____
<input type="checkbox"/> Tyenne (tocilizumab-aazg)	<input type="checkbox"/> 162 mg/0.9 mL PEN	<input type="checkbox"/> Inject 162 mg SC every other week	<input type="checkbox"/> 28 days	_____
	<input type="checkbox"/> 162 mg/0.9 mL PFS	<input type="checkbox"/> Inject 162 mg SC every week	<input type="checkbox"/> 84 days	_____
<input type="checkbox"/> Xeljanz	<input type="checkbox"/> 5 mg Tablet	<input type="checkbox"/> Take one 5 mg tablet PO twice daily	<input type="checkbox"/> 30 days	_____
	<input type="checkbox"/> 11 mg XR Tablet	<input type="checkbox"/> Take one 11 mg tablet PO once daily	<input type="checkbox"/> 90 days	_____
<input type="checkbox"/> Yuflyma	<input type="checkbox"/> 40 mg/0.4 mL PEN	<input type="checkbox"/> Inject 40 mg SC every week	<input type="checkbox"/> 28 days	_____
	<input type="checkbox"/> 40 mg/0.4 mL PFS (with safety guard)	<input type="checkbox"/> Inject 40 mg SC every other week	<input type="checkbox"/> 84 days	_____
	<input type="checkbox"/> 40 mg/0.4 mL PFS	<input type="checkbox"/> Inject 80 mg SC every other week		
	<input type="checkbox"/> 80 mg/0.8 mL PEN			
<input type="checkbox"/> Other	_____			

Patient is interested in patient support programs

STAMP SIGNATURE NOT ALLOWED

Ancillary supplies and kits provided as needed for administration

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