

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

DATIENT INCOM		Six Simple Steps to Submitting a	Referral		
	RMATION (Complete or inclu	O 1			
Patient Name:		DOB: City, State, ZIP Code:	Gender:	Male	le
Address:		City, State, ZIP Code:			
		y # provided below) 🗌 Text (to cell			below)
		act via text or email, Specialty Pharr			
Primary Phone:		Alternate	Phone:		
Email:		Last Four of SSN:	Primary Language	:	
		Relationship to	patient:		
PRESCRIBER IN					
Prescriber's Name	:		State Lice	ense #:	
NPI #:	DEA #:	Group or Hospital:			
Address:		City, State, ZIP Code Contact Person:	o:		
Phone:	Fax	Contact Person:	Contact's Phon	e:	
		of prescription and insurance cards		m, if available	
		CAL INFORMATION (Include copy	of clinicals)		
M06.9 Rheuma	itoid Arthritis (RA)	M45.9 Ankylosing Spondylitis (AS)			
		L40.54 Juvenile Psoriatic Arthritis (JPsA)		
☐ M45.A0 Non-R	adiographic Axial Spondylarthı	ritis (nr-axSpA)			
		M08.00 Juvenile Idiopathic Arthritis	s (JIA)		
H44.139 Uveitis	, unspecified eye				
Other Code: _	Description	NKDA Weight:			
Allergies:	-	NKDA Weight:	🔲 lb 🗌 kg He	ight: 🔲	In Cm
Treatment status:	New to therapy 🔲 Continu	ation of therapy; Date of last treatm	ent//		
Samples provided	☐ No ☐ Yes, if so, how many	/ samples given? 🔲 TB Te	est Date// Pos [☐ Neg	
	ment dates, and reason(s) for				
		Patient Office Other:			
	STRENGTH	DOSE & DIRE	CTIONS	QUANTITY	REFILL
_	162 mg/0.9 mL ACTPen	☐ Inject 162 mg SC every other wee		28 days	
Actemra Actemra	☐ 162 mg/0.9 mL PFS	☐ Inject 162 mg SC every week		84 days	
Adalimumab-		_			
aacf	☐ 40 mg/0.8 mL PEN	Inject 40 mg SC every week		28 days	
(unbranded			k	<u></u>	
		Inject 40 mg SC every other wee		□ 84 days	
•		Inject 40 mg SC every other wee		84 days	
version of Idacio)				☐ 84 days	
version of Idacio) Adalimumab-	☐ 40 mg/0.4 mL PEN	☐ Inject 80 mg SC every other wee		84 days	
version of Idacio) Adalimumabadaz	40 mg/0.4 mL PFS (with	☐ Inject 80 mg SC every other wee ☐ Inject 40 mg SC every week	k		
version of Idacio) Adalimumabadaz (unbranded		☐ Inject 80 mg SC every other wee ☐ Inject 40 mg SC every week ☐ Inject 40 mg SC every other wee	k k	☐ 28 days	
version of Idacio) Adalimumabadaz (unbranded version of	40 mg/0.4 mL PFS (with	☐ Inject 80 mg SC every other wee ☐ Inject 40 mg SC every week	k k		
version of Idacio) Adalimumabadaz (unbranded version of Hyrimoz)	40 mg/0.4 mL PFS (with needle guard)	☐ Inject 80 mg SC every other wee ☐ Inject 40 mg SC every week ☐ Inject 40 mg SC every other wee ☐ Inject 80 mg SC every other wee	k k k	☐ 28 days	
version of Idacio) Adalimumabadaz (unbranded version of Hyrimoz) Adalimumabadalimumabada	40 mg/0.4 mL PFS (with needle guard)	☐ Inject 80 mg SC every other wee ☐ Inject 40 mg SC every week ☐ Inject 40 mg SC every other wee ☐ Inject 80 mg SC every other wee ☐ Inject 20 mg SC every other wee	k k k	28 days	
version of Idacio) Adalimumabadaz (unbranded version of Hyrimoz) Adalimumabfkjp	☐ 40 mg/0.4 mL PFS (with needle guard) ☐ 20 mg/0.4 mL PFS ☐ 40 mg/0.8 mL PFS	☐ Inject 80 mg SC every other wee ☐ Inject 40 mg SC every week ☐ Inject 40 mg SC every other wee ☐ Inject 80 mg SC every other wee ☐ Inject 20 mg SC every other wee ☐ Inject 40 mg SC every week	k k k	28 days 84 days	
version of Idacio) Adalimumabadaz (unbranded version of Hyrimoz) Adalimumabfkjp (unbranded	40 mg/0.4 mL PFS (with needle guard)	☐ Inject 80 mg SC every other wee ☐ Inject 40 mg SC every week ☐ Inject 40 mg SC every other wee ☐ Inject 80 mg SC every other wee ☐ Inject 20 mg SC every other wee ☐ Inject 40 mg SC every week ☐ Inject 40 mg SC every other wee	k k k k	28 days	
version of Idacio) Adalimumabadaz (unbranded version of Hyrimoz) Adalimumabfkjp	☐ 40 mg/0.4 mL PFS (with needle guard) ☐ 20 mg/0.4 mL PFS ☐ 40 mg/0.8 mL PFS	☐ Inject 80 mg SC every other wee ☐ Inject 40 mg SC every week ☐ Inject 40 mg SC every other wee ☐ Inject 80 mg SC every other wee ☐ Inject 20 mg SC every other wee ☐ Inject 40 mg SC every week ☐ Inject 40 mg SC every other wee ☐ Inject 80 mg SC every other wee	k k k k	28 days 84 days	
version of Idacio) Adalimumabadaz (unbranded version of Hyrimoz) Adalimumabfkjp (unbranded	☐ 40 mg/0.4 mL PFS (with needle guard) ☐ 20 mg/0.4 mL PFS ☐ 40 mg/0.8 mL PFS ☐ 40 mg/0.8 mL PEN	☐ Inject 80 mg SC every other wee ☐ Inject 40 mg SC every week ☐ Inject 40 mg SC every other wee ☐ Inject 80 mg SC every other wee ☐ Inject 20 mg SC every other wee ☐ Inject 40 mg SC every week ☐ Inject 40 mg SC every other wee ☐ Inject 80 mg SC every other wee ☐ Inject 10 mg SC every other weel ☐ Inject 10 mg SC every other weel	k k k k k	28 days 84 days	
version of Idacio) Adalimumabadaz (unbranded version of Hyrimoz) Adalimumabfkjp (unbranded version of Hulio)	☐ 40 mg/0.4 mL PFS (with needle guard) ☐ 20 mg/0.4 mL PFS ☐ 40 mg/0.8 mL PFS ☐ 40 mg/0.8 mL PEN ☐ 10 mg/0.2 mL PFS	☐ Inject 80 mg SC every other wee ☐ Inject 40 mg SC every week ☐ Inject 40 mg SC every other wee ☐ Inject 80 mg SC every other wee ☐ Inject 20 mg SC every other wee ☐ Inject 40 mg SC every week ☐ Inject 40 mg SC every other wee ☐ Inject 80 mg SC every other wee ☐ Inject 10 mg SC every other weel ☐ Inject 20 mg SC every other weel ☐ Inject 20 mg SC every other wee	k k k k k k k	28 days 84 days	
version of Idacio) Adalimumabadaz (unbranded version of Hyrimoz) Adalimumabfkjp (unbranded	☐ 40 mg/0.4 mL PFS (with needle guard) ☐ 20 mg/0.4 mL PFS ☐ 40 mg/0.8 mL PFS ☐ 40 mg/0.8 mL PEN ☐ 10 mg/0.2 mL PFS ☐ 20 mg/0.4 mL PFS	☐ Inject 80 mg SC every other wee ☐ Inject 40 mg SC every week ☐ Inject 40 mg SC every other wee ☐ Inject 80 mg SC every other wee ☐ Inject 20 mg SC every other wee ☐ Inject 40 mg SC every week ☐ Inject 40 mg SC every other wee ☐ Inject 80 mg SC every other wee ☐ Inject 10 mg SC every other weel ☐ Inject 20 mg SC every other weel ☐ Inject 40 mg SC every other weel ☐ Inject 40 mg SC every other weel ☐ Inject 40 mg SC every other weel	k k k k k k k	28 days 84 days 28 days 84 days	
version of Idacio) Adalimumabadaz (unbranded version of Hyrimoz) Adalimumab- fkjp (unbranded version of Hulio) Amjevita	□ 40 mg/0.4 mL PFS (with needle guard) □ 20 mg/0.4 mL PFS □ 40 mg/0.8 mL PFS □ 40 mg/0.8 mL PEN □ 10 mg/0.2 mL PFS □ 20 mg/0.4 mL PFS □ 40 mg/0.8 mL PFS	☐ Inject 80 mg SC every other wee ☐ Inject 40 mg SC every week ☐ Inject 40 mg SC every other wee ☐ Inject 80 mg SC every other wee ☐ Inject 20 mg SC every other wee ☐ Inject 40 mg SC every week ☐ Inject 40 mg SC every other wee ☐ Inject 80 mg SC every other wee ☐ Inject 10 mg SC every other weel ☐ Inject 20 mg SC every other weel ☐ Inject 20 mg SC every other wee	k k k k k k k k	28 days 84 days	
version of Idacio) Adalimumabadaz (unbranded version of Hyrimoz) Adalimumabfkjp (unbranded version of Hulio) Amjevita (adalimumab-	☐ 40 mg/0.4 mL PFS (with needle guard) ☐ 20 mg/0.4 mL PFS ☐ 40 mg/0.8 mL PFS ☐ 40 mg/0.8 mL PEN ☐ 10 mg/0.2 mL PFS ☐ 20 mg/0.4 mL PFS	☐ Inject 80 mg SC every other wee ☐ Inject 40 mg SC every week ☐ Inject 40 mg SC every other wee ☐ Inject 80 mg SC every other wee ☐ Inject 20 mg SC every other wee ☐ Inject 40 mg SC every week ☐ Inject 40 mg SC every other wee ☐ Inject 80 mg SC every other wee ☐ Inject 10 mg SC every other weel ☐ Inject 20 mg SC every other weel ☐ Inject 40 mg SC every other weel ☐ Inject 40 mg SC every week	k k k k k k k k k	28 days 84 days 28 days 84 days	
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version of Idacio) Adalimumabadaz (unbranded version of Hyrimoz) Adalimumabafkjp (unbranded version of Hulio) Amjevita (adalimumabatto) Other:	□ 40 mg/0.4 mL PFS (with needle guard) □ 20 mg/0.4 mL PFS □ 40 mg/0.8 mL PFS □ 40 mg/0.8 mL PEN □ 10 mg/0.2 mL PFS □ 20 mg/0.4 mL PFS □ 40 mg/0.8 mL PFS □ 40 mg/0.8 mL PFS □ 40 mg/0.8 mL PEN	☐ Inject 80 mg SC every other wee ☐ Inject 40 mg SC every week ☐ Inject 40 mg SC every other wee ☐ Inject 80 mg SC every other wee ☐ Inject 20 mg SC every other wee ☐ Inject 40 mg SC every week ☐ Inject 40 mg SC every other wee ☐ Inject 80 mg SC every other wee ☐ Inject 10 mg SC every other weel ☐ Inject 20 mg SC every other weel ☐ Inject 40 mg SC every other weel ☐ Inject 40 mg SC every other weel ☐ Inject 40 mg SC every other weel ☐ Inject 80 mg SC every other weel ☐ Inject 80 mg SC every other weel ☐ Inject 80 mg Day 1, followed by 4 starting one week after initial dose	k k k k k k k k k k k k k o mg every other week	28 days 84 days 28 days 84 days	
version of Idacio) Adalimumabadaz (unbranded version of Hyrimoz) Adalimumabfkjp (unbranded version of Hulio) Amjevita (adalimumabatto) Other:	□ 40 mg/0.4 mL PFS (with needle guard) □ 20 mg/0.4 mL PFS □ 40 mg/0.8 mL PFS □ 40 mg/0.8 mL PEN □ 10 mg/0.2 mL PFS □ 20 mg/0.4 mL PFS □ 40 mg/0.8 mL PFS □ 40 mg/0.8 mL PFS □ 40 mg/0.8 mL PEN	☐ Inject 80 mg SC every other wee ☐ Inject 40 mg SC every week ☐ Inject 40 mg SC every other wee ☐ Inject 80 mg SC every other wee ☐ Inject 20 mg SC every other wee ☐ Inject 40 mg SC every week ☐ Inject 40 mg SC every other wee ☐ Inject 80 mg SC every other wee ☐ Inject 10 mg SC every other weel ☐ Inject 20 mg SC every other weel ☐ Inject 40 mg SC every other weel ☐ Inject 40 mg SC every other weel ☐ Inject 40 mg SC every week ☐ Inject 80 mg SC every other weel ☐ Inject 80 mg SC every other weel ☐ Inject 80 mg Day 1, followed by 4	k k k k k k k k k k k k k o mg every other week	28 days 84 days 28 days 84 days	
version of Idacio) Adalimumabadaz (unbranded version of Hyrimoz) Adalimumabfkjp (unbranded version of Hulio) Amjevita (adalimumabatto) Other: PRESCRIBER S	□ 40 mg/0.4 mL PFS (with needle guard) □ 20 mg/0.4 mL PFS □ 40 mg/0.8 mL PFS □ 40 mg/0.8 mL PEN □ 10 mg/0.2 mL PFS □ 20 mg/0.4 mL PFS □ 40 mg/0.8 mL PFS □ 40 mg/0.8 mL PFS □ 40 mg/0.8 mL PEN	☐ Inject 80 mg SC every other wee ☐ Inject 40 mg SC every week ☐ Inject 40 mg SC every other wee ☐ Inject 80 mg SC every other wee ☐ Inject 20 mg SC every other wee ☐ Inject 40 mg SC every week ☐ Inject 40 mg SC every other wee ☐ Inject 80 mg SC every other wee ☐ Inject 10 mg SC every other wee ☐ Inject 20 mg SC every other wee ☐ Inject 40 mg SC every other wee ☐ Inject 40 mg SC every other wee ☐ Inject 40 mg SC every week ☐ Inject 80 mg SC every other wee ☐ Inject 80 mg SC every other wee ☐ Inject 80 mg Day 1, followed by 4 starting one week after initial dose MP SIGNATURE NOT ALLOWED)	k k k k k k k k k k k k k o mg every other week	28 days 84 days 28 days 84 days 28 days 84 days	
version of Idacio) Adalimumabadaz (unbranded version of Hyrimoz) Adalimumabfkjp (unbranded version of Hulio) Amjevita (adalimumabatto) Other: PRESCRIBER S	□ 40 mg/0.4 mL PFS (with needle guard) □ 20 mg/0.4 mL PFS □ 40 mg/0.8 mL PFS □ 40 mg/0.8 mL PEN □ 10 mg/0.2 mL PFS □ 20 mg/0.4 mL PFS □ 40 mg/0.8 mL PFS □ 40 mg/0.8 mL PEN □ 40 mg/0.8 mL PEN □ 40 mg/0.8 mL PEN	☐ Inject 80 mg SC every other wee ☐ Inject 40 mg SC every week ☐ Inject 40 mg SC every other wee ☐ Inject 80 mg SC every other wee ☐ Inject 20 mg SC every other wee ☐ Inject 40 mg SC every week ☐ Inject 40 mg SC every other wee ☐ Inject 80 mg SC every other wee ☐ Inject 10 mg SC every other wee ☐ Inject 20 mg SC every other wee ☐ Inject 40 mg SC every other wee ☐ Inject 40 mg SC every other wee ☐ Inject 40 mg SC every other wee ☐ Inject 80 mg SC every other wee ☐ Inject 80 mg SC every other wee ☐ Inject 80 mg Day 1, followed by 4 starting one week after initial dose MP SIGNATURE NOT ALLOWED) Substitute / No Substitution / May Substitute / No Substitute / No Substitute / May Substitute / No Substitute / No Substitute / May Substitute / No Substitute / May Substitute / No Substitute / No Substitute / May Substitute / No Substitute / N	k k k k k k k k k k k k k k k o mg every other week	28 days 84 days 28 days 84 days 28 days 84 days	
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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.

Patient Name:	Please Comple		and Patient Clinical Informa Patient	<u>tion</u> : Phone:			
	escriber 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	Loading Dose: ☐ Inject 75 mg SC on Weeks 0, 1, 2, 3 ☐ Inject 150 mg SC on Weeks 0, 1, 2, 3 ☐ Inject 300 mg SC on Weeks 0, 1, 2, 3 Maintenance Dose: ☐ Inject 75 mg SC on Week 4, then every 4 weeks thereafter ☐ Inject 150 mg SC every 4 weeks ☐ Inject 150 mg SC on Week 4, then every 4 weeks thereafter ☐ Inject 150 mg SC every 4 weeks ☐ Inject 300 mg SC on Week 4, then every 4 weeks thereafter ☐ Inject 300 mg SC 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		

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.

			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			
☐ Hadlima	☐ 40 mg/0.8 mL PEN	Inject 40 mg SC every ot	her week	28 days	
	☐ 40 mg/0.4 mL PFS	Inject 80 mg SC every of	☐ 84 days		
	☐ 40 mg/0.8 mL PFS		☐ Inject 80 mg SC on Day 1, 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	☐ 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		
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

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.

	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 Yes, 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 once daily			30 days 90 days	
☐ 1 mg/ 1 mL	3 mg (3 mL oral solution) PO twice daily 4 mg (4 mL oral solution) PO twice daily 6 mg (6 mL oral solution) PO twice daily			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		eks		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	0 O
☐ 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		
			ng week 2	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

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	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	eek 0			
	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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