

# Dermatology Enrollment Form



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 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. By providing the phone number(s) and email address above, you are consenting to receive automated calls, emails and/or text messages from CVS Specialty® about your prescription(s), account, and health care. Standard data rates apply. Message frequency varies. 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 with this form, if available (front and back)

Is the Patient Insured? ☐ Yes ☐ No Is the Patient enrolled or eligible for Medicare/Medicaid? ☐ Yes ☐ No

Policy Holder's Name: \_\_\_\_\_ Policy Holder's DOB: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Medical Insurance: \_\_\_\_\_ Telephone: \_\_\_\_\_ Policy ID: \_\_\_\_\_ Group #: \_\_\_\_\_

Prescription Insurance: \_\_\_\_\_ Prescription Plan Telephone: \_\_\_\_\_

Policy ID: \_\_\_\_\_ Group #: \_\_\_\_\_ RX BIN #: \_\_\_\_\_ RX PCN #: \_\_\_\_\_

☐ Check box if patient is enrolled in manufacturer copay assistance If yes, please provide ID# \_\_\_\_\_

### 4 DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: \_\_\_\_\_ Ship to: ☐ Patient ☐ Office ☐ Other: \_\_\_\_\_

#### Diagnosis (ICD-10):

☐ L28.1 Prurigo Nodularis

☐ L40.0 Psoriasis Vulgaris

☐ L40.1 Generalized Pustular Psoriasis

☐ L40.4 Guttate Psoriasis

☐ L40.50 Arthropathic Psoriasis, Unspecified

☐ L40.54 Juvenile psoriatic arthritis

☐ L40.59 Other Psoriatic Arthropathy ☐ L40.8 Other Psoriasis

☐ L40.9 Psoriasis, Unspecified

☐ L63.8 Other alopecia areata

☐ L63.9 Alopecia areata, unspecified

☐ L73.2 Hidradenitis Suppurativa

☐ Other Code: \_\_\_\_\_ Description: \_\_\_\_\_

#### Patient Clinical Information:

Allergies: \_\_\_\_\_

Weight: \_\_\_\_\_ lb/kg Height: \_\_\_\_\_ in/cm TB Test Result: \_\_\_\_\_ Date: \_\_\_\_\_

Prior therapy, treatment dates, and reason(s) for discontinuation: \_\_\_\_\_

Treatment status: ☐ New to therapy ☐ Continuation of therapy; date of last treatment \_\_\_\_/\_\_\_\_/\_\_\_\_ Needs by date: \_\_\_\_\_

#### Nursing and Administration:

Specialty pharmacy to coordinate home health Infusion nurse visit as necessary? ☐ Yes ☐ No

Site of Care: ☐ Home Infusion\* ☐ Coram Ambulatory Infusion Suite (AIS)\* ☐ Prescriber's Office\*\* ☐ Other Infusion Clinic

**For Remicade/Remicade Biosimilars: First three doses to be given in controlled setting.**

\*Home Infusion/Coram AIS: Diluents, Flushes, Supplies, Nursing Services for drug administration/therapy teach train.

\*\*Prescriber's Office/Other Infusion Clinic: Drug only for facility administration

### 5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Adalimumab-aacf (Unbranded 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"/> 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 Refills: _____
<input type="checkbox"/> Adalimumab-aaty (unbranded version of Yuflyma)	<input type="checkbox"/> 1 x 40 mg/0.4 mL PEN <input type="checkbox"/> 2 x 40 mg/0.4 mL PEN	<input type="checkbox"/> Inject 40mg SC every week <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"/> 28 days <input type="checkbox"/> 84 days Refills: _____
<input type="checkbox"/> Other	<input type="checkbox"/> Strength: _____	<input type="checkbox"/> Dose: _____	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)

<p>"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute</p> <p>Prescriber's Signature: _____ Date: _____</p>	<p>May Substitute / Product Selection Permitted / Substitution Permissible</p> <p>Prescriber's Signature: _____ Date: _____</p>
<p>CA, MA, NC &amp; PR: Interchange is mandated unless Prescriber writes the words "No Substitution" ATTN: New York and Iowa providers, please submit electronic prescription</p>	

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 Address: \_\_\_\_\_

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
<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"/> Inject 80 mg SC on Day 1, followed by 40 mg every other week starting one week after initial dose <input type="checkbox"/> Inject 160 mg SC on Day 1 (single-dose or split over two consecutive days), 80 mg on Day 15, then 40 mg every week starting on Day 29 <input type="checkbox"/> Inject 160 mg SC on Day 1 (single-dose or split over two consecutive days), 80 mg on Day 15, then 80 mg every other week starting on Day 29	Quantity: _____ <input type="checkbox"/> 28 days <input type="checkbox"/> 84 days Refills: _____
<input type="checkbox"/> Adalimumab-fkjp (unbranded version of Hulio)	<input type="checkbox"/> 40 mg/0.8 mL PFS <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"/> Inject 80 mg SC on Day 1, followed by 40 mg every other week starting one week after initial dose <input type="checkbox"/> Inject 160 mg SC on Day 1 (single-dose or split over two consecutive days), 80 mg on Day 15, then 40 mg every week starting on Day 29 <input type="checkbox"/> Inject 160 mg SC on Day 1 (single-dose or split over two consecutive days), 80 mg on Day 15, then 80 mg every other week starting on Day 29	Quantity: _____ <input type="checkbox"/> 28 days <input type="checkbox"/> 84 days Refills: _____
<input type="checkbox"/> Amjevita (adalimumab-atto)	<input type="checkbox"/> 40 mg/0.8 mL PFS <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"/> Inject 80 mg Day 1, followed by 40 mg every other week starting one week after initial dose <input type="checkbox"/> Inject 160 mg SC on Day 1 (given in one day or split over two consecutive days), 80 mg on Day 15. Begin 40 mg weekly or 80 mg every other week dosing two weeks later on Day 29	Quantity: _____ <input type="checkbox"/> 28 days <input type="checkbox"/> 84 days Refills: _____
<input type="checkbox"/> Avsola	100 mg vial	<input type="checkbox"/> Induction Dose: Infuse IV at 5 mg/kg (Dose = ____ mg) at weeks 0, 2, 6 and every 8 weeks thereafter <input type="checkbox"/> Maintenance Dose: Infuse IV at 5 mg/kg (Dose = ____ mg) every 8 weeks	Quantity: _____ # of 100 mg vial(s) Refills: _____
<input type="checkbox"/> Bimzelx	<input type="checkbox"/> 1 x 320 mg/2 mL PEN <input type="checkbox"/> 2 x 160 mg/mL PEN <input type="checkbox"/> 1 x 320 mg/2 mL PFS <input type="checkbox"/> 2 x 160 mg/mL PFS	<b>PsO Loading Dose:</b> <input type="checkbox"/> Inject 320 mg (2 x 160 mg/mL) SC at weeks 0, 4, 8, and 12	Quantity: 28 DS Refills: 3
		<b>PsO Maintenance Dose:</b> <input type="checkbox"/> Inject 320 mg (2 x 160 mg/mL) SC on week 16 and every 8 weeks thereafter	Quantity: 56 DS Refills: _____
		<b>PsO Maintenance Dose for pts ≥ 120 kg (264 lbs):</b> <input type="checkbox"/> Inject 320 mg (2 x 160 mg/mL) SC on week 16 and every 4 weeks thereafter	Quantity: 28 DS Refills: _____
		<b>HS Loading Dose:</b> <input type="checkbox"/> Inject 320 mg (2 x 160 mg/mL) SC at week 0, 2, 4, 6, 8, 10, 12, and 14	Quantity: 28 DS Refills: 3
		<b>HS Maintenance Dose:</b> <input type="checkbox"/> Inject 320 mg (2 x 160 mg/mL) SC on week 16 and every 4 weeks thereafter	Quantity: 28 DS Refills: _____
<input type="checkbox"/> Other	<input type="checkbox"/> Strength: _____	<input type="checkbox"/> Dose: _____	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)

<p>"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute</p> <p><b>Prescriber's Signature:</b> _____ <b>Date:</b> _____</p>	<p>May Substitute / Product Selection Permitted / Substitution Permissible</p> <p><b>Prescriber's Signature:</b> _____ <b>Date:</b> _____</p>
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**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.

# Dermatology Enrollment Form

## Please Complete Patient, Prescriber and Patient Clinical Information

Patient Name: \_\_\_\_\_ Patient DOB: \_\_\_\_\_ Patient Phone: \_\_\_\_\_

Patient Address: \_\_\_\_\_

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
<input type="checkbox"/> Cimzia	Cimzia Starter Kit (6 prefilled syringes)	<b>Psoriasis Loading Dose:</b> <input type="checkbox"/> 400 mg (given as 2 subcutaneous injections of 200 mg each) every other week <input type="checkbox"/> 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 <b>Psoriatic Arthritis Loading Dose:</b> <input type="checkbox"/> 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	Quantity: 1 Kit Refills: 0
<input type="checkbox"/> Cimzia	<input type="checkbox"/> 200 mg/1 mL prefilled syringe  <input type="checkbox"/> 200 mg vial	<b>Psoriasis Maintenance Dose:</b> <input type="checkbox"/> 400 mg (given as 2 subcutaneous injections of 200 mg each) every other week <input type="checkbox"/> 200 mg every other week <b>Psoriatic Arthritis Maintenance Dose:</b> <input type="checkbox"/> 200 mg every other week <input type="checkbox"/> 400 mg (given as 2 subcutaneous injections of 200 mg each) every 4 weeks	Quantity: _____ Refills: _____
<input type="checkbox"/> Cosentyx	<input type="checkbox"/> 75 mg/0.5 mL PFS <input type="checkbox"/> 150 mg/mL PEN <input type="checkbox"/> 150 mg/mL PFS <input type="checkbox"/> 150 mg/mL PEN <input type="checkbox"/> 150 mg/mL PFS <input type="checkbox"/> 300 mg/2 mL PEN	<b>Loading Dose:</b> <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 <b>Maintenance Dose:</b> <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 <input type="checkbox"/> Inject 300 mg SC every 2 weeks	<b>Loading Dose:</b> Quantity: <u>28 days</u> Refills: <u>0</u>  <b>Maintenance Dose:</b> Quantity: <u>28 days</u> Refills: _____
<input type="checkbox"/> Dupixent	<input type="checkbox"/> PFS 300 mg/2 mL prefilled syringe <input type="checkbox"/> Pen 300 mg/2 mL prefilled pen	<b>Loading Dose:</b> <input type="checkbox"/> Inject 600 mg SC (2-300 mg injections) initially, followed by 300 mg SC every 2 weeks  <b>Maintenance Dose:</b> <input type="checkbox"/> Inject 300 mg SC every 2 weeks	Quantity: <input type="checkbox"/> 28-day supply <input type="checkbox"/> 84-day supply <input type="checkbox"/> Other: _____ Day supply Refills: <input type="checkbox"/> 1 year <input type="checkbox"/> Other: _____ 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 Vial	<b>Loading Dose:</b> <input type="checkbox"/> Inject 50 mg SC twice a week (3 to 4 days apart) for 3 months, then maintenance dosing  <b>Maintenance Dose:</b> <input type="checkbox"/> Inject 50 mg SC once weekly <input type="checkbox"/> Inject _____ mg SC once weekly	<b>Loading Dose:</b> Quantity: <u>84 days</u> Refills: <u>0</u>  <b>Maintenance Dose:</b> Quantity: <u>28 days</u> Refills: _____
<input type="checkbox"/> Other	<input type="checkbox"/> Strength: _____	<input type="checkbox"/> Dose: _____	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 <b>Prescriber's Signature:</b> _____ <b>Date:</b> _____	May Substitute / Product Selection Permitted / Substitution Permissible <b>Prescriber's Signature:</b> _____ <b>Date:</b> _____
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**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

## Please Complete Patient, Prescriber and Patient Clinical Information

Patient Name: \_\_\_\_\_ Patient DOB: \_\_\_\_\_ Patient Phone: \_\_\_\_\_  
 Patient Address: \_\_\_\_\_  
 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
<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 40 mg every other week starting one week after initial dose <input type="checkbox"/> Inject 160 mg SC on Day 1 (single-dose or split over two consecutive days), 80 mg on Day 15, then 40 mg every week starting on Day 29 <input type="checkbox"/> Inject 160 mg SC on Day 1 (single-dose or split over two consecutive days), 80 mg on Day 15, then 80 mg every other week starting on Day 29	Quantity: _____ <input type="checkbox"/> 28 days <input type="checkbox"/> 84 days Refills: _____
<input type="checkbox"/> Hulio	<input type="checkbox"/> 40 mg/0.8 mL PFS <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"/> Inject 80 mg SC on Day 1, followed by 40 mg every other week starting one week after initial dose <input type="checkbox"/> Inject 160 mg SC on Day 1 (single-dose or split over two consecutive days), 80 mg on Day 15, then 40 mg every week starting on Day 29 <input type="checkbox"/> Inject 160 mg SC on Day 1 (single-dose or split over two consecutive days), 80 mg on Day 15, then 80 mg every other week starting on Day 29	Quantity: _____ <input type="checkbox"/> 28 days <input type="checkbox"/> 84 days Refills: _____
<input type="checkbox"/> Humira	<input type="checkbox"/> 40 mg/0.4 mL PFS <input type="checkbox"/> 40 mg/0.4 mL Pen <input type="checkbox"/> 80 mg/0.8 mL PFS <input type="checkbox"/> 80 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"/> Inject 80 mg SC on day 1, then 40 mg every other week on day 8 and subsequent doses <input type="checkbox"/> Inject 160 mg SC on Day 1 (single-dose or split over two consecutive days), 80 mg on Day 15, then 40 mg every week starting on Day 29 <input type="checkbox"/> Inject 160 mg SC on Day 1 (single-dose or split over two consecutive days), 80 mg on Day 15, then 80 mg every other week starting on Day 29	<input type="checkbox"/> 28 days <input type="checkbox"/> 84 days Refills: _____
<input type="checkbox"/> 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"/> Inject 80 mg SC on Day 1, followed by 40 mg every other week starting one week after initial dose <input type="checkbox"/> Inject 160 mg SC on Day 1 (single-dose or split over two consecutive days), 80 mg on Day 15, then 40 mg every week starting on Day 29 <input type="checkbox"/> Inject 160 mg SC on Day 1 (single-dose or split over two consecutive days), 80 mg on Day 15, then 80 mg every other week starting on Day 29	<input type="checkbox"/> 28 days <input type="checkbox"/> 84 days Refills: _____
<input type="checkbox"/> Ilumya	100 mg/mL prefilled syringe	<input type="checkbox"/> <u>Psoriasis Induction Dose:</u> Inject one pre-filled syringe (100 mg) SC at weeks 0 and 4, then maintenance dosing. <input type="checkbox"/> <u>Psoriasis Maintenance Dose:</u> Inject one pre-filled syringe (100 mg) SC every 12 weeks.	Quantity: _____ Refills: _____
<input type="checkbox"/> Other	<input type="checkbox"/> Strength: _____	<input type="checkbox"/> Dose: _____	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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"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute <b>Prescriber's Signature:</b> _____ <b>Date:</b> _____	May Substitute / Product Selection Permitted / Substitution Permissible <b>Prescriber's Signature:</b> _____ <b>Date:</b> _____
<b>CA, MA, NC &amp; PR:</b> Interchange is mandated unless Prescriber writes the words " <b>No Substitution</b> " _____ <b>ATTN: New York and Iowa providers,</b> 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 Address: \_\_\_\_\_

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/REFILL
<input type="checkbox"/> Inflectra	100 mg vial	<input type="checkbox"/> Induction Dose: Infuse IV at 5 mg/kg (Dose = ____mg) at weeks 0, 2, 6 and every 8 weeks thereafter <input type="checkbox"/> Maintenance Dose: Infuse IV at 5 mg/kg (Dose= ____mg) every 8 weeks	Quantity: _____ # of 100 mg vial(s) Refills: _____
<input type="checkbox"/> Infliximab			
<input type="checkbox"/> Leqselvi	8 mg tablet	<input type="checkbox"/> Take 8 mg orally twice daily with or without food	<input type="checkbox"/> 30 days <input type="checkbox"/> 90 days Refills: _____
<input type="checkbox"/> Litfulo	<input type="checkbox"/> 50 mg capsule	<input type="checkbox"/> Take 50 mg orally once daily with or without food	<input type="checkbox"/> 28 days <input type="checkbox"/> 84 days Refills: _____
<input type="checkbox"/> Olumiant	<input type="checkbox"/> 2 mg tablet <input type="checkbox"/> 4 mg tablet	<input type="checkbox"/> 2 mg PO once daily <input type="checkbox"/> 4 mg PO once daily	Quantity: _____ Refills: _____
<input type="checkbox"/> Orencia	125 mg/mL prefilled syringe	Inject 125 mg SC once weekly	Quantity: _____ Refills: _____
<input type="checkbox"/> Otezla	<input type="checkbox"/> Titration Starter Pack for 30 mg BID dosage	<input type="checkbox"/> Adult Patients and Pediatric Patients 6 years of age and older weighing 50 kg or more: 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"/> Titration Starter Pack for 20 mg BID dosage	<input type="checkbox"/> Pediatric Patients 6 years of age and older weighing 20 kg to less than 50 kg: 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 20 mg PO in the evening. Day 6 and thereafter: 20 mg PO twice daily.	
<input type="checkbox"/> Otezla	<input type="checkbox"/> 20 mg tablet <input type="checkbox"/> 30 mg tablet <input type="checkbox"/> Sample already provided/no titration needed	<input type="checkbox"/> 20 mg PO twice daily <input type="checkbox"/> 30 mg PO twice daily	<input type="checkbox"/> 30 days <input type="checkbox"/> 90 days Refills: _____
<input type="checkbox"/> Other	<input type="checkbox"/> Strength: _____	<input type="checkbox"/> Dose: _____	Quantity: _____ Refills: _____

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May Substitute / Product Selection Permitted / Substitution Permissible

Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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### Patient Clinical Information:

Allergies: \_\_\_\_\_

Weight: \_\_\_\_\_ lb/kg Height: \_\_\_\_\_ In/cm TB Test Result: \_\_\_\_\_ Date: \_\_\_\_\_

## 5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILL
<input type="checkbox"/> Pzychiva	<input type="checkbox"/> 45 mg/0.5 mL vial <input type="checkbox"/> 45 mg/0.5 mL prefilled syringe <input type="checkbox"/> 90 mg/mL prefilled syringe	PsO Peds patients (6 to 17yo): <input type="checkbox"/> < 60 kg: Inject 0.75 mg/kg SC at weeks 0 and 4, then every 12 weeks thereafter. <input type="checkbox"/> 60 kg to 100 kg: Inject 45 mg SC at weeks 0 and 4, then every 12 weeks thereafter. <input type="checkbox"/> > 100 kg: Inject 90 mg SC at weeks 0 and 4, then every 12 weeks thereafter. PsA Peds patients (6 to 17yo): <input type="checkbox"/> < 60 kg: Inject 0.75 mg/kg SC at weeks 0 and 4, then every 12 weeks thereafter. <input type="checkbox"/> ≥ 60 kg: Inject 45 mg SC at weeks 0 and 4, then every 12 weeks thereafter. <input type="checkbox"/> > 100 kg with co-existent mod-severe PsO: Inject 90 mg SC at weeks 0 and 4, then every 12 weeks thereafter. PsO Adult dosing: <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. PsA Adult dosing: <input type="checkbox"/> Inject 45 mg SC at weeks 0 and 4, then every 12 weeks thereafter. <input type="checkbox"/> > 100 kg (220lbs) with co-existent mod-severe PsO: Inject 90 mg SC weeks 0 and 4, then every 12 weeks thereafter.	Quantity: _____ Refills: _____
<input type="checkbox"/> Remicade  <input type="checkbox"/> Renflexis	100 mg vial	<input type="checkbox"/> Induction Dose: Infuse IV at 5 mg/kg (Dose = ____mg) at weeks 0, 2, 6 and every 8 weeks thereafter <input type="checkbox"/> Maintenance Dose: Infuse IV at 5 mg/kg (Dose = ____mg) every 8 weeks	Quantity: _____ # of 100 mg vial(s) Refills: _____
<input type="checkbox"/> Rinvoq	15 mg	Take one 15 mg tablet PO daily	Quantity: _____ Refills: _____
<input type="checkbox"/> Selarsdi	<input type="checkbox"/> 45 mg/0.5 mL vial <input type="checkbox"/> 45 mg/0.5 mL prefilled syringe <input type="checkbox"/> 90 mg/mL prefilled syringe	PsO Peds patients (6 to 17yo): <input type="checkbox"/> < 60 kg: Inject 0.75 mg/kg SC at weeks 0 and 4, then every 12 weeks thereafter. <input type="checkbox"/> 60 kg to 100 kg: Inject 45 mg SC at weeks 0 and 4, then every 12 weeks thereafter. <input type="checkbox"/> > 100 kg: Inject 90 mg SC at weeks 0 and 4, then every 12 weeks thereafter. PsA Peds patients (6 to 17yo): <input type="checkbox"/> < 60 kg: Inject 0.75 mg/kg SC at weeks 0 and 4, then every 12 weeks thereafter. <input type="checkbox"/> ≥ 60 kg: Inject 45 mg SC at weeks 0 and 4, then every 12 weeks thereafter. <input type="checkbox"/> > 100 kg with co-existent mod-severe PsO: Inject 90 mg SC at weeks 0 and 4, then every 12 weeks thereafter. PsO Adult dosing: <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. PsA Adult dosing: <input type="checkbox"/> Inject 45 mg SC at weeks 0 and 4, then every 12 weeks thereafter. <input type="checkbox"/> > 100 kg (220lbs) with co-existent mod-severe PsO: Inject 90 mg SC weeks 0 and 4, then every 12 weeks thereafter.	Quantity: _____ Refills: _____
<input type="checkbox"/> Other	<input type="checkbox"/> Strength: _____	<input type="checkbox"/> Dose: _____	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

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.

# Dermatology Enrollment Form

## Please Complete Patient, Prescriber and Patient Clinical Information

Patient Name: \_\_\_\_\_ Patient DOB: \_\_\_\_\_ Patient Phone: \_\_\_\_\_

Patient Address: \_\_\_\_\_

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/REFILL
<input type="checkbox"/> Siliq	<input type="checkbox"/> 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: <a href="https://siliqrems.com/SiliqUI/home.u">SILIQ REMS Website</a> (https://siliqrems.com/SiliqUI/home.u)	Quantity: _____ Refills: _____
<input type="checkbox"/> Simlandi (adalimumab-ryvk)	<input type="checkbox"/> 40 mg/0.4mL 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"/> Inject 80 mg Day 1, followed by 40mg every other week starting one week after initial dose <input type="checkbox"/> Inject 160 mg SC on Day 1, (given in one day or split over two consecutive days), 80mg on Day 15. Begin 40mg weekly or 80mg every other week dosing two weeks later starting day 29.	Quantity: _____ <input type="checkbox"/> 28 days <input type="checkbox"/> 84 days Refills: _____
<input type="checkbox"/> Simponi	<input type="checkbox"/> 50 mg/0.5 mL SmartJect Autoinjector <input type="checkbox"/> 50 mg/0.5 mL prefilled syringe	<input type="checkbox"/> Psoriatic Arthritis Dose: Inject 50 mg SC once a month.	Quantity: _____ Refills: _____
<input type="checkbox"/> Simponi ARIA	50 mg/4 mL in a single-dose vial	Psoriatic Arthritis Dosing: <input type="checkbox"/> Induction Dose: 2 mg/kg IV infusion over 30 minutes at weeks 0 and 4, then every 8 weeks thereafter <input type="checkbox"/> Maintenance Dose: 2 mg/kg IV infusion over 30 minutes every 8 weeks	Quantity: _____ # of 50 mg vial Refills: _____
<input type="checkbox"/> Skyrizi	<input type="checkbox"/> 150 mg/mL single-dose Pen <input type="checkbox"/> 150 mg/mL single-dose prefilled syringe	<input type="checkbox"/> Psoriasis Induction Dose: Inject 150 mg SC at Weeks 0 and 4, then maintenance dosing. <input type="checkbox"/> Psoriasis Maintenance Dose: Inject 150 mg SC every 12 weeks.	Quantity: _____ Refills: _____
<input type="checkbox"/> Sotyktu	6 mg tablet	Take one 6 mg tablet PO once daily	Quantity: _____ Refills: _____
<input type="checkbox"/> Stelara	<input type="checkbox"/> 45 mg/0.5 mL vial <input type="checkbox"/> 45 mg/0.5 mL prefilled syringe <input type="checkbox"/> 90 mg/mL prefilled syringe	<b>PsO Peds patients (6 to 17yo):</b> <input type="checkbox"/> < 60 kg: Inject 0.75 mg/kg SC at weeks 0 and 4, then every 12 weeks thereafter. <input type="checkbox"/> 60 kg to 100 kg: Inject 45 mg SC at weeks 0 and 4, then every 12 weeks thereafter. <input type="checkbox"/> > 100 kg: Inject 90 mg SC at weeks 0 and 4, then every 12 weeks thereafter. <b>PsA Peds patients (6 to 17yo):</b> <input type="checkbox"/> < 60 kg: Inject 0.75 mg/kg SC at weeks 0 and 4, then every 12 weeks thereafter. <input type="checkbox"/> ≥ 60 kg: Inject 45 mg SC at weeks 0 and 4, then every 12 weeks thereafter. <input type="checkbox"/> > 100 kg with co-existent mod-severe PsO: Inject 90 mg SC at weeks 0 and 4, then every 12 weeks thereafter. <b>PsO Adult dosing:</b> <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. <b>PsA Adult dosing:</b> <input type="checkbox"/> Inject 45 mg SC at weeks 0 and 4, then every 12 weeks thereafter. <input type="checkbox"/> > 100 kg (220lbs) with co-existent mod-severe PsO: Inject 90 mg SC weeks 0 and 4, then every 12 weeks thereafter.	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

## Please Complete Patient, Prescriber and Patient Clinical Information

Patient Name: \_\_\_\_\_ Patient DOB: \_\_\_\_\_ Patient Phone: \_\_\_\_\_

Patient Address: \_\_\_\_\_

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
<input type="checkbox"/> Steqeyma	<input type="checkbox"/> 45 mg/0.5 mL prefilled syringe <input type="checkbox"/> 90 mg/mL prefilled syringe	<p><b>PsO Peds patients (6 to 17yo):</b></p> <p><input type="checkbox"/> &lt; 60 kg: Inject 0.75 mg/kg SC at weeks 0 and 4, then every 12 weeks thereafter.</p> <p><input type="checkbox"/> 60 kg to 100 kg: Inject 45 mg SC at weeks 0 and 4, then every 12 weeks thereafter.</p> <p><input type="checkbox"/> &gt; 100 kg: Inject 90 mg SC at weeks 0 and 4, then every 12 weeks thereafter.</p> <p><b>PsA Peds patients (6 to 17yo):</b></p> <p><input type="checkbox"/> &lt; 60 kg: Inject 0.75 mg/kg SC at weeks 0 and 4, then every 12 weeks thereafter.</p> <p><input type="checkbox"/> ≥ 60 kg: Inject 45 mg SC at weeks 0 and 4, then every 12 weeks thereafter.</p> <p><input type="checkbox"/> &gt; 100 kg with co-existent mod-severe PsO: Inject 90 mg SC at weeks 0 and 4, then every 12 weeks thereafter.</p> <p><b>PsO Adult dosing:</b></p> <p><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.</p> <p><input type="checkbox"/> For patients weighing &gt;100 kg (220 lbs): Inject 90 mg SC initially and 4 weeks later, followed by 90 mg every 12 weeks.</p> <p><b>PsA Adult dosing:</b></p> <p><input type="checkbox"/> Inject 45 mg SC at weeks 0 and 4, then every 12 weeks thereafter.</p> <p><input type="checkbox"/> &gt; 100 kg (220lbs) with co-existent mod-severe PsO: Inject 90 mg SC weeks 0 and 4, then every 12 weeks thereafter.</p>	Quantity: _____ Refills: _____
<input type="checkbox"/> Taltz	<input type="checkbox"/> 80 mg/mL PEN <input type="checkbox"/> 80 mg/mL PFS <input type="checkbox"/> 40 mg/0.5 mL PFS <input type="checkbox"/> 20 mg/0.25 mL PFS	<p><b>Psoriasis Dosing:</b></p> <p><input type="checkbox"/> Starting Dose: Inject two 80 mg SC injections on Day 1, then begin first induction dose 2 weeks later</p> <p><input type="checkbox"/> Induction Dose: Inject one 80 mg injection SC every 2 weeks (weeks 2-10)</p> <p><input type="checkbox"/> Final Induction Dose: Inject one 80 mg injection SC week 12</p> <p><input type="checkbox"/> Maintenance Dose: Inject one 80 mg injection SC every 4 weeks</p> <p><b>Pediatric Psoriasis Dosing (6 years and older):</b></p> <p><b>Patients weighing less than 25 kg:</b></p> <p><input type="checkbox"/> Inject 40 mg SC at Week 0, followed by 20 mg every 4 weeks</p> <p><b>Patients weighing 25-50 kg:</b></p> <p><input type="checkbox"/> Inject 80 mg SC at Week 0, followed by 40 mg every 4 weeks</p> <p><b>Patients weighing greater than 50 kg:</b></p> <p><input type="checkbox"/> Inject 160 mg (two 80 mg injections) SC at Week 0, followed by 80 mg every 4 weeks</p> <p><b>Psoriatic Arthritis Dosing:</b></p> <p><input type="checkbox"/> Starting Dose: Inject SC two 80 mg injections on Day 1</p> <p><input type="checkbox"/> Maintenance Dose: Inject SC one 80 mg injection every 4 weeks</p>	Quantity: _____ <input type="checkbox"/> 28 days <input type="checkbox"/> 84 days Refills: _____
<input type="checkbox"/> Tremfya	<input type="checkbox"/> 100 mg/mL PEN <input type="checkbox"/> 100 mg/mL PFS <input type="checkbox"/> 100 mg/mL One-Press patient-controlled injector	<input type="checkbox"/> Starting Dose: Inject 100 mg SC at weeks 0 and 4, then maintenance dosing <input type="checkbox"/> Maintenance Dose: Inject 100 mg SC every 8 weeks	Quantity: _____ Refills: _____
<input type="checkbox"/> Other	<input type="checkbox"/> Strength: _____	<input type="checkbox"/> Dose: _____	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:** \_\_\_\_\_

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# Dermatology Enrollment Form

## Please Complete Patient, Prescriber and Patient Clinical Information

Patient Name: \_\_\_\_\_ Patient DOB: \_\_\_\_\_ Patient Phone: \_\_\_\_\_

Patient Address: \_\_\_\_\_

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
<input type="checkbox"/> Ustekinumab	<input type="checkbox"/> 45 mg/0.5 mL vial <input type="checkbox"/> 45 mg/0.5 mL prefilled syringe <input type="checkbox"/> 90 mg/mL prefilled syringe	<u>PsO Peds patients (6 to 17yo):</u> <input type="checkbox"/> < 60 kg: Inject 0.75 mg/kg SC at weeks 0 and 4, then every 12 weeks thereafter. <input type="checkbox"/> 60 kg to 100 kg: Inject 45 mg SC at weeks 0 and 4, then every 12 weeks thereafter. <input type="checkbox"/> > 100 kg: Inject 90 mg SC at weeks 0 and 4, then every 12 weeks thereafter. <u>PsA Peds patients (6 to 17yo):</u> <input type="checkbox"/> < 60 kg: Inject 0.75 mg/kg SC at weeks 0 and 4, then every 12 weeks thereafter. <input type="checkbox"/> ≥ 60 kg: Inject 45 mg SC at weeks 0 and 4, then every 12 weeks thereafter. <input type="checkbox"/> > 100 kg with co-existent mod-severe PsO: Inject 90 mg SC at weeks 0 and 4, then every 12 weeks thereafter. <u>PsO Adult dosing:</u> <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. <u>PsA Adult dosing:</u> <input type="checkbox"/> Inject 45 mg SC at weeks 0 and 4, then every 12 weeks thereafter. <input type="checkbox"/> > 100 kg (220lbs) with co-existent mod-severe PsO: Inject 90 mg SC weeks 0 and 4, then every 12 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	Quantity: _____ Refills: _____
<input type="checkbox"/> Other	<input type="checkbox"/> Strength: _____	<input type="checkbox"/> Dose: _____	Quantity: _____ Refills: _____

☐ Patient is interested in patient support programs

**STAMP SIGNATURE NOT ALLOWED**

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## 6 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute <b>Prescriber's Signature:</b> _____ <b>Date:</b> _____	May Substitute / Product Selection Permitted / Substitution Permissible <b>Prescriber's Signature:</b> _____ <b>Date:</b> _____
<b>CA, MA, NC &amp; PR:</b> Interchange is mandated unless Prescriber writes the words " <b>No Substitution</b> " _____ <b>ATTN: New York and Iowa providers,</b> please submit electronic prescription	

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# Dermatology Enrollment Form

## Please Complete Patient, Prescriber and Patient Clinical Information

Patient Name: \_\_\_\_\_ Patient DOB: \_\_\_\_\_ Patient Phone: \_\_\_\_\_

Patient Address: \_\_\_\_\_

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
<input type="checkbox"/> Yesintek	<input type="checkbox"/> 45 mg/0.5 mL vial <input type="checkbox"/> 45 mg/0.5 mL prefilled syringe <input type="checkbox"/> 90 mg/mL prefilled syringe	<u>PsO Peds patients (6 to 17yo):</u> <input type="checkbox"/> < 60 kg: Inject 0.75 mg/kg SC at weeks 0 and 4, then every 12 weeks thereafter. <input type="checkbox"/> 60 kg to 100 kg: Inject 45 mg SC at weeks 0 and 4, then every 12 weeks thereafter. <input type="checkbox"/> > 100 kg: Inject 90 mg SC at weeks 0 and 4, then every 12 weeks thereafter. <u>PsA Peds patients (6 to 17yo):</u> <input type="checkbox"/> < 60 kg: Inject 0.75 mg/kg SC at weeks 0 and 4, then every 12 weeks thereafter. <input type="checkbox"/> ≥ 60 kg: Inject 45 mg SC at weeks 0 and 4, then every 12 weeks thereafter. <input type="checkbox"/> > 100 kg with co-existent mod-severe PsO: Inject 90 mg SC at weeks 0 and 4, then every 12 weeks thereafter. <u>PsO Adult dosing:</u> <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. <u>PsA Adult dosing:</u> <input type="checkbox"/> Inject 45 mg SC at weeks 0 and 4, then every 12 weeks thereafter. <input type="checkbox"/> > 100 kg (220lbs) with co-existent mod-severe PsO: Inject 90 mg SC weeks 0 and 4, then every 12 weeks thereafter.	Quantity: _____ Refills: _____
<input type="checkbox"/> Yuflyma	<input type="checkbox"/> 40 mg/0.4 mL PEN <input type="checkbox"/> 40 mg/0.4 mL PFS <input type="checkbox"/> 40 mg/0.4 mL PFS (with safety guard) <input type="checkbox"/> 80 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"/> Inject 80 mg SC on Day 1, followed by 40 mg every other week starting one week after initial dose <input type="checkbox"/> Inject 160 mg SC on Day 1 (single-dose or split over two consecutive days), 80 mg on Day 15, then 40 mg every week starting on Day 29 <input type="checkbox"/> Inject 160 mg SC on Day 1 (single-dose or split over two consecutive days), 80 mg on Day 15, then 80 mg every other week starting on Day 29	<input type="checkbox"/> 28 days <input type="checkbox"/> 84 days Refills: _____
<input type="checkbox"/> Other	<input type="checkbox"/> Strength: _____	<input type="checkbox"/> Dose: _____	Quantity: _____ Refills: _____

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<b>CA, MA, NC &amp; PR:</b> Interchange is mandated unless Prescriber writes the words " <b>No Substitution</b> " <b>ATTN: New York and Iowa providers,</b> please submit electronic prescription	

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# Dermatology Enrollment Form

## Nursing Orders

### Please Complete Patient, Prescriber and Patient Clinical Information

Patient Name: \_\_\_\_\_ Patient DOB: \_\_\_\_\_ Patient Phone: \_\_\_\_\_

Patient Address: \_\_\_\_\_

Prescriber Name: \_\_\_\_\_ Prescriber Phone: \_\_\_\_\_

#### Patient Clinical Information:

Allergies: \_\_\_\_\_

Weight: \_\_\_\_\_ lb/kg Height: \_\_\_\_\_ In/cm TB Test Result: \_\_\_\_\_ Date: \_\_\_\_\_

### 5 PRESCRIPTION INFORMATION \*\*ITEMS BELOW THIS LINE WILL ONLY BE SENT FOR INFUSIONS DONE AT HOME/CORAM AIS\*\*

MEDICATION/SUPPLIES	ROUTE	DOSE /STRENGTH/ DIRECTIONS	QUANTITY/REFILLS
Catheter: <input type="checkbox"/> PIV <input type="checkbox"/> PORT <input type="checkbox"/> CVC/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) CVC/PICC: NS 10 mL & <input type="checkbox"/> Heparin 10 units/mL or <input type="checkbox"/> 100 units/mL 3-5 mL PORT: 10 mL sterile saline to access PORT w/ huber needle NS 10 mL & Heparin 100 units/mL 3-5 mL	Quantity: _____ Refills: _____
Hydration: <input type="checkbox"/> NS <input type="checkbox"/> D5W	IV	Pre: <input type="checkbox"/> 500 mL <input type="checkbox"/> 1000 mL <input type="checkbox"/> Other: _____ Concurrent: <input type="checkbox"/> 500 mL <input type="checkbox"/> 1000 mL <input type="checkbox"/> Other: _____ Post: <input type="checkbox"/> 500 mL <input type="checkbox"/> 1000 mL <input type="checkbox"/> Other: _____	Hydration max infusion rate _____ mL/hr (Adult max rate 250 mL/hr unless otherwise indicated)
<input type="checkbox"/> Epinephrine <b>**nursing requires**</b>	<input type="checkbox"/> IM <input type="checkbox"/> SC	<input type="checkbox"/> 1:1000, 0.3 mg/0.3 mL (greater than 30 kg/66lbs) <input type="checkbox"/> 1:1000, 0.15 mg/0.3 mL (15-30 kg/33-66lbs) <input type="checkbox"/> 1:1000, 0.01 mg/kg, Max 0.3 mg (under 15 kg) Mild-Moderate Reactions. May repeat in 3-5 minutes as needed For severe allergic reaction also call 911	Quantity: _____ Refills: _____
<input type="checkbox"/> Diphenhydramine Oral	PO	Premedication: <input type="checkbox"/> 12.5 mg/kg (0-30 kg) <input type="checkbox"/> 25 mg <input type="checkbox"/> 50 mg (Over 30 kg)	Quantity: _____ Refills: _____
<input type="checkbox"/> Diphenhydramine 50 mg/mL vial <b>**nursing required**</b>	<input type="checkbox"/> Slow IV <input type="checkbox"/> IM	<input type="checkbox"/> 1 mg/kg (under 15 kg) <input type="checkbox"/> 12.5 mg-50 mg (15-30 kg) <input type="checkbox"/> 25 mg-50 mg (Over 30 kg) If mild/moderate reaction: may repeat in 3-5 minutes as needed (Adult max dose: 100 mg/day) If severe allergic reaction: call 911	Quantity: _____ Refills: _____
<input type="checkbox"/> Flush Orders:	<input type="checkbox"/> Peripheral Access <input type="checkbox"/> Central Venous Access	<input type="checkbox"/> 10 mL NS post flush <input type="checkbox"/> 50 mL NS post flush (Recommended if no post-hydration) <input type="checkbox"/> Other: _____	Send quantity sufficient for medication days supply
<input type="checkbox"/> Additional Medication: _____	_____ _____ _____	_____ _____ _____	_____ _____ _____

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**CONFIDENTIALITY NOTICE:** This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by telephone and destroy all copies of this communication and any attachments.

Plan member privacy is important to us. Our employees are trained regarding the appropriate way to handle members' private health information.

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