

Fax Referral To: 1-877-232-5455 Address: 500 Ala Moana Blvd., Bldg 1 Honolulu, HI 96813

Six Simple Steps to Submitting a Referral PATIENT INFORMATION (Complete or include demographic sheet) DOB: \_\_\_\_\_ Gender: Male Female Patient Name: \_\_\_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. Alternate Phone: \_\_\_\_\_ Last Four of SSN: Primary Language: Email: 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: \_\_\_\_\_ \_\_\_\_\_ Contact Person: \_\_\_\_\_ 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:
 \_\_\_\_\_\_ Group #: \_\_\_\_\_\_
 Prescription Insurance: \_\_\_\_\_ Prescription Plan Telephone: \_\_\_ \_\_\_\_\_\_ Group #: \_\_\_\_\_ RX BIN #: \_\_\_\_\_ RX PCN #: \_\_\_\_\_ Policy ID: Check box if patient is enrolled in manufacturer copay assistance If yes, please provide ID#\_ DIAGNOSIS AND CLINICAL INFORMATION Needs by Date: Ship to: Patient Office Other: Diagnosis (ICD-10): K50.90 Crohn's Disease, unspecified, without complications Date of Diagnosis \_\_/\_\_/\_ Date of Diagnosis \_\_/\_\_/ K51.90 Ulcerative colitis, unspecified, without complications Other Code: \_\_\_\_\_ Description \_\_\_\_ **Patient Clinical Information:** □ NKDA Weight: \_\_\_\_ □ kg □ lb Height: \_\_\_\_ □ cm □ in Allergies: \_ Treatment status: New to therapy Continuation of therapy; Date of last treatment \_\_/\_/\_\_ Is the patient on samples? 
No Yes; If yes, how many samples has patient received? TB Test Date \_\_/\_\_/ Positive Negative Hepatitis status: \_\_\_\_\_ Prior therapy, treatment dates, and reason(s) for discontinuation: \_\_\_\_ **Nursing and Administration:** 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** Adalimumab-☐ Inject 40 mg SC every other week Ouantity: 40 mg/0.8 mL PEN ☐ Inject 160 mg SC on Day 1 (given in one day or split over two ☐ 28 davs aacf ☐ 40 mg/0.8 mL PFS (unbranded version consecutive days), 80 mg on Day 15, then 40 mg SC every other ☐ 84 days of Idacio) week starting Day 29 Refills: ☐ Inject 40 mg SC every other week Adalimumab-aatv ☐ 1 x 40 mg/0.4 mL PEN Ouantity: Inject 160 mg SC on Day 1 (given in one day or split over two (unbranded version 2 x 40 mg/0.4 mL PEN 28 days consecutive days), 80 mg on Day 15, then 40 mg SC every other of Yuflyma) ☐ 84 days week starting Day 29 Refills: ☐ Inject 40 mg SC every other week Quantity: Adalimumab-adaz ☐ 40 mg/0.4 mL PEN ☐ Inject 160 mg SC on Day 1 (given in one day or split over two 28 days (unbranded version 40 mg/0.4 mL PFS (with consecutive days), 80 mg on Day 15, then 40 mg every other 84 days of Hyrimoz) needle guard) week starting Day 29 Refills: Quantity: Refills: ☐ Dose: \_\_\_\_ Other Strength: 6 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED) "Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / May Substitute / Product Selection Permitted / DAW / May Not Substitute Substitution Permissible Prescriber's Signature: \_\_ Prescriber's Signature: \_\_ 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.

Phone: 1-808-254-2727

NCPDP: 1203417

|                       |  |                              | Prescriber Information  |                                       |
|-----------------------|--|------------------------------|---|---------------------------------------|
|                       |  |                              | Patient Phone:  |                                       |
|                       |  |                              |   | <del></del>                           |
|                       |  | Pr                           | rescriber Phone:  |                                       |
| Patient Clinical In   |  |                              |   | <b>-</b>                              |
| Allergies:            |  | NKDA W                       | /eight:   | l cm                                  |
|                       | New to therapy Continua                                |                              |   |                                       |
|                       |  |                              | tient received?   |                                       |
|                       |  |                              | is status:  |                                       |
| PRESCRIPTION          |  | uation                       |   |                                       |
| MEDICATION            | STRENGTH   |                              | DOSE & DIRECTIONS   | QUANTITY/REFILLS                      |
|                       |  |                              | SC every other week   | ,                                     |
|                       |  | ☐ Inject 40 mg               |   | Quantity:                             |
| Adalimumab-           | ☐ 20 mg/0.4 mL PFS                                     |                              | SC on Day 1, 40mg Day 15, then 20 mg                          | 28 days                               |
| fkjp                  | ☐ 40 mg/0.8 mL PFS                                     |                              | k starting Day 29   | 84 days                               |
| (unbranded            | 40 mg/0.8 mL PEN                                       |                              | SC on Day 1 (given in one day or split over                   | Refills:                              |
| version of Hulio)     |  |                              | days), 80 mg on Day 15, then 40 mg every                      |                                       |
| voision or mailo,     |  | other week start             |   |                                       |
|                       |  |                              | SC every other week   |                                       |
|                       |  |                              | SC every other week   | Quantity:                             |
| Amjevita              | ☐ 20 mg/0.4 mL PFS                                     |                              | SC on Day 1, 40 mg on Day 15, then 20 mg                      | 28 days                               |
| (adalimumab-          | ☐ 40 mg/0.8 mL PFS                                     |                              | k starting Day 29   | 84 days                               |
| atto)                 | ☐ 40 mg/0.8 mL PEN                                     |                              | SC on Day 1 (given in one day or split over                   | Refills:                              |
|                       | 3 - 1  |                              | days), 80 mg on Day 15, 40 mg every other                     |                                       |
|                       |  | week starting Da             |   |                                       |
|                       |  |                              | ase (Adult and Pediatric ≥ 6 years old)                       |                                       |
|                       |  | Induction Dose:              | ,                       |                                       |
|                       |  |                              | g/kg (Dose =mg) at weeks 0, 2,                                |                                       |
|                       |  | 6 and every 8 we             |   |                                       |
|                       |  |                              | ase (Adult) Maintenance Dose:                                 |                                       |
|                       |  |                              | mg/kg (Dose =mg) every 8 weeks                                |                                       |
|                       |  |                              | ase (Pediatric ≥6 years old)                                  |                                       |
|                       |  | Maintenance Do               |   | Quantity:                             |
| Avsola                | 100 mg vial  |                              | <u>se</u> .<br>g/kg (Dose =mg) every 8 weeks                  | # of 100 mg vial(s)                   |
|                       |  |                              | olitis (Adult and Pediatric ≥ 6 years old)                    | Refills:                              |
|                       |  | Induction Dose:              | onds (Addit and 1 calatric = 0 years old)                     | Renus.                                |
|                       |  |                              | g/kg (Dose =mg) at weeks 0, 2,                                |                                       |
|                       |  | 6 and every 8 we             |   |                                       |
|                       |  | l ′                          | eeks therearter<br>blitis (Adult and Pediatric ≥ 6 years old) |                                       |
|                       |  |                              | · · · · · · · · · · · · · · · · · · ·                         |                                       |
|                       |  |                              | se: Infuse IV at 5 mg/kg                                      |                                       |
|                       |  |                              | _mg) every 8 weeks  | l Occanita in 41.55                   |
| ☐ Cim=:-              | Cinamia Chautau Kit (Cinamitili aliania)               |                              | Inject SC 400 mg (2 injections) on day 1, and                 | -                                     |
| ☐ Cimzia              | Cimzia Starter Kit (6 prefilled syringes)              |                              | I. If response occurs, follow with                            | (6 prefilled syringes)                |
|                       | Посо и и и и   | 400 mg every fo              |   | Refills: 0                            |
| Cimzia                | 200 mg/1 mL prefilled syringe                          |                              | se: Inject SC 400 mg  | Quantity:                             |
| =                     | 200 mg vial  | (2 injections) eve           | ery 4 weeks   | Refills:                              |
|                       |  | Induction Dose:              |   | Quantity:                             |
|                       |  | ☐ Week 0: Infus              | sion 300 mg IV  | 1 Vial                                |
|                       |  | ☐ Week 2: Infus              |   | 2 Vials                               |
|                       | 300 mg vial  | ☐ Week 6: Infus              | <del>-</del>  | 3 Vials                               |
| ☐ Entyvio             |  |                              |   | Refills: 0                            |
|                       |  | Maintenance Do               |   | Quantity: 1 Vial                      |
|                       |  | ☐ inject 300 mg              | g IV every 8 weeks  | Refills:                              |
|                       | 108 mg/0.68 mL PEN                                     | ☐ Inject 108 mg              | SC every 2 weeks  | Quantity: 2 pens<br>Refills:          |
| 6 PRESCRIBER S        | ∣<br>SIGNATURE REQUIRED (STAMP SIGN                    | IATURE NOT AL                | LOWED)  | Nonus                                 |
|                       | " / Brand Medically Necessary / Do Not Substitute /    |                              | May Substitute / Product Selection Permitted /                |                                       |
| DAW / May Not Subs    |  | 110 GabatitutiOH /           | Substitution Permissible                                      |                                       |
|                       |  | ate:                         | Prescriber's Signature:                                       | Date:                                 |
|                       | -  |                              |   |                                       |
| CA, MA, NC & PR: Inte | erchange is mandated unless Prescriber writes the word | s " <b>No Substitution</b> " | ATTN: New York and Iowa providers,                            | please submit electronic prescription |

|                  |  | ase Complete Patient and                                       |   |                                    |
|------------------|--|--|---|------------------------------------|
|                  |  |  | Patient Phone:                                    |                                    |
|                  | ·  |  |   |                                    |
|                  | 9:                                       | Pi   | rescriber Phone:                                  |                                    |
| Patient Clinica  | <u> </u>                                 | NKDA W   | /eight: kg 🗌 lb Height: 📗                         | cm $\square$ in                    |
|                  | us: New to therapy                       | Continuation of therapy: F                                     | Date of last treatment//                          |                                    |
|                  |  |  | tient received?                                   |                                    |
| TB Test Date _   | _//                                      | Negative  Hepatit  | is status:  |                                    |
| _                |  | (s) for discontinuation:                                       |   | <u> </u>                           |
|                  | ON INFORMATION                           |  |   |                                    |
| MEDICATION       | STRENGTH                                 |  | SE & DIRECTIONS                                   | QUANTITY/REFILLS                   |
|                  |  | Inject 40 mg SC every other                                    |   | Overtity:                          |
|                  | ☐ 40 mg/0.4 mL PEN                       |  | given in one day or split over two consecutive    | Quantity:  28 days                 |
| ☐ Hadlima        | ☐ 40 mg/0.8 mL PEN                       | days), 80 mg on Day 15,<br>then 40 mg every other week s       | tarting Day 20                                    | 84 days                            |
| <u> </u>         | ☐ 40 mg/0.4 mL PFS                       |  | given in one day or split over two consecutive    | Refills:                           |
|                  | ☐ 40 mg/0.8 mL PFS                       | days), 80 mg on Day 15, then                                   | green in one day or opinione in o concedure       |                                    |
|                  |  | 40 mg every other week startin                                 | g Day 29  |                                    |
|                  |  | ☐ Inject 20 mg SC every other                                  |   |                                    |
|                  |  | ☐ Inject 40 mg SC every other                                  |   | Quantity:                          |
| _                | 20 mg/0.4 mL PFS                         |  | 0 mg Day 15, then 20 mg every other week          | 28 days                            |
| ☐ Hulio          | 40 mg/0.8 mL PFS                         | starting Day 29  |   | 84 days                            |
|                  | ☐ 40 mg/0.8 mL PEN                       |  | given in one day or split over two consecutive    | Refills:                           |
|                  |  | days), 80 mg on Day 15, then<br>40 mg every other week startin | a Doy 20  |                                    |
|                  |  | ☐ Inject 20 mg SC every week                                   |   |                                    |
|                  |  | ☐ Inject 20 mg SC every other                                  |   |                                    |
|                  |  | ☐ Inject 40 mg SC every week                                   |   |                                    |
|                  |  | ☐ Inject 40 mg SC every other                                  |   |                                    |
|                  |  | ☐ Inject 80 mg SC every other                                  | week  |                                    |
|                  |  | ☐ Inject 80 mg SC on day 1, 40                                 | O mg on day 15, then 20 mg every other week       |                                    |
|                  |  | starting Day 29  |   |                                    |
|                  | 20 mg/0.2 mL PFS                         |  | o mg on day 8, 40 mg on day 15, then 20 mg        | Quantity:                          |
| □ I I i inne ime | 40 mg/0.4 mL PFS                         | every week starting day 29                                     | omg on day 8, 40 mg on day 15, then 40 mg         | 28 days                            |
| Humira           | ☐ 40 mg/0.4 mL Pen<br>☐ 80 mg/0.8 mL PFS | every other week starting day 2                                |   | 84 days                            |
|                  | 80 mg/0.8 mL Pen                         |  | single-dose or split over two consecutive         | ivenus                             |
|                  |  | days), 80 mg on Day 8, 80 mg o                                 |   |                                    |
|                  |  | 80 mg every other week startin                                 |   |                                    |
|                  |  | ☐ Inject 160 mg SC on Day 1 (s                                 | single-dose or split over two consecutive         |                                    |
|                  |  | days), 80 mg on Day 8, 80 mg o                                 | • •   |                                    |
|                  |  | 40 mg every week starting on [                                 |   |                                    |
|                  |  |  | single-dose or split over two consecutive         |                                    |
|                  |  | ays), 80 mg on Day 15, then 40                                 | 0 mg every other week starting on Day 29          |                                    |
|                  | ☐ 40 mg/0.4 mL PEN                       |  | r weeк<br>Omg Day 15, then 20 mg every other week | Quantity:                          |
| Hyrimoz          | 40 mg/0.4 mL PFS                         | starting Day 29  | ong bay 10, mon 20 mg every other week            | 28 days                            |
| ,                | (with needle guard)                      | 9  | given in one day or split over two consecutive    | 84 days                            |
|                  | ,  |  | 0 mg every other week starting Day 29             | Refills:                           |
| Other            | Strength:                                | ☐ Dose:  |   | Quantity: Refills:                 |
| 6 PRESCRIB       | ER SIGNATURE REQUII                      | RED (STAMP SIGNATURE N   |   | 1                                  |
|                  |  | Do Not Substitute / No Substitution /                          | May Substitute / Product Selection Permitted /    |                                    |
| DAW / May Not S  | substitute                               |  | Substitution Permissible                          |                                    |
| Prescriber's     | Signature:                               | Date:  | Prescriber's Signature:                           | Date:                              |
| CA, MA, NC & PR  | t: Interchange is mandated unless Pres   | criber writes the words "No Substitution"                      | ATTN: New York and Iowa providers, ple            | ase submit electronic prescription |

|  | Please Co   | <u>mplete Patient and I</u>  | Prescriber Information  |                     |  |
|--|---|--|---|---------------------|--|
|  |   |  | Patient Phone:  |                     |  |
| Patient Address: _                       |   |  |   |                     |  |
|  |   | Pr   | rescriber Phone:  |                     |  |
| Patient Clinical I                       |   |  | 65.10 D II D  | 🗖 • .               |  |
| illergies:                               | o: ☐ Now to thorony ☐ C                                 | NKDA W   | /eight:   | cm 🔛 in             |  |
|  |   |  | tient received?   |                     |  |
|  | //_ Positive Negative                                   |  | is status:  |                     |  |
|  |   |  |   |                     |  |
|  | ION INFORMATION   |  |   |                     |  |
| MEDICATION                               | STRENGTH  | D  | OSE & DIRECTIONS  | QUANTITY/REFILL     |  |
|  |   |  | It and Pediatric ≥ 6 years old) Induction Dose:   |                     |  |
|  |   | Infuse IV at 5 mg/kg (Dos  | se =mg) at weeks 0, 2, 6 and every 8  |                     |  |
| ☐ Inflectra                              |   | weeks thereafter   |   |                     |  |
|  |   | Crohn's Disease (Adu   |   |                     |  |
|  |   |  | e IV at 5-10 mg/kg (Dose =mg) every   |                     |  |
| ☐ Infliximab                             |   | 8 weeks  |   | Quantity:           |  |
|  | 100 mg vial   | Crohn's Disease (Pedi  | •   | # of 100 mg vial(s) |  |
| Remicade                                 |   | 8 weeks  | e IV at 5 mg/k (Dose =mg) every   | Refills:            |  |
| Nerriicade                               |   |  | ult and Pediatric ≥ 6 years old) Induction  |                     |  |
|  |   |  | g (Dose =mg) at weeks 0, 2, 6 and   |                     |  |
| Renflexis                                |   | every 8 weeks thereafter   |   |                     |  |
|  |   | Ulcerative Colitis (Adu  | ☐ Ulcerative Colitis (Adult and Pediatric ≥ 6 years old) Maintenance  |                     |  |
|  |   | Dose: Infuse IV at 5 mg/k  | g (Dose =mg) every 8 weeks  |                     |  |
|  |   | Induction Dose  Week 0: Infuse 300 mg via IV infusion over at least 30 minutes Week 4: Infuse 300 mg via IV infusion over at least 30 minutes Week 8: Infuse 300 mg via IV infusion over at least 30 minutes |   | Quantity:           |  |
|  |   |  |   | 1 Vial              |  |
|  |   |  |   | 2 Vials 3 Vials     |  |
|  | 300 mg/15 mL single dose                                |  |   | Refills: 0          |  |
|  | vial  | Induction Dose  Week 0: Infuse 900 mg via IV infusion over at least 30 minutes  Week 4: Infuse 900 mg via IV infusion over at least 30 minutes   |   | Quantity:           |  |
|  |   |  |   | 3 Vials             |  |
| П оh                                     |   |  |   | 6 Vials             |  |
| Omvoh                                    |   |  |   | 9 Vials             |  |
|  |   | Week 8: Infuse 900 mg via IV infusion over at least 30 minutes   |   | Refills: 0          |  |
|  | ☐ 2 x 100 mg/mL PEN                                     | Maintenance Dose   |   |                     |  |
|  | 2 x 100 mg/mL PFS                                       |  | Inject 200 mg SC (given as two consecutive injections of 100 mg each) at Week 12 and every 4 weeks thereafter |                     |  |
|  | 1 x 100 mg/mL + 1 x 200 mg/                             | each) at week 12 and eve   | ery 4 weeks thereafter  | Quantity:  28 days  |  |
|  | 2 mL PEN  | Maintenance Dose   |   | 84 days             |  |
|  | 1 x 100 mg/mL + 1 x 200 mg/                             |  | en as two consecutive injections of 100 mg  | Refills:            |  |
|  | 2 mL PFS  | each) at Week 12 and eve   | ery 4 weeks thereafter  |                     |  |
|  | 130 mg/26 mL (5 mg/mL) IV                               |  |   | Quantity:           |  |
|  | single-dose vial  | Single IV Induction Dose:  |   | 2 Vials             |  |
|  | Date Infusion was completed or                          |  | at Week 0: # of vials to be used 2  | 3 Vials             |  |
| ☐ Pyzchiva                               | scheduled: (This date is                                | more than 55 kg to 85  | ☐ 4 Vials   |                     |  |
|  | needed to determine shipment of Stelara SC maintenance  | more than 85 kg 520 i  | mg at Week 0: # of vials to be used 4   | Refills: 0          |  |
|  | dosage)   |  |   |                     |  |
|  | 90 mg/mL  | ☐ Inject 90 mg SC 8 wee  | eks after the initial IV induction dose, then   | Quantity:           |  |
| Pyzchiva                                 | SC dose in a single-dose                                | every 8 weeks thereafter.  |   | Refills:            |  |
|  | prefilled syringe                                       | ☐ Inject 90 mg SC every  | y 8 weeks   |                     |  |
|  |   | Induction Dose:  |   | Quantity:           |  |
| Rinvoq                                   | 45 mg   | Take 1 tablet once dai   |   | Refills:            |  |
|  |   | ☐ Take 1 tablet once dai   | ly for 12 weeks   |                     |  |
| PRESCRIR                                 | ER SIGNATURE REQUIRE                                    | D (STAMP SIGNAT  | URF NOT ALLOWED)  |                     |  |
|  |   |  |   |                     |  |
| "Dispense As Writte<br>DAW / May Not Sub | en" / Brand Medically Necessary / Do Not Si<br>ostitute | ubstitute / No Substitution /  | May Substitute / Product Selection Permitted / Substitution Permissible                                       |                     |  |
| •  | ignature:   | Date:  | Prescriber's Signature:   | Date:               |  |
|  | _   |  | -   |                     |  |

|                     |  | nplete Patient and Pr   |  |  |
|---------------------|--|---|--|--|
|                     |  |   | Patient Phone:                                     |  |
| Patient Address: _  |  |   |  |  |
| Prescriber Name:    |  | Pres  | scriber Phone:                                     |  |
| Patient Clinical I  | nformation:                                      | _   |  | _  |
| Allergies:          |  | ☐ NKDA We   | ight: 🗌 kg 🗌 lb Height: 🗌                          | cm 🔲 in                                    |
|                     |  |   | te of last treatment//                             |  |
|                     | samples? 🔲 No 🗌 Yes; If yes, how                 | · · · · · · · · · · · · · · · · · · ·                               |  |  |
|                     | // Positive Negative                             |   | status:  |  |
| _                   |  | continuation:   |  |  |
|                     | ON INFORMATION                                   | D   | SEE & DIDECTIONS                                   | OHANTITY/DEELLO                            |
| MEDICATION          | STRENGTH   |   | DSE & DIRECTIONS                                   | QUANTITY/REFILLS                           |
| Rinvoq              | ☐ 15 mg  | Maintenance Dose:   | il.  | Quantity:                                  |
|                     | 30 mg  | ☐ Take 1 tablet once da   | шу   | Refills:                                   |
|                     | 130 mg/26 mL (5 mg/mL) IV                        | Single IV Induction Dose  | ;  | Quantity:                                  |
|                     | single-dose vial  Date Infusion was completed or | ☐ 55 kg or less 260 mg  | at Week 0: # of vials to be used 2                 | 3 Vials                                    |
| Selarsdi            | •  | more than 55 kg to 8  | 5 kg 390 mg at Week 0: # of vials to be            | 4 Vials                                    |
|                     | scheduled: (This date is                         | used 3  |  |  |
|                     | needed to determine shipment of                  | more than 85 kg 520   | mg at Week 0: # of vials to be used 4              | Refills: 0                                 |
|                     | Stelara SC maintenance dosage) 90 mg/mL          | ☐ Inject 90 mg SC 8 wg  | eks after the initial IV induction dose, then      | Quantity:                                  |
| Selarsdi            | SC dose in a single-dose prefilled               | every 8 weeks thereafter  |  | Refills:                                   |
| Selaisui            | syringe  | ☐ Inject 90 mg SC ever  |  | ixemus.                                    |
|                     | Syringe  | ☐ Inject 90 mg SC ever  |  | Quantity:                                  |
| Simlandi            | 40 mg/0.4 mL PEN                                 |   | Day 1 (given in one day or split over two          | 28 days                                    |
| (adalimumab-        | ☐ 40 mg/0.4 mL PFS                               |   | g on Day 15, then 40mg SC every other              | 84 days                                    |
| ryvk)               | ☐ 80 mg/0.8 mL PEN                               | week starting Day 29  | g on Bay 10, then 40mg 00 every other              | Refills:                                   |
|                     | 100 mg/mL in a single-dose                       |   | t SC 200 mg initially (given as 2                  | Tronico.                                   |
|                     | prefilled SmartJect autoinjector                 |   | of 100 mg each) at Week 0, followed by             | Quantity:                                  |
| Simponi             | 100 mg/mL in a single-dose                       | •   | nen 100 mg every 4 weeks                           | Refills:                                   |
|                     | prefilled syringe                                | <u> </u>  | nject SC 100 mg every 4 weeks                      |  |
|                     | , , ,  | Intravenous CD Inducti  |  | Quantity: 1 Vial Refills: 0                |
|                     |  | Week 0: Infuse 600 mg IV over at least one hour                     |  | Quantity: 1 Vial Refills: 0                |
|                     |  |   | ng IV over at least one hour                       | Quantity: 1 Vial Refills: 0                |
|                     | ☐ 600 mg/10 mL                                   | _   | ng IV over at least one hour                       |  |
|                     | (60 mg/mL) single dose vial                      | Intravenous UC Inducti  | · ·  |  |
|                     |  |   | Week 0: Infuse 1,200 mg IV over at least two hours |  |
| Па                  |  |   | mg IV over at least two hours                      | Quantity: 2 Vials Refills: 0               |
| Skyrizi             |  | Week 8: Infuse 1,200  | mg IV over at least two hours                      | Quantity: <u>2 Vials</u> Refills: <u>0</u> |
|                     | ☐ 180 mg/1.2 mL (150 mg/mL)                      | Maintenance UC or CD  | Dose (Option 1):                                   |  |
|                     | single-dose prefilled cartridge                  | Inject 180 mg SC week 12 and every 8 weeks thereafter               |  | Quantity: 1 device with                    |
|                     | with on-body injector                            | ☐ Inject 180 mg SC eve  | ry 8 weeks   | prefilled cartridge                        |
|                     | ☐ 360 mg/2.4 mL                                  | Maintenance UC or CD  |  |  |
|                     | (150 mg/mL) single-dose prefilled                |   | ek 12 and every 8 weeks thereafter                 | Refills:                                   |
|                     | cartridge with on-body injector                  | ☐ Inject 360 mg SC eve  | ery 8 weeks  |  |
|                     | 130 mg/26 mL (5 mg/mL) IV                        | Single IV Induction Dose  |  | Quantity:                                  |
|                     | single-dose vial                                 |   | at Week 0: # of vials to be used 2                 | 2 Vials                                    |
| Stelara             | Date Infusion was completed or                   |   | 5 kg 390 mg at Week 0: # of vials to be            | 3 Vials                                    |
| 5.5.6.6             | scheduled: (This date is                         | used 3  | ong Joo mg at Wook o. # of Viais to be             | 4 Vials                                    |
|                     | needed to determine shipment of                  |   | mg at Week 0: # of vials to be used 4              | Refills: 0                                 |
|                     | Stelara SC maintenance dosage)                   |   |  |  |
|                     | 90 mg/mL   | ☐ Inject 90 mg SC 8 weeks after the initial IV induction dose, then |  | Quantity:                                  |
| ☐ Stelara           | SC dose in a single-dose prefilled               |   |  | Refills:                                   |
|                     | syringe  | ☐ Inject 90 mg SC ever  | y 8 weeks  |  |
| S DDESC DIDE        | ER SIGNATURE REQUIRED                            | (STAMD SIGNATII   | IDE NOT ALLOWED)                                   |  |
|                     |  |   |  |  |
| "Dispense As Writte | n" / Brand Medically Necessary / Do Not Subs     | stitute / No Substitution /   | May Substitute / Product Selection Permitted /     |  |
|                     | ctituto  |   |  |  |
| DAW / May Not Sub   | stitute<br><b>gnature:</b>                       | Date:   | Substitution Permissible  Prescriber's Signature:  | Date:                                      |

|               |   | Prescriber Information  | nplete Patient and I  | <u>Please Con</u>   |   |
|---------------|---|---|---|---|---|
|               |   | Patient Phone:  |   |   |   |
|               |   |   |   | S:  |   |
|               |   | escriber Phone:   | Pr  | ne:   |   |
|               | cm 🗌 in   | /eight: ☐ kg ☐ lb Height:   | □ NKDA W  | al Information:   | Allergies:  |
|               |   | ate of last treatment//<br>ient received?<br>s status:  | many samples has pat  |   | Is the patient o  |
|               |   |   | continuation:   | treatment dates, and reason(s) for dis  | Prior therapy, t  |
|               |   |   |   | TION INFORMATION  | <b>PRESCRIP</b>   |
| NTITY/REFILLS | QUANTITY/   | SE & DIRECTIONS   | DO  | STRENGTH  | MEDICATION  |
|               | Quantity: 2 Vials 3 Vials 4 Vials Refills: 0  | se:<br>g at Week 0: # of vials to be used 2<br>85 kg 390 mg at Week 0: # of vials to<br>0 mg at Week 0: # of vials to be used 4   | more than 55 kg to be used 3  | 130 mg/26 mL (5 mg/mL) IV single-<br>dose vial Date Infusion was completed or<br>scheduled: (This date is<br>needed to determine shipment of<br>Stelara SC maintenance dosage)      | Steqeyma  |
|               | Quantity:<br>Refills:   |   | ☐ Inject 90 mg SC 8 w<br>then every 8 weeks the<br>☐ Inject 90 mg SC eve  | 90 mg/mL<br>SC dose in a single-dose prefilled<br>syringe   | Steqeyma  |
|               |   |   | Intravenous UC or CD  | , , ,   |   |
| Refills: 0    | Quantity: 1 Vial Refills:<br>Quantity: 1 Vial Refills:<br>Quantity: 1 Vial Refills: | mg IV over at least one hour<br>mg IV over at least one hour<br>mg IV over at least one hour  | Week 0: Infuse 200 Week 4: Infuse 200   | 200 mg/20 mL<br>(10 mg/mL) single-dose vial   |   |
| k Refills: 0  | Quantity:1Pack Refills<br>Quantity:1Pack Refills<br>Quantity:1Pack Refills          | mg SC at Week 0<br>mg SC at Week 4  | Subcutaneous CD Ind Week 0: Inject 400 Week 4: Inject 400 Week 8: Inject 400  | ☐ Induction Pack for Crohn's<br>Disease (2 x 200 mg/2 mL Pens)  | ☐ Tremfya   |
|               | Quantity: 56 DS Ref   | mg SC at week 16 and every 8 weeks  | Maintenance UC or CI Week 16: Inject 100 thereafter Inject 100 mg SC ev   | ☐ 200 mg/2 mL PEN ☐ 200 mg/2 mL PFS ☐ 100 mg/mL single-dose One-  |   |
| B DS Refills: | Quantity: 28 DS Ref   | mg SC week 12 and every 4 weeks   | Maintenance UC or CI Week 12: Inject 200 thereafter Inject 200 mg SC ex   | Press patient-controlled injector  100 mg/mL PEN  100 mg/mL PFS   |   |
| IDS Refills:  | Quantity: 84 DS Ref   | very 4 weeks  | ☐ Inject 200 mg 3C ev   |   |   |
|               | Quantity: 0<br>Refills: 0   | TOUCH/Tysabri enrollment form and as your preferred pharmacy provider. contact TOUCH Prescribing Program  | indicate CVS/specialty  | NA  | ☐ Tysabri   |
|               | Quantity: 2 Vials 3 Vials 4 Vials Refills: 0  | Single IV Induction Dose:  55 kg or less 260 mg at Week 0: # of vials to be used 2 more than 55 kg to 85 kg 390 mg at Week 0: # of vials to be used 3 more than 85 kg 520 mg at Week 0: # of vials to be used 4 |   | 130 mg/26 mL (5 mg/mL) IV single-dose vial Date Infusion was completed or scheduled: (This date is needed to determine shipment of Stelara SC maintenance dosage)                   | Ustekinumab   |
|               | Quantity:<br>Refills:   | ☐ Inject 90 mg SC 8 weeks after the initial IV induction dose, then every 8 weeks thereafter. ☐ Inject 90 mg SC every 8 weeks   |   | 90 mg/mL<br>SC dose in a single-dose prefilled<br>syringe   |   |
| Refills:      | Quantity: Refills   |   | _ , _ ,   | , ,   | Other   |
|               |   |   | 1   | BER SIGNATURE REQUIRED  | _   |
|               | Date: _   | May Substitute / Product Selection Permitted / Substitution Permissible  Prescriber's Signature:  |   | ritten" / Brand Medically Necessary / Do Not Sub<br>Substitute<br><b>Signature:</b>   | DAW / May Not S   |
| <br>Da        | Quantity:   Refills:   Quantity:  | veeks after the initial IV induction dose, ereafter. ery 8 weeks  URE NOT ALLOWED)  May Substitute / Product Selection Permitted / Substitution Permissible  Prescriber's Signature:                            | more than 85 kg 52  Inject 90 mg SC 8 w then every 8 weeks the Inject 90 mg SC eve Dose:  (STAMP SIGNAT stitute / No Substitution / | Stelara SC maintenance dosage)  90 mg/mL SC dose in a single-dose prefilled syringe  Strength:  BER SIGNATURE REQUIRED  ritten" / Brand Medically Necessary / Do Not Sub Substitute | "Dispense As Wi<br>DAW / May Not S<br><b>Prescriber's</b> |

|  |   |  | Prescriber Information  |   |
|--|---|--|---|---|
|  |   |  | Patient Phone:  |   |
| _  |   |  | anni hay Dhana.   |   |
| rescriber Name:                          |   | Pr   | rescriber Phone:  |   |
| <b>atient Clinical I</b><br>.llergies:   |   | IKDA W   | /eight: 🗌 kg 🗌 lb Height: 🔲 c   | m∏ in   |
|  |   | on of therapy. D   | eight kg _ to height co   |   |
|  |   |  | ient received?  |   |
|  |   |  | s status:   |   |
| rior therapy, tre                        | atment dates, and reason(s) for discontinua   | ation:   |   |   |
| PRESCRIPT                                | ION INFORMATION   |  |   |   |
| MEDICATION                               | STRENGTH  |  | DOSE & DIRECTIONS   | QUANTITY/REFILLS                                |
| ☐ Velsipity                              | 2 mg  | ☐ Take 1 table   | t by mouth once daily   | Quantity:  30 days  90 days  Refills:           |
| ☐ Xeljanz                                | ☐ 5 mg<br>☐ 10 mg   | 10 mg twice<br>mg twice daily,<br>lowest effective<br>Discontinue Xel<br>twice daily if ad   | Quantity:<br>Refills:   |   |
| ☐ Yesintek                               | 130 mg/26 mL (5 mg/mL) IV single-dose vial Date Infusion was completed or scheduled: (This date is needed to determine shipment of Stelara SC maintenance dosage) | Single IV Induct 55 kg or less more than 5 be used 3   |   | Quantity: 2 Vials 3 Vials 4 Vials Refills: 0    |
| Yesintek                                 | 90 mg/mL<br>SC dose in a single-dose prefilled syringe  | ☐ Inject 90 mg SC 8 weeks after the initial IV induction dose, then every 8 weeks thereafter. ☐ Inject 90 mg SC every 8 weeks  |   | Quantity:<br>Refills:                           |
| ☐ Yuflyma                                | ☐ 40 mg/0.4 mL PEN ☐ 40 mg/0.4 mL PFS ☐ 40 mg/0.4 mL PFS (with safety guard) ☐ 80 mg/0.8 mL PEN   | ☐ Inject 40 mg SC every other week ☐ Inject 160 mg SC on Day 1 (given in one day or split over two consecutive days), 80 mg on Day 15, then 40 mg every other week starting Day 29 |   | Quantity: 28 days 84 days Refills:              |
| ☐ Zeposia                                | 28-day Starter Kit: (Four 0.23 mg capsules, three 0.46 mg capsules, and one bottle containing twenty-one 0.92 mg capsules)  | Take 0.23 mg capsule orally once daily on days 1-4, then 0.46 mg capsule once daily on days 5-7, then 0.92 mg capsule once daily starting on day 8 and thereafter.                 |   | Quantity: 1 Kit (28-day<br>supply)<br>Refill: 0 |
| Zeposia                                  | 7-Day Starter Pack<br>(4 capsules of 0.23 mg and 3 capsules of<br>0.46 mg)  | Take 0.23 mg capsule orally once daily on days 1-4, followed by 0.46 mg capsule once daily on days 5-7.  |   | Quantity: 7-day supply<br>Refill: 0             |
| Zeposia                                  | 0.92 mg capsules  | ☐ Take 0.92 mg capsule orally once daily.  |   | Quantity:<br>Refills:                           |
| Zymfentra                                | ☐ 120 mg/ mL PEN☐ 120 mg/ mL PFS (with needle guard)  | Maintenance dose only starting at week 10: ☐ 120 mg SC once every two weeks  |   | Quantity: 28 days 84 days Refills:              |
| Other                                    | Strength:   | Dose:  |   | Quantity:                                       |
| PRESCRIBI                                | ER SIGNATURE REQUIRED (STA  | MP SIGNAT  | URE NOT ALLOWED)  | 1   |
| "Dispense As Writte<br>DAW / May Not Sub | en" / Brand Medically Necessary / Do Not Substitute / Nostitute   |  | May Substitute / Product Selection Permitted / Substitution Permissible Prescriber's Signature: | Date:   |

## Inflammatory Bowel Disease Enrollment Form Nursing Orders

|   | Flea                      | se Complete Patient and P                         | rescriber information                          |                                       |
|---|---------------------------|---|--|---------------------------------------|
|   |                           |   | Patient Phone:                                 |                                       |
| Patient Address:  |                           |   |  |                                       |
| Prescriber Name:  |                           | Pre   | escriber Phone:                                |                                       |
| Patient Clinical Informatio                             |                           |   |  |                                       |
| Allergies: Now  | to thorony                | NKDA We   | eight:   | _                                     |
| s the nationt on samples?                               | IO merapy  ☐ No ☐ Vectors | Continuation of therapy; Da                       | ient received?                                 |                                       |
| TB Test Date//  | Positive No               | egative Hepatitis                                 | s status:                                      |                                       |
|   |                           | ) for discontinuation:                            |  |                                       |
| PRESCRIPTION INFO                                       |                           |   | ONLY BE SENT FOR INFUSIONS DONE                | AT HOME/CORAM AIS**                   |
| MEDICATION/SUPPLIES                                     | ROUTE                     |   | NGTH/ DIRECTIONS                               | QUANTITY/REFILLS                      |
|   |                           | Catheter Care/Flush - Only or                     | n drug admin days – SASH or PRN to             | -                                     |
|   |                           | maintain IV access and paten                      | cy   |                                       |
| Catheter:   |                           | PIV: NS 5 mL (Heparin 10 units                    | s/mL 3-5 mL if multiple days)                  | Quantity:                             |
| ☐ PIV ☐ PORT  | IV                        |   | eparin 10 units/mL or 🗌 100 units/mL           | Refills:                              |
| CVC/PICC  |                           | 3-5 mL.   | DODT // /                                      |                                       |
|   |                           | PORT: 10 mL sterile saline to a                   |  |                                       |
|   |                           | NS 10 mL & Heparin 10                             | o units/file 3-5ffle.                          | Hydration max infusion                |
|   |                           | Pre: 500 mL 1000 mL                               | Other:   | rate mL/hr                            |
| Hydration:  | IV                        | Concurrent: 500 mL 100                            |  | (Adult max rate                       |
| ☐ NS ☐ D5W  |                           | Post: 500 mL 1000 mL                              |  | 250 mL/hr unless                      |
|   |                           |   |  | otherwise indicated)                  |
|   |                           | 1:1000, 0.3mg/0.3 mL (gre                         | eater than 30 kg/66 lbs)                       |                                       |
| ☐ <i>Epinephrine</i>                                    | □ ім                      | 1:1000, 0.15mg/0.3 mL (15                         | -30 kg/33-66 lbs)                              | Quantity:                             |
| **nursing requires**                                    | □ sc                      | 1:1000, 0.1 mg/kg, Max 0.3                        |  | Refills:                              |
| riar sirig requires                                     |                           |   | ay repeat in 3-5 minutes as needed             | Nonus.                                |
|   |                           | for severe allergic reaction, als                 | so call 911                                    |                                       |
| Diphenhydramine   |                           | Premedication:                                    |  |                                       |
| Oral  | PO                        | 12.5 mg/kg (0-30 kg)                              |  | Quantity:                             |
|   |                           | ☐ 25 mg<br>☐ 50 mg (Over 30 kg)                   |  | Refills:                              |
|   |                           | ☐ 1 mg/kg (under 15 kg)                           |  |                                       |
| Diphenhydramine   |                           | 12.5 mg-50 mg (15-30 kg)                          |  |                                       |
| 50 mg/mL vial   | ☐ Slow IV                 | 25 mg-50 mg (Over 30 kg)                          |  | Quantity:                             |
| **nursing required**                                    | ☐ IM                      |   | y repeat in 3-5 minutes as needed              | Refills:                              |
|   |                           | (Adult max dose: 100 mg/day                       | •  |                                       |
|   |                           | If severe allergic reaction: call                 |  |                                       |
|   | Peripheral                | 10 mL NS post flush                               |  | Cand avantity                         |
| Flush Orders:   | Access                    | 50 mL NS post flush                               |  | Send quantity sufficient              |
| riusii Orders.  | ☐ Central                 | (recommended if no post-hyd                       | dration)                                       | for medication days                   |
|   | Venous                    | Other:  |  | supply                                |
| _   | Access                    | - Guier.  |  | оцрогу                                |
| Additional  |                           |   |  |                                       |
| Medication:   |                           |   |  |                                       |
|   |                           |   |  |                                       |
| Deticat is into a start in matter :                     | a sit in un ausans -      | CTAMP CICNATURE NOT ALL OWNER                     | A  | munidad on pode diferential to the    |
| Patient is interested in patient supper PRESCRIBER SIGN |                           | STAMP SIGNATURE NOT ALLOWED  JIRED (STAMP SIGNATU |  | provided as needed for administration |
|   |                           | o Not Substitute / No Substitution /              | May Substitute / Product Selection Permitted / |                                       |
| DAW / May Not Substitute                                |                           |   | Substitution Permissible                       |                                       |
|   |                           | Date:   | Prescriber's Signature:                        | Date:                                 |

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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