Rheumatology Oral/Subcutaneous Enrollment Form

Medications A-G (Actemra, Cimzia, Cosentyx, Enbrel)

Fax Referral To: 1-877-232-5455
Address: 500 Ala Moana Blvd., Ste 1-A Honolulu, HI 96813
Phone: 1-800-896-1464

Six Simple Steps to Submitting a Referral

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

Patient Name: ______________________ DOB: ______________ Gender: ☐ Male ☐ Female
Address: ______________________ City, State, ZIP Code: ______________________
Preferred Contact Methods: ☐ Phone (to primary # provided below) ☐ Text (to cell # provided below) ☐ Email (to email provided below)
Note: Carrier charges may apply. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.
Primary Phone: ______________________ Alternate Phone: ______________________
Email: ______________________ Last Four of SSN: ____________ Primary Language: ______________
If **Minor**, Parent/Caregiver/Guardian Name (Last, First): ______________________ **Relationship to minor**: ______________

2 PRESCRIBER INFORMATION

Prescriber's Name: ______________________ State License #: ______________
NPI #: ______________ DEA #: ______________ Group or Hospital: ______________________
Address: ______________________ City, State, ZIP Code: ______________________
Phone: ______________ Fax______________ Contact Person: ______________ Contact's Phone: ______________

3 INSURANCE INFORMATION *Please fax copy of prescription and insurance cards (front and back) with this form, if available*

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

☐ M06.9 Rheumatoid Arthritis (RA) ☐ M45.9 Ankylosing Spondylitis (AS)
☐ L40.50 Arthropathic Psoriasis (PsA) ☐ M45.A0 Non-Radiographic Axial Spondylarthritis (nr-axSpA)
☐ Other Code: _______ Description ______________________
Allergies: ______________________ ☐ NKDA Weight: __________ ☐ lb ☐ kg Height: ________ ☐ In ☐ Cm
Treatment status: ☐ New to therapy ☐ Continuation of therapy; Date of last treatment ___/__/____
Samples provided ☐ No ☐ Yes, if so, how many samples given? _______ ☐ TB Test Date ___/__/___ ☐ Pos ☐ Neg
Prior therapy, treatment dates, and reason(s) for discontinuation______________________

5 PRESCRIPTION INFORMATION Ship to: ☐ Patient ☐ Office ☐ Other: ______________

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY	REFILLS
☐ Actemra	☐ 162 mg/0.9 mL ACTPen ☐ 162 mg/0.9 mL PFS	☐ Inject 162 mg SC every other week ☐ Inject 162 mg SC every week	☐ 28 days ☐ 84 days	________
☐ Cimzia	☐ Cimzia Starter Kit	Loading Dose: ☐ Inject 400 mg SC on weeks 0, 2 and 4	1 kit	0
	☐ 200 mg/mL PFS ☐ 200 mg/mL vial	Maintenance Dose: ☐ Inject 200 mg SC every other week ☐ Inject 400 mg SC every 4 weeks	☐ 28 days ☐ 84 days	________
☐ Cosentyx	☐ 150 mg/mL Pen ☐ 150 mg/mL PFS	PsA Loading Dose (w/o psoriasis): ☐ Inject 150 mg SC on weeks 0, 1, 2, 3	☐ 28 days	0
		PsA Maintenance Dose (w/o psoriasis): ☐ Inject 150 mg SC on week 4, then every 4 weeks thereafter	☐ 28 days ☐ 84 days	________
		PsA Loading Dose (with psoriasis): ☐ Inject 300 mg SC on weeks 0, 1, 2, 3	☐ 28 days	0
		PsA Maintenance Dose (with psoriasis): ☐ Inject 300 mg SC on week 4, then every 4 weeks thereafter	☐ 28 days ☐ 84 days	________
☐ Enbrel	☐ 50 mg/mL Pen ☐ 50 mg/mL PFS ☐ 50 mg/mL Mini cartridge	☐ Inject 50 mg SC once a week	☐ 28 days ☐ 84 days	________
☐ Other:	______________	______________________	__________	________

☐ 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.

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Rheumatology Oral/Subcutaneous Enrollment Form

Medications H-R (Humira, Ilaris, Kevzara, Olumiant, Orencia, Otezla, Rinvoq)

Please Complete Patient , Prescriber and Patient Clinical Information

Patient Name: ______________________________ Patient DOB: ____________________

Prescriber Name: ______________________________ Prescriber Phone: ____________________

Patient Clinical Information:

Allergies:______________________ ☐ NKDA Weight:__________ ☐ lb ☐ kg Height:________ ☐ In ☐ Cm

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

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

Prior therapy, treatment dates, and reason(s) for discontinuation______________________________

5 PRESCRIPTION INFORMATION Ship to: ☐ Patient ☐ Office ☐ Other: ______________________________

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY	REFILLS
☐ Humira	☐ 40 mg/0.4 mL Pen (citrate free) ☐ 40 mg/0.4 mL PFS (citrate free) ☐ 80 mg/0.8 mL Pen (citrate free) ☐ 80 mg/0.8 mL PFS (citrate free)	☐ Inject 40 mg SC every other week ☐ Inject 40 mg SC every week ☐ Inject 80 mg SC every other week	☐ 28 days ☐ 84 days	_____
☐ Ilaris	150 mg/mL injection SDV	For patients weighing ≥ 7.5 kg: Inject _____mg (4 mg/kg) SC every 4 weeks (*max 300 mg per dose)	☐ 28 days ☐ 84 days	_____
☐ Kevzara	☐ 200 mg/1.14 mL PFS ☐ 150 mg/1.14 mL PFS ☐ 200 mg/1.14 mL PEN ☐ 150 mg/1.14 mL PEN	☐ Inject 200 mg SC once every two weeks ☐ Inject 150 mg SC once every two weeks	☐ 28 days ☐ 84 days	_____
☐ Olumiant	2 mg tablet	Take 2 mg PO once daily	☐ 30 days ☐ 90 days	_____
☐ Orencia	☐ 125 mg PFS ☐ 125mg PEN	Inject 125 mg SC every week	☐ 28 days ☐ 84 days	_____
☐ Otezla	☐ 28-day starter kit	Day 1: Take 10 mg PO in the morning. Day 2: 10 mg in morning and 10 mg in evening. Day 3: 10 mg in morning and 20 mg in evening. Day 4: 20 mg in morning and 20 mg in evening. Day 5: 20 mg in morning and 30 mg in evening. Day 6 and thereafter: 30 mg PO twice daily	1 kit	0
	☐ 30 mg tablet ☐ Sample already provided/no titration needed	Take 30 mg PO twice daily	☐ 30 days ☐ 90 days	_____
☐ Rinvoq	15 mg tablet	Take one 15 mg tablet PO once daily	☐ 30 days ☐ 90 days	_____
☐ Other	______________________	______________________	_________	_____

☐ Patient is interested in patient support programs **STAMP SIGNATURE NOT ALLOWED** Ancillary supplies and kits provided as needed for administration

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ATTN: New York and Iowa providers, please submit electronic prescription

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing above, I hereby authorize CVS Specialty Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.

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Rheumatology Oral/Subcutaneous Enrollment Form
Medications S-Z (Simponi, Skyrizi, Taltz, Tremfya, Xeljanz)

Please Complete Patient , Prescriber and Patient Clinical Information

Patient Name: ____________________ Patient DOB: ____________________

Prescriber Name: ____________________ Prescriber Phone: ____________________

Patient Clinical Information:

Allergies:____________________ ☐ NKDA Weight:__________ ☐ lb ☐ kg Height:_________ ☐ In ☐ Cm

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

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

Prior therapy, treatment dates, and reason(s) for discontinuation____________________

5 PRESCRIPTION INFORMATION Ship to: ☐ Patient ☐ Office ☐ Other: ____________________

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY	REFILLS
☐ Simponi	☐ 50 mg/0.5 mL PEN ☐ 50 mg/0.5 mL PFS	Inject 50 mg SC every 4 weeks	☐ 28 days ☐ 84 days	______
☐ Skyrizi	☐ 150 mg/mL PFS ☐ 150 mg/mL PEN	Loading Dose: ☐ Inject 150 mg SC at week 0	☐ 28 days	0
		Maintenance Dose: ☐ Inject 150 mg SC at week 4, and every 12 weeks thereafter	☐ 84 days	______
☐ Taltz	☐ 80 mg PEN ☐ 80 mg PFS	AS Loading Dose: ☐ Inject 160 mg (two 80 mg injections) SC on week 0	☐ 28 days	0
		AS Maintenance Dose: ☐ Inject 80 mg SC injection every 4 weeks	☐ 28 days ☐ 84 days	______
		nr-axSpA: ☐ Inject 80 mg SC every 4 weeks	☐ 28 days ☐ 84 days	______
		PsA Loading Dose (w/o psoriasis): ☐ Inject 160 mg (two 80 mg injections) SC on week 0	☐ 28 days	0
		PsA Maintenance Dose (w/o psoriasis): ☐ Inject 80 mg SC every 4 weeks	☐ 28 days ☐ 84 days	______
		PsA Loading Dose (with psoriasis): ☐ Inject 160 mg (two 80 mg injections) week 0, then 80 mg week 2	☐ 28 days (3-pack)	0
		☐ Inject 80 mg week 4, 6, 8, and 10	☐ 28 days (2-pack)	1
		PsA Maintenance Dose (with psoriasis): ☐ Inject 80 mg SC week 12 and every 4 weeks thereafter	☐ 28 days (1-pack)	______
☐ Tremfya	☐ 100 mg/mL PFS ☐ 100 mg/mL PEN	Loading Dose: ☐ Inject 100 mg SC on week 0	☐ 28 days	0
		Maintenance Dose: ☐ Inject 100 mg SC week 4, then every 8 weeks thereafter	☐ 56 days	______
☐ Xeljanz	☐ 5 mg Tablet ☐ 11 mg XR Tablet	☐ Take one 5 mg tablet PO twice daily ☐ Take one 11 mg tablet PO once daily	☐ 30 days ☐ 90 days	______
☐ Other	______________	____________________	_________	______

☐ Patient is interested in patient support programs **STAMP SIGNATURE NOT ALLOWED** Ancillary supplies and kits provided as needed for administration

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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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