

Fax Referral To: 1-877-232-5455

Address: 500 Ala Moana Blvd., Bldg 1 Honolulu, HI 96813

Phone: 1-808-254-2727 NCPDP: 1203417

Patient Name:		de demographic sheet)			·
			DOB:	Gender: 🗌 Male 🔲 Fen	nale
Address:		City, State, ZIF	P Code:		
				elow) 🗌 Email (to email provide	ed below)
	ges may apply. If unable to cont				
			_ Alternate Phone:		
Email:		Last Four of	f SSN: Prin	nary Language:	
	egal Guardian Name (Last, First)	:Rela	tionship to patient:		
PRESCRIBER IN					
Prescriber's Name	:			State License #:	
NPI #:	DEA #:	Group or Hospita	al:		
Address:		City, State	e, ZIP Code:	Contact's Phone:	
Phone:	Fax	Contact Person:		Contact's Phone:	
INSURANCE IN	FORMATION Please fax copy	of prescription and insura	ance cards (front and bac	ck) with this form, if available	
	d? Yes No Is the Pati				
Policy Holder's Nam	ne:	Policy Holder's DO	B: Relations	ship to Patient:	
Medical Insurance:		Telephone:	Policy ID:	Group #:	
	ice:	Pres	scription Plan Telephone:		
Policy ID:	Group	#: R)	X BIN #: R	X PCN #:	
	ient is enrolled in manufacturer o	copay assistance	If ves. please provide ID#		
	D-10) AND PATIENT CLINIC				
M06 9 Rhouma	atoid Arthritis (RA)	M45 9 Ankylosing Spons	Hylitis (AS)		
	eathic Psoriasis (PsA)				
			o Arumus (JFSA)		
	adiographic Axial Spondylarth				
	algia Rheumatica (PMR)	M08.00 Juvenile Idiopati	nic Arthritis (JIA)		
H44.139 Uveitis					
Other Code:	Description				
Allergies:		LJ NKDA	Weight:	lb kg Height:[	
	🔲 New to therapy 🔲 Continu	lation of therapy: Date of	In addition advantage   / /		
Treatment status:		adion of therapy, Date of	last treatment//_		
Treatment status:   Samples provided	☐ No ☐ Yes, if so, how man	y samples given?	TB Test Date /		
Samples provided	☐ No ☐ Yes, if so, how many	y samples given?	ast treatment// TB Test Date/_	Pos	
Samples provided Prior therapy, treat	$\square$ No $\square$ Yes, if so, how many transfer that dates, and reason(s) for	y samples given? discontinuation	_	Pos  Neg	
Samples provided Prior therapy, treat PRESCRIPTION	☐ No ☐ Yes, if so, how man tment dates, and reason(s) for INFORMATION Ship to:	y samples given? discontinuation Patient Office C	_	_/ Pos Neg	Y REFUL
Samples provided Prior therapy, treat	No Yes, if so, how many trment dates, and reason(s) for INFORMATION Ship to:	y samples given? discontinuation Patient Office C	TB Test Date/_ Other: DSE & DIRECTIONS	_/ Pos Neg	Y REFILL
Samples provided Prior therapy, treat PRESCRIPTION	No Yes, if so, how many trment dates, and reason(s) for INFORMATION Ship to: STRENGTH	y samples given? discontinuation Office C Office C Do Inject 162 mg SC ever	TB Test Date/_  Other:  OSE & DIRECTIONS  ry other week	_/ Pos Neg	Y REFILLS
Samples provided Prior therapy, treat PRESCRIPTION MEDICATION  Actemra	No Yes, if so, how many trment dates, and reason(s) for INFORMATION Ship to:	y samples given?	TB Test Date/_ Other:  DSE & DIRECTIONS  ry other week ry week	_/ Pos Neg  QUANTIT  28 days	Y REFILLS
Samples provided Prior therapy, treat PRESCRIPTION MEDICATION  Actemra  Adalimumab-	No Yes, if so, how many timent dates, and reason(s) for INFORMATION Ship to: STRENGTH  162 mg/0.9 mL ACTPen 162 mg/0.9 mL PFS	y samples given?	TB Test Date/_  Other:  OSE & DIRECTIONS  ry other week  ry week  y week	QUANTITY 28 days 84 days	Y REFILLS
Samples provided Prior therapy, treat PRESCRIPTION MEDICATION  Actemra  Adalimumab- aacf	No Yes, if so, how many timent dates, and reason(s) for INFORMATION Ship to: STRENGTH  162 mg/0.9 mL ACTPen 162 mg/0.9 mL PFS  40 mg/0.8 mL PEN	y samples given?	TB Test Date/_  Other:  OSE & DIRECTIONS  ry other week  ry week  y week y other week	QUANTITY 28 days 84 days	Y REFILLS
Samples provided Prior therapy, treat PRESCRIPTION MEDICATION  Actemra Adalimumabaacf (unbranded	No Yes, if so, how many timent dates, and reason(s) for INFORMATION Ship to: STRENGTH  162 mg/0.9 mL ACTPen 162 mg/0.9 mL PFS	y samples given?	TB Test Date/_  Other:  OSE & DIRECTIONS  ry other week  ry week  y week y other week	QUANTITY 28 days 84 days	Y REFILLS
Samples provided Prior therapy, treat PRESCRIPTION MEDICATION  Actemra Adalimumabaacf (unbranded version of Idacio)	No Yes, if so, how many timent dates, and reason(s) for INFORMATION Ship to: STRENGTH  162 mg/0.9 mL ACTPen 162 mg/0.9 mL PFS  40 mg/0.8 mL PEN	y samples given?	TB Test Date/_  Other:  OSE & DIRECTIONS  ry other week  ry week  y week y other week	QUANTITY 28 days 84 days	Y REFILLS
Samples provided Prior therapy, treat PRESCRIPTION MEDICATION  Actemra Adalimumabaacf (unbranded version of Idacio) Adalimumab-	No Yes, if so, how many timent dates, and reason(s) for INFORMATION Ship to: STRENGTH  162 mg/0.9 mL ACTPen 162 mg/0.9 mL PFS  40 mg/0.8 mL PEN 40 mg/0.8 mL PFS	y samples given?	TB Test Date/_  Other:  DSE & DIRECTIONS  ry other week ry week y week y other week y other week y other week	QUANTITY 28 days 84 days 28 days 84 days	Y REFILLS
Samples provided Prior therapy, treat PRESCRIPTION MEDICATION  Actemra Adalimumabaacf (unbranded version of Idacio) Adalimumabaaty	No Yes, if so, how many timent dates, and reason(s) for INFORMATION Ship to: STRENGTH  162 mg/0.9 mL ACTPen 162 mg/0.9 mL PFS  40 mg/0.8 mL PEN 40 mg/0.8 mL PFS	y samples given?	TB Test Date/_ Other: DSE & DIRECTIONS  ry other week ry week y week y other week y other week y other week	QUANTITY 28 days 84 days 28 days 84 days	Y REFILLS
Samples provided Prior therapy, treat PRESCRIPTION MEDICATION  Actemra Adalimumabaacf (unbranded version of Idacio) Adalimumabaaty (unbranded	No Yes, if so, how many timent dates, and reason(s) for INFORMATION Ship to: STRENGTH  162 mg/0.9 mL ACTPen 162 mg/0.9 mL PFS  40 mg/0.8 mL PEN 40 mg/0.8 mL PFS	y samples given?	TB Test Date/_  Other:  DSE & DIRECTIONS  ry other week ry week y week y other week y other week y other week y other week	QUANTITY 28 days 84 days 28 days 84 days	Y REFILLS
Samples provided Prior therapy, treat PRESCRIPTION MEDICATION  Actemra Adalimumab- aacf (unbranded version of Idacio) Adalimumab- aaty (unbranded version of	No Yes, if so, how many timent dates, and reason(s) for INFORMATION Ship to: STRENGTH  162 mg/0.9 mL ACTPen 162 mg/0.9 mL PFS  40 mg/0.8 mL PEN 40 mg/0.8 mL PFS	y samples given?	TB Test Date/_  Other:  DSE & DIRECTIONS  ry other week ry week y week y other week y other week y other week y other week	QUANTITY 28 days 84 days 28 days 84 days	Y REFILLS
Samples provided Prior therapy, treat PRESCRIPTION MEDICATION  Actemra Adalimumabaacf (unbranded version of Idacio) Adalimumabaaty (unbranded version of yuflyma)	No Yes, if so, how many timent dates, and reason(s) for INFORMATION Ship to: STRENGTH  162 mg/0.9 mL ACTPen 162 mg/0.9 mL PFS  40 mg/0.8 mL PEN 40 mg/0.8 mL PFS	y samples given?	TB Test Date/_  Other:  DSE & DIRECTIONS  ry other week ry week y week y other week y other week y other week y other week	QUANTITY  QUANTITY  28 days  84 days  28 days  28 days  28 days	Y REFILLS
Samples provided Prior therapy, treat PRESCRIPTION MEDICATION  Actemra Adalimumabaacf (unbranded version of Idacio) Adalimumabaaty (unbranded version of	No Yes, if so, how many timent dates, and reason(s) for INFORMATION Ship to: STRENGTH  162 mg/0.9 mL ACTPen 162 mg/0.9 mL PFS  40 mg/0.8 mL PEN 40 mg/0.8 mL PFS  1 x 40 mg/0.4 mL PEN 2 x 40 mg/0.4 mL PEN	y samples given?	TB Test Date/_  Other:  DSE & DIRECTIONS  ry other week ry week y week y other week y other week y other week y other week	QUANTITY  QUANTITY  28 days  84 days  28 days  28 days  28 days	Y REFILL:
Samples provided Prior therapy, treat PRESCRIPTION MEDICATION  Actemra Adalimumabaacf (unbranded version of Idacio) Adalimumabaaty (unbranded version of yuflyma)	No Yes, if so, how many timent dates, and reason(s) for INFORMATION Ship to: STRENGTH  162 mg/0.9 mL ACTPen 162 mg/0.9 mL PFS  40 mg/0.8 mL PEN 40 mg/0.8 mL PFS  1 x 40 mg/0.4 mL PEN 2 x 40 mg/0.4 mL PEN 40 mg/0.4 mL PEN	y samples given?	TB Test Date/_  Other:  DSE & DIRECTIONS  ry other week ry week y other week	QUANTITY  QUANTITY  28 days  84 days  28 days  28 days  28 days	Y REFILL
Samples provided Prior therapy, treat PRESCRIPTION MEDICATION  Actemra  Adalimumabaacf (unbranded version of Idacio)  Adalimumabaaty (unbranded version of Yuflyma)  Adalimumabadalimumaba	No Yes, if so, how many timent dates, and reason(s) for INFORMATION Ship to: STRENGTH  162 mg/0.9 mL ACTPen 162 mg/0.9 mL PFS  40 mg/0.8 mL PEN 40 mg/0.8 mL PFS  1 x 40 mg/0.4 mL PEN 2 x 40 mg/0.4 mL PEN 40 mg/0.4 mL PEN 40 mg/0.4 mL PFS (with	y samples given?	TB Test Date/_  Other:  DSE & DIRECTIONS  ry other week ry week y other week	QUANTITY  QUANTITY  28 days  84 days  28 days  28 days  84 days  28 days  84 days	Y REFILL:
Samples provided Prior therapy, treat PRESCRIPTION MEDICATION  Actemra  Adalimumabaacf (unbranded version of Idacio)  Adalimumabaaty (unbranded version of Yuflyma)  Adalimumabadaz	No Yes, if so, how many timent dates, and reason(s) for INFORMATION Ship to: STRENGTH  162 mg/0.9 mL ACTPen 162 mg/0.9 mL PFS  40 mg/0.8 mL PEN 40 mg/0.8 mL PFS  1 x 40 mg/0.4 mL PEN 2 x 40 mg/0.4 mL PEN 40 mg/0.4 mL PEN	y samples given?	TB Test Date/_  Other:  DSE & DIRECTIONS  ry other week ry week y week y other week	QUANTITY 28 days 84 days 28 days 28 days 28 days 28 days 84 days	Y REFILL:
Samples provided Prior therapy, treat Prior therapy, treat PRESCRIPTION MEDICATION  Actemra  Adalimumabaacf (unbranded version of Idacio)  Adalimumabaaty (unbranded version of Yuflyma)  Adalimumabadaz (unbranded	No Yes, if so, how many timent dates, and reason(s) for INFORMATION Ship to: STRENGTH  162 mg/0.9 mL ACTPen 162 mg/0.9 mL PFS  40 mg/0.8 mL PEN 40 mg/0.8 mL PFS  1 x 40 mg/0.4 mL PEN 2 x 40 mg/0.4 mL PEN 40 mg/0.4 mL PEN 40 mg/0.4 mL PFS (with	y samples given?	TB Test Date/_  Other:  DSE & DIRECTIONS  ry other week ry week y week y other week	QUANTITY  QUANTITY  28 days  84 days  28 days  28 days  84 days  28 days  84 days	Y REFILLS
Samples provided Prior therapy, treat PRESCRIPTION  MEDICATION  Actemra  Adalimumabaacf (unbranded version of Idacio)  Adalimumabaaty (unbranded version of Yuflyma)  Adalimumabadaz (unbranded version of	No Yes, if so, how many timent dates, and reason(s) for INFORMATION Ship to: STRENGTH  162 mg/0.9 mL ACTPen 162 mg/0.9 mL PFS  40 mg/0.8 mL PEN 40 mg/0.8 mL PFS  1 x 40 mg/0.4 mL PEN 2 x 40 mg/0.4 mL PEN 40 mg/0.4 mL PEN 40 mg/0.4 mL PFS (with needle guard)	y samples given?	TB Test Date/_ Other: DSE& DIRECTIONS  ry other week ry week y week y other week	QUANTITY  QUANTITY  28 days  84 days  28 days  28 days  84 days  28 days  84 days	Y REFILL:
Samples provided Prior therapy, treat PRESCRIPTION MEDICATION  Actemra  Adalimumabaacf (unbranded version of Idacio) Adalimumabaaty (unbranded version of Yuflyma) Adalimumabadaz (unbranded version of Hyrimoz) Adalimumab	No Yes, if so, how many the there is the thickness of the terminal strength of the terminal stre	y samples given?  discontinuation  Patient Office C  Inject 162 mg SC every Inject 162 mg SC every Inject 40 mg SC every	TB Test Date/_ Other: DSE& DIRECTIONS  ry other week ry week y week y other week	QUANTIT  QUANTIT  28 days 84 days	Y REFILL
Samples provided Prior therapy, treat Prior therapy, treat PRESCRIPTION MEDICATION  Actemra  Adalimumabaacf (unbranded version of Idacio)  Adalimumabaaty (unbranded version of Yuflyma)  Adalimumabadaz (unbranded version of Hyrimoz)  Adalimumabfkjp	No Yes, if so, how many timent dates, and reason(s) for INFORMATION Ship to: STRENGTH  162 mg/0.9 mL ACTPen 162 mg/0.9 mL PFS  40 mg/0.8 mL PEN 40 mg/0.8 mL PFS  1 x 40 mg/0.4 mL PEN 2 x 40 mg/0.4 mL PEN 40 mg/0.4 mL PFS (with needle guard)  20 mg/0.4 mL PFS 40 mg/0.8 mL PFS	y samples given?  discontinuation  Patient Office C  Inject 162 mg SC every Inject 162 mg SC every Inject 40 mg SC every	TB Test Date/_ Other: DSE& DIRECTIONS  ry other week ry week y week y other week	QUANTITY  QUANTITY  28 days  84 days  28 days  84 days  28 days  84 days  28 days	Y REFILLS
Samples provided Prior therapy, treat PRESCRIPTION MEDICATION  Actemra  Adalimumabaacf (unbranded version of Idacio)  Adalimumabaaty (unbranded version of Yuflyma)  Adalimumabadaz (unbranded version of Hyrimoz)  Adalimumabfkjp (unbranded	No Yes, if so, how many the there is the thickness of the terminal strength of the terminal stre	y samples given?  discontinuation  Patient Office C  Inject 162 mg SC every Inject 162 mg SC every Inject 40 mg SC every	TB Test Date/_ Other: DSE& DIRECTIONS  ry other week ry week y week y other week	QUANTIT  QUANTIT  28 days 84 days	Y REFILLS
Samples provided Prior therapy, treat PRESCRIPTION  MEDICATION  Actemra  Adalimumabaacf (unbranded version of Idacio)  Adalimumabaaty (unbranded version of Yuflyma)  Adalimumabadaz (unbranded version of Hyrimoz)  Adalimumabadaz (unbranded version of Hyrimoz)  Adalimumabadaz version of Hyrimoz)	No Yes, if so, how many timent dates, and reason(s) for INFORMATION Ship to: STRENGTH  162 mg/0.9 mL ACTPen 162 mg/0.9 mL PFS  40 mg/0.8 mL PEN 40 mg/0.8 mL PFS  1 x 40 mg/0.4 mL PEN 2 x 40 mg/0.4 mL PEN 40 mg/0.4 mL PFS (with needle guard)  20 mg/0.4 mL PFS 40 mg/0.8 mL PFS	y samples given?  discontinuation  Patient Office C  Inject 162 mg SC every Inject 162 mg SC every Inject 40 mg SC every	TB Test Date/_ Other: DSE& DIRECTIONS  ry other week ry week y week y other week	QUANTITY  QUANTITY  28 days  84 days  28 days  84 days  28 days  84 days  28 days	Y REFILLS
Gamples provided Prior therapy, treat PRESCRIPTION MEDICATION  Actemra  Adalimumabaacf (unbranded version of Idacio)  Adalimumabaaty (unbranded version of Yuflyma)  Adalimumabadaz (unbranded version of Hyrimoz)  Adalimumabadaz (unbranded version of Hyrimoz)  Other:	No Yes, if so, how many the there the the the the the the the the the th	y samples given? discontinuation Patient Office C Inject 162 mg SC every Inject 40 mg SC every	TB Test Date/_  Other:  DSE & DIRECTIONS  ry other week ry week y other week	QUANTITY  QUANTITY  28 days  84 days  28 days  84 days  28 days  84 days  28 days	Y REFILLS
Samples provided Prior therapy, treat PRESCRIPTION MEDICATION  Actemra  Adalimumabaacf (unbranded version of Idacio)  Adalimumabaaty (unbranded version of Yuflyma)  Adalimumabadaz (unbranded version of Hyrimoz)  Adalimumabadaz (unbranded version of Hyrimoz)  Other:	No Yes, if so, how many timent dates, and reason(s) for INFORMATION Ship to: STRENGTH  162 mg/0.9 mL ACTPen 162 mg/0.9 mL PFS  40 mg/0.8 mL PEN 40 mg/0.8 mL PFS  1 x 40 mg/0.4 mL PEN 2 x 40 mg/0.4 mL PEN 40 mg/0.4 mL PFS (with needle guard)  20 mg/0.4 mL PFS 40 mg/0.8 mL PFS	y samples given? discontinuation Patient Office C Inject 162 mg SC every Inject 40 mg SC every	TB Test Date/_  Other:  DSE & DIRECTIONS  ry other week ry week y other week	QUANTITY  QUANTITY  28 days  84 days  28 days  84 days  28 days  84 days  28 days	Y REFILLS
Samples provided Prior therapy, treat PRESCRIPTION MEDICATION  Actemra  Adalimumabaacf (unbranded version of Idacio)  Adalimumabaaty (unbranded version of Yuflyma)  Adalimumabadaz (unbranded version of Hyrimoz)  Adalimumabadaz (unbranded version of Hyrimoz)  Other:  PRESCRIBER SI	No Yes, if so, how many the there the the the the the the the the the th	y samples given? discontinuation Patient Office O  Inject 162 mg SC ever Inject 162 mg SC ever Inject 40 mg SC every	TB Test Date/_  Other:  DSE & DIRECTIONS  ry other week ry week y other week	Pos	Y REFILLS
Gamples provided Prior therapy, treat PRESCRIPTION MEDICATION  Actemra  Adalimumabaacf (unbranded version of Idacio)  Adalimumabaaty (unbranded version of Yuflyma)  Adalimumabadaz (unbranded version of Hyrimoz)  Adalimumabfkjp (unbranded version of Hyrimoz)  Other:  PRESCRIBER SI  "Dispense As Written" DAW / May Not Subst	No Yes, if so, how many tement dates, and reason(s) for INFORMATION Ship to: STRENGTH  162 mg/0.9 mL ACTPen 162 mg/0.9 mL PFS  40 mg/0.8 mL PEN 40 mg/0.8 mL PFS  1 x 40 mg/0.4 mL PEN 2 x 40 mg/0.4 mL PEN 40 mg/0.4 mL PFS (with needle guard)  20 mg/0.4 mL PFS 40 mg/0.8 mL PFS 40 mg/0.8 mL PFS  40 mg/0.8 mL PFS  7 Brand Medically Necessary / Do Not	y samples given?  discontinuation  Patient Office C  Inject 162 mg SC every Inject 162 mg SC every Inject 40 mg SC every Inject 80 mg SC every	TB Test Date/_ Other:	QUANTIT  QUANTIT  28 days 84 days	Y REFILLS

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

Patient Name:	Please Comple		and Patient Clinical Information Patient Pho	ne:	
			Prescriber Phone:		
Patient Clinical I	nformation:	_			
Allergies: Treatment status Samples provided	: New to therapy Continua		Veight: ☐ lb ☐ kg	Height:	∐ In ∐ Cm
Prior therapy, trea	atment dates, and reason(s) for di	scontinuation			
	NINFORMATION Ship to:		ner:		
MEDICATION	STRENGTH	DOSE	& DIRECTIONS	QUANTITY	REFILLS
Amjevita (adalimumab- atto)	☐ 10 mg/0.2 mL PFS ☐ 20 mg/0.4 mL PFS ☐ 40 mg/0.8 mL PFS ☐ 40 mg/0.8 mL PEN	☐ Inject 10 mg SC every ☐ Inject 20 mg SC every ☐ Inject 40 mg SC every ☐ Inject 40 mg SC every ☐ Inject 80 mg SC every ☐ Inject 80 mg Day 1, fol starting one week after in	other week other week week other week lowed by 40 mg every other week	☐ 28 days ☐ 84 days	
☐ Bimzelx	☐ 2 x 160 mg/mL PEN ☐ 2 x 160 mg/mL PFS ☐ 160 mg/mL PEN ☐ 160 mg/mL PFS	☐ Inject 320 mg SC at w	y 4 weeks at weeks 0, 4, 8, and 12 eek 16 and then every 8 weeks eek 16 and then every 4 weeks	28 days 28 days 28 days 56 days 28 days	3 0 0
		☐ Inject 320 mg SC ever	ry 4 weeks	☐ 84 days	
	Cimzia Starter Kit	☐ Inject 400 mg SC on w	veeks 0, 2 and 4	1 kit	0
☐ Cimzia	200 mg/mL PFS (carton of 1) 200 mg/mL PFS (carton of 2) 200 mg/mL vial kit (carton of 2-HCP administration	self-administration for do	reeks 0, 2 and 4 y other week veeks 0, 2 and 4 ry other week ry 4 weeks for Cimzia that allows for patient	☐ 28 days ☐ 84 days	
☐ Cosentyx	☐ 1x75 mg/mL PFS ☐ 1x150 mg/mL PEN ☐ 1x150 mg/mL PFS ☐ 2x150 mg/mL PEN ☐ 2x150 mg/mL PFS ☐ 300 mg/2 mL PEN	Loading Dose:  Inject 75 mg SC on Weeks 0, 1, 2, 3  Inject 150 mg SC on Weeks 0, 1, 2, 3  Inject 300 mg SC on Weeks 0, 1, 2, 3  Maintenance Dose:  Inject 75 mg SC on Week 4, then every 4 weeks thereafter  Inject 75 mg SC every 4 weeks  Inject 150 mg SC on Week 4, then every 4 weeks thereafter  Inject 150 mg SC every 4 weeks  Inject 150 mg SC every 4 weeks  Inject 300 mg SC on Week 4, then every 4 weeks thereafter  Inject 300 mg SC every 4 weeks		Loading Dose: Quantity: 28 days  Maintenance Dose: Quantity: 28 days	Loading Dose: Refills: 0  Maintenance Dose: Refills:
Other					
6 DRESCRIRED	SIGNATURE REQUIRED (STAM	P SIGNATURE NOT ALL	LOWED)	1	1
"Dispense As Writte DAW / May Not Sub <b>Prescriber's Si</b>	n" / Brand Medically Necessary / Do Not Su stitute	bstitute / No Substitution /	May Substitute / Product Selection Permitte Substitution Permissible Prescriber's Signature:  ATTN: New York and lowa prov		_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.

		ete Patient, Prescriber and Patient Clinical Information		
Patient Name: Patient Address:		Patient DOB: Patient Phone:		
Prescriber Name: .		Prescriber Phone:		
Patient Clinical In	formation:			
Allergies:		NKDA Weight: lb kg He	ight: [	] In [] Cm
Treatment status:	☐ New to therapy ☐ Continuatio	nof therapy; Date of last treatment/_/		
Samples provided Prior therapy treat	tment dates, and reason(s) for disc	riples given? [] IB Test Date/_/[] Pos [] Ne continuation	:g	
	INFORMATION Ship to: Pat			
MEDICATION	·	DOSE & DIRECTIONS	QUANTITY	REFILLS
☐ Enbrel	☐ 50 mg/mL Mini ☐ 50 mg/mL PEN ☐ 50 mg/mL PFS ☐ 25 mg/0.5 mL PFS ☐ 25 mg/0.5 mL single dose vial ☐ 25 mg/0.5 mL lyophilized powder multi-dose vial for reconstitution	☐ Inject 50 mg SC once weekly ☐ Inject 0.8 mg/kg (Dose=mg) weekly, with a maximum of 50 mg per week	☐ 28 days ☐ 84 days	
☐ Hadlima	☐ 40 mg/0.4 mL PEN ☐ 40 mg/0.8 mL PEN ☐ 40 mg/0.4 mL PFS ☐ 40 mg/0.8 mL PFS	☐ Inject 40 mg SC every week ☐ Inject 40 mg SC every other week ☐ Inject 80 mg SC every other week ☐ Inject 80 mg SC on Day 1, followed by 40mg every other week starting one week after initial dose	28 days	
☐ Hulio	☐ 20 mg/0.4 mL PFS ☐ 40 mg/0.8 mL PFS ☐ 40 mg/0.8 mL PEN	☐ Inject 20 mg SC every other week ☐ Inject 40 mg SC every week ☐ Inject 40 mg SC every other week ☐ Inject 80 mg SC every other week	☐ 28 days ☐ 84 days	
Humira	☐ 10 mg/0.1 mL PFS ☐ 20 mg/0.2 mL PFS ☐ 40 mg/0.4 mL PEN ☐ 80 mg/0.8 mL PEN ☐ 40 mg/0.4 mL PFS ☐ 80 mg/0.8 mL PFS	☐ Inject 10 mg SC every other week ☐ Inject 20 mg SC every other week ☐ Inject 40 mg SC every week ☐ Inject 40 mg SC every other week ☐ Inject 80 mg SC every other week ☐ Inject 80 mg SC on Day 1, followed by 40 mg every other week starting one week after initial dose	28 days	
Hyrimoz	40 mg/0.4 mL PEN 40 mg/0.4 mL PFS (with needle guard)	☐ Inject 40 mg SC every week ☐ Inject 40 mg SC every other week ☐ Inject 80 mg SC every other week	28 days 84 days	
☐ Ilaris	150 mg/mL injection SDV	For patients weighing ≥ 7.5 kg: Injectmg (4 mg/kg) SC every 4 weeks (*max 300 mg per dose)	28 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	
Olumiant	2 mg tablet	Take 2 mg PO once daily	30 days 90 days	
☐ Orencia	☐ 50 mg/0.4 mL PFS ☐ 87.5 mg/0.7 mL PFS ☐ 125 mg PFS ☐ 125 mg PEN	Peds JIA or PsA (>2 years old) Dosing:  10 kg to < 25 kg: ☐ Inject 50 mg SC once weekly  25 kg to < 50 kg: ☐ Inject 87.5 mg SC once weekly  ≥50 kg: ☐ Inject 125 mg SC once weekly	28 days	
		Adult RA or PsA Dosing: Inject 125 mg SC once weekly		
Other				
6 PRESCR	IBER SIGNATURE REQUIR	ED (STAMP SIGNATURE NOT ALLOWED)		
"Dispense As W	Vritten" / Brand Medically Necessary / Do No			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.

				and Patient Clinical Information		
Patient Nan	ne:		Patient DOB:	Patient Phone:		
Patient Add	dress:					
Prescriber I	Name:			Prescriber Phone:		
Patient Cli	nical Infor		_			_
Allergies:			L NKDA Weig	ht: 🗌 lb 🗌 kg Height:_		_ Cm
Treatment	status: 📙	New to therapy   Continuation	on of therapy; Date of last tr	eatment// FB Test Date// Pos \[ \] Neg		
				TB Test Date// Pos Neg		
		ent dates, and reason(s) for disc				
		<b>IFORMATION</b> Ship to: Pa				
MEDIC	ATION	STRENGTH	DOSE & DIRECT		QUANTITY	REFILLS
☐ Otezla		☐ Titration Starter Pack for 30 mg BID dosage	Day 3: Take 10 mg PO in the Day 4: Take 20 mg PO in th	e morning and 10 mg PO in the evening. e morning and 20 mg PO in the evening. e morning and 20 mg PO in the evening. e morning and 30 mg PO in the evening.	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 c	nce daily	30 days 90 days	
Rinvoq	LQ	☐ 1 mg/ 1 mL	3 mg (3 mL oral solution 4 mg (4 mL oral solution 6 mg (6 mL oral solution	n) PO twice daily	Quantity(ml)	
Simland (adalimum		☐ 40 mg/0.4 mL PEN	☐ Inject 40mg SC every w☐ Inject 40mg SC every of☐ Inject 80mg SC every of☐	eek ther week	28 days	
Simpon	ni	☐ 50 mg/0.5 mL PEN☐ 50 mg/0.5 mL PFS	Inject 50 mg SC every 4 we	eeks	28 days 84 days	
Skyrizi		☐ 150 mg/mL PFS ☐ 150 mg/mL PEN	Loading Dose:  Inject 150 mg SC at wee  Maintenance Dose:	ek 0 ek 4, and every 12 weeks thereafter	☐ 28 days	0
		☐ 80 mg PEN☐ 80 mg PFS	AS Loading Dose:	ng injections) SC on week 0	28 days	0
			☐ Inject 80 mg SC injectio	n every 4 weeks	☐ 84 days	
			nr-axSpA:  Inject 80 mg SC every 4	weeks	28 days 84 days	
			PsA Loading Dose (w/o pso			_
☐ Taltz			☐ 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,		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)		
Other						
6 PRI	ESCRIBI	ER SIGNATURE REQUIR	RED (STAMP SIGNAT	URE NOT ALLOWED)		
DAW /	/ May Not Sub	en" / Brand Medically Necessary / Do No ostitute ignature:	t Substitute / No Substitution /  Date:	May Substitute / Product Selection Permitted / Substitution Permissible Prescriber's Signature:	Date: _	
CA, M	A, NC & PR: II	nterchange is mandated unless Prescriber v	vrites the words "No Substitution"	ATTN: New York and Iowa providers, plea	ase submit electronic pro	escription

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

Patient Name:			Patient Ph	none:	
	Prescriber Phone:				
Patient Clinical Informat	tion:				
Allergies:		NKDA Weig	ght: 🔲 lb 🗌 kg	Height:	☐ In ☐ Cm
Γreatment status: 🗌 Nev	v to therapy 🔲 Continuation of	therapy; Date of last t	reatment//		
Samples provided 🗌 No	Yes, if so, how many sample	es given?	TB Test Date/_/ Pos [	Neg	
Prior therapy, treatment o	lates, and reason(s) for disconti	nuation			
PRESCRIPTION INFO	RMATION Ship to: Patient	Office Other: _			
MEDICATION	STRENGTH	DOSE &	DIRECTIONS	QUANTITY	REFILLS
		Loading Dose:		28 days	0
☐ Tremfya	100 mg/mL PFS	☐ Inject 100 mg S	C on week 0	☐ 56 days	
<u> Пеннуа</u>	100 mg/mL PEN		Maintenance Dose:		
		☐ Inject 100 mg SC week 4, then every 8 weeks thereafter			
Tyenne (tocilizumab-	☐ 162 mg/0.9 mL PEN	Inject 162 mg SC every other week		28 days	
aazg)	☐ 162 mg/0.9 mL PFS	☐ Inject 162 mg S	C every week	☐ 84 days	
□ v-:	5 mg Tablet	☐ Take one 5 mg tablet PO twice daily		30 days	
☐ Xeljanz	11 mg XR Tablet	☐ Take one 11 mg	tablet PO once daily	90 days	
	☐ 40 mg/0.4 mL PEN				
	40 mg/0.4 mL PFS (with	☐ Inject 40 mg SC	28 days		
☐ Yuflyma	safety guard)	Inject 40 mg SC every other week		☐ 84 days	
	☐ 40 mg/0.4 mL PFS	☐ Inject 80 mg SC every other week			
	☐ 80 mg/0.8 mL PEN				
Other					
Patient is interested in patient su	Inport programs	STAMP SIGNATURE NOT	ALLOWED Ancillary supplies and kits	provided as peeded for a	desiration
Tatient is interested in patient so	pport programs	STAMP SIGNATURE NOT	Anomaly supplies and kits	provided as needed for at	armistration
PRESCRIBER SIGNAT	URE REQUIRED (STAMP SIG	NATURE NOT ALLO	WED)		
"Diamana A - \\/"	Brand Medically Necessary / D	o Not Substitute /	May Substitute / Product Selection	on Permitted /	
Dispense As written A			Substitution Permissible	31111111007	
No Substitution / DAW	' May NOL SHOSHILLE		Cascatadorri Cirrisoloto		
No Substitution / DAW	:	Date:	Prescriber's Signature:		Date:

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