Dermatology Enrollment Form

CVS specialty®

Fax Referral To: 1-855-297-1270 **Phone:** 1-888-280-1190
Address: 6020 Ave Roberto Sanchez Vilella Carolina, PR 00982 **NCPDP:** 4026325

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
☐ Adalimumab-aacf (Unbranded Idacio)	☐ 40 mg/0.8 mL PEN ☐ 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 Day 1, followed by 40 mg every other week starting one week after initial dose	☐ 28 days ☐ 84 days Refills: _____
☐ Adalimumab-aaty (unbranded version of Yuflyma)	☐ 1 x 40 mg/0.4 mL PEN ☐ 2 x 40 mg/0.4 mL PEN	☐ Inject 40mg SC every week ☐ Inject 40mg SC every other week ☐ Inject 80mg SC every other week ☐ Inject 80 mg Day 1, followed by 40 mg every other week starting one week after initial dose	☐ 28 days ☐ 84 days Refills: _____
☐ Other	☐ Strength: _____	☐ 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.

©2025 CVS Specialty and/or one of its affiliates. 75-35829E 04/30/25

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
☐ Adalimumab-adaz (unbranded version of 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 ☐ Inject 80 mg SC on Day 1, followed by 40 mg every other week starting one week after initial dose ☐ 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 ☐ 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: ☐ 28 days ☐ 84 days Refills: _____
☐ Adalimumab-fkjp (unbranded version of Hulio)	☐ 40 mg/0.8 mL PFS ☐ 40 mg/0.8 mL PEN	☐ 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 ☐ 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 ☐ 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: ☐ 28 days ☐ 84 days Refills: _____
☐ Amjevita (adalimumab-atto)	☐ 40 mg/0.8 mL PFS ☐ 40 mg/0.8 mL PEN	☐ Inject 40 mg SC every week ☐ Inject 40 mg SC every other week ☐ Inject 80 mg SC every other week ☐ Inject 80 mg Day 1, followed by 40 mg every other week starting one week after initial dose ☐ 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: ☐ 28 days ☐ 84 days Refills: _____
☐ Avsola	100 mg vial	☐ Induction Dose: Infuse IV at 5 mg/kg (Dose = _____mg) at weeks 0, 2, 6 and every 8 weeks thereafter ☐ Maintenance Dose: Infuse IV at 5 mg/kg (Dose = ___mg) every 8 weeks	Quantity: _____ # of 100 mg vial(s) Refills: _____
☐ Bimzelx	☐ 1 x 320 mg/2 mL PEN ☐ 2 x 160 mg/mL PEN ☐ 1 x 320 mg/2 mL PFS ☐ 2 x 160 mg/mL PFS	PsO Loading Dose: ☐ Inject 320 mg (2 x 160 mg/mL) SC at weeks 0, 4, 8, and 12	Quantity: 28 DS Refills: 3
		PsO Maintenance Dose: ☐ Inject 320 mg (2 x 160 mg/mL) SC on week 16 and every 8 weeks thereafter	Quantity: 56 DS Refills: _____
		PsO Maintenance Dose for pts ≥ 120 kg (264 lbs): ☐ Inject 320 mg (2 x 160 mg/mL) SC on week 16 and every 4 weeks thereafter	Quantity: 28 DS Refills: _____
		HS Loading Dose: ☐ 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
		HS Maintenance Dose: ☐ Inject 320 mg (2 x 160 mg/mL) SC on week 16 and every 4 weeks thereafter	Quantity: 28 DS Refills: _____
☐ Other	☐ Strength: _____	☐ 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/REFILLS
☐ Cimzia	Cimzia Starter Kit (6 prefilled syringes)	Psoriasis Loading Dose: ☐ 400 mg (given as 2 subcutaneous injections of 200 mg each) every other week ☐ 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 Psoriatic Arthritis Loading Dose: ☐ 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
☐ Cimzia	☐ 200 mg/1 mL prefilled syringe ☐ 200 mg vial	Psoriasis Maintenance Dose: ☐ 400 mg (given as 2 subcutaneous injections of 200 mg each) every other week ☐ 200 mg every other week Psoriatic Arthritis Maintenance Dose: ☐ 200 mg every other week ☐ 400 mg (given as 2 subcutaneous injections of 200 mg each) every 4 weeks	Quantity: _____ Refills: _____
☐ Cosentyx	☐ 75 mg/0.5 mL PFS ☐ 150 mg/mL PEN ☐ 150 mg/mL PFS ☐ 150 mg/mL PEN ☐ 150 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 300 mg SC on Week 4, then every 4 weeks thereafter ☐ Inject 300 mg SC every 4 weeks ☐ Inject 300 mg SC every 2 weeks	Loading Dose: Quantity: 28 days Refills: 0 Maintenance Dose: Quantity: 28 days Refills: _____
☐ Dupixent	☐ PFS 300 mg/2 mL prefilled syringe ☐ Pen 300 mg/2 mL prefilled pen	Loading Dose: ☐ Inject 600 mg SC (2-300 mg injections) initially, followed by 300 mg SC every 2 weeks Maintenance Dose: ☐ Inject 300 mg SC every 2 weeks	Quantity: ☐ 28-day supply ☐ 84-day supply ☐ Other: _____Day supply Refills: ☐ 1 year ☐ Other: _____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 Vial	Loading Dose: ☐ Inject 50 mg SC twice a week (3 to 4 days apart) for 3 months, then maintenance dosing Maintenance Dose: ☐ Inject 50 mg SC once weekly ☐ Inject _____ mg SC once weekly	Loading Dose: Quantity: 84 days Refills: 0 Maintenance Dose: Quantity: 28 days Refills: _____
☐ Other	☐ Strength: _____	☐ 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/REFILLS
☐ 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 40 mg every other week starting one week after initial dose ☐ 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 ☐ 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: ☐ 28 days ☐ 84 days Refills: _____
☐ Hulio	☐ 40 mg/0.8 mL PFS ☐ 40 mg/0.8 mL PEN	☐ 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 ☐ 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 ☐ 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: ☐ 28 days ☐ 84 days Refills: _____
☐ Humira	☐ 40 mg/0.4 mL PFS ☐ 40 mg/0.4 mL Pen ☐ 80 mg/0.8 mL PFS ☐ 80 mg/0.8 mL Pen	☐ 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, then 40 mg every other week on day 8 and subsequent doses ☐ 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 ☐ 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	☐ 28 days ☐ 84 days Refills: _____
☐ 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 ☐ Inject 80 mg SC on Day 1, followed by 40 mg every other week starting one week after initial dose ☐ 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 ☐ 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	☐ 28 days ☐ 84 days Refills: _____
☐ Ilumya	100 mg/mL prefilled syringe	☐ Psoriasis Induction Dose: Inject one pre-filled syringe (100 mg) SC at weeks 0 and 4, then maintenance dosing. ☐ Psoriasis Maintenance Dose: Inject one pre-filled syringe (100 mg) SC every 12 weeks.	Quantity: _____ Refills: _____
☐ Other	☐ Strength: _____	☐ 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
☐ Inflectra ☐ Infliximab	100 mg vial	☐ Induction Dose: Infuse IV at 5 mg/kg (Dose = ____mg) at weeks 0, 2, 6 and every 8 weeks thereafter ☐ Maintenance Dose: Infuse IV at 5 mg/kg (Dose= ____mg) every 8 weeks	Quantity: _____ # of 100 mg vial(s) Refills: _____
☐ Leqselvi	8 mg tablet	☐ Take 8 mg orally twice daily with or without food	☐ 30 days ☐ 90 days Refills: _____
☐ Litfulo	☐ 50 mg capsule	☐ Take 50 mg orally once daily with or without food	☐ 28 days ☐ 84 days Refills: _____
☐ Olumiant	☐ 2 mg tablet ☐ 4 mg tablet	☐ 2 mg PO once daily ☐ 4 mg PO once daily	Quantity: _____ Refills: _____
☐ Orencia	125 mg/mL prefilled syringe	Inject 125 mg SC once weekly	Quantity: _____ Refills: _____
☐ Otezla	☐ Titration Starter Pack for 30 mg BID dosage	☐ 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
	☐ Titration Starter Pack for 20 mg BID dosage	☐ 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.	
☐ Otezla	☐ 20 mg tablet ☐ 30 mg tablet ☐ Sample already provided/no titration needed	☐ 20 mg PO twice daily ☐ 30 mg PO twice daily	☐ 30 days ☐ 90 days Refills: _____
☐ Other	☐ Strength: _____	☐ 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
☐ Pzychiva	☐ 45 mg/0.5 mL vial ☐ 45 mg/0.5 mL prefilled syringe ☐ 90 mg/mL prefilled syringe	PsO Peds patients (6 to 17yo): ☐ < 60 kg: Inject 0.75 mg/kg SC at weeks 0 and 4, then every 12 weeks thereafter. ☐ 60 kg to 100 kg: Inject 45 mg SC at weeks 0 and 4, then every 12 weeks thereafter. ☐ > 100 kg: Inject 90 mg SC at weeks 0 and 4, then every 12 weeks thereafter. PsA Peds patients (6 to 17yo): ☐ < 60 kg: Inject 0.75 mg/kg SC at weeks 0 and 4, then every 12 weeks thereafter. ☐ ≥ 60 kg: Inject 45 mg SC at weeks 0 and 4, then every 12 weeks thereafter. ☐ > 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: ☐ For patients weighing ≤100 kg (220 lbs): Inject 45 mg SC initially and 4 weeks later, followed by 45 mg every 12 weeks. ☐ 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: ☐ Inject 45 mg SC at weeks 0 and 4, then every 12 weeks thereafter. ☐ > 100 kg (220lbs) with co-existent mod-severe PsO: Inject 90 mg SC weeks 0 and 4, then every 12 weeks thereafter.	Quantity: _____ Refills: _____
☐ Remicade ☐ Renflexis	100 mg vial	☐ Induction Dose: Infuse IV at 5 mg/kg (Dose = ____mg) at weeks 0, 2, 6 and every 8 weeks thereafter ☐ Maintenance Dose: Infuse IV at 5 mg/kg (Dose = ___mg) every 8 weeks	Quantity: _____ # of 100 mg vial(s) Refills: _____
☐ Rinvoq	15 mg	Take one 15 mg tablet PO daily	Quantity: _____ Refills: _____
☐ Selarsdi	☐ 45 mg/0.5 mL vial ☐ 45 mg/0.5 mL prefilled syringe ☐ 90 mg/mL prefilled syringe	PsO Peds patients (6 to 17yo): ☐ < 60 kg: Inject 0.75 mg/kg SC at weeks 0 and 4, then every 12 weeks thereafter. ☐ 60 kg to 100 kg: Inject 45 mg SC at weeks 0 and 4, then every 12 weeks thereafter. ☐ > 100 kg: Inject 90 mg SC at weeks 0 and 4, then every 12 weeks thereafter. PsA Peds patients (6 to 17yo): ☐ < 60 kg: Inject 0.75 mg/kg SC at weeks 0 and 4, then every 12 weeks thereafter. ☐ ≥ 60 kg: Inject 45 mg SC at weeks 0 and 4, then every 12 weeks thereafter. ☐ > 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: ☐ For patients weighing ≤100 kg (220 lbs): Inject 45 mg SC initially and 4 weeks later, followed by 45 mg every 12 weeks. ☐ 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: ☐ Inject 45 mg SC at weeks 0 and 4, then every 12 weeks thereafter. ☐ > 100 kg (220lbs) with co-existent mod-severe PsO: Inject 90 mg SC weeks 0 and 4, then every 12 weeks thereafter.	Quantity: _____ Refills: _____
☐ Other	☐ Strength: _____	☐ 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
☐ Siliq	☐ 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: SILIQ REMS Website (https://siliqrems.com/SiliqUI/home.u)	Quantity: _____ Refills: _____
☐ Simlandi (adalimumab-ryvk)	☐ 40 mg/0.4mL PEN	☐ Inject 40 mg SC every week ☐ Inject 40 mg SC every other week ☐ Inject 80 mg SC every other week ☐ Inject 80 mg Day 1, followed by 40mg every other week starting one week after initial dose ☐ 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: ☐ 28 days ☐ 84 days Refills: _____
☐ Simponi	☐ 50 mg/0.5 mL SmartJect Autoinjector ☐ 50 mg/0.5 mL prefilled syringe	☐ Psoriatic Arthritis Dose: Inject 50 mg SC once a month.	Quantity: _____ Refills: _____
☐ Simponi ARIA	50 mg/4 mL in a single-dose vial	Psoriatic Arthritis Dosing: ☐ Induction Dose: 2 mg/kg IV infusion over 30 minutes at weeks 0 and 4, then every 8 weeks thereafter ☐ Maintenance Dose: 2 mg/kg IV infusion over 30 minutes every 8 weeks	Quantity: _____ # of 50 mg vial Refills: _____
☐ Skyrizi	☐ 150 mg/mL single-dose Pen ☐ 150 mg/mL single-dose prefilled syringe	☐ Psoriasis Induction Dose: Inject 150 mg SC at Weeks 0 and 4, then maintenance dosing. ☐ Psoriasis Maintenance Dose: Inject 150 mg SC every 12 weeks.	Quantity: _____ Refills: _____
☐ Sotyktu	6 mg tablet	Take one 6 mg tablet PO once daily	Quantity: _____ Refills: _____
☐ Stelara	☐ 45 mg/0.5 mL vial ☐ 45 mg/0.5 mL prefilled syringe ☐ 90 mg/mL prefilled syringe	PsO Peds patients (6 to 17yo): ☐ < 60 kg: Inject 0.75 mg/kg SC at weeks 0 and 4, then every 12 weeks thereafter. ☐ 60 kg to 100 kg: Inject 45 mg SC at weeks 0 and 4, then every 12 weeks thereafter. ☐ > 100 kg: Inject 90 mg SC at weeks 0 and 4, then every 12 weeks thereafter. PsA Peds patients (6 to 17yo): ☐ < 60 kg: Inject 0.75 mg/kg SC at weeks 0 and 4, then every 12 weeks thereafter. ☐ ≥ 60 kg: Inject 45 mg SC at weeks 0 and 4, then every 12 weeks thereafter. ☐ > 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: ☐ For patients weighing ≤100 kg (220 lbs): Inject 45 mg SC initially and 4 weeks later, followed by 45 mg every 12 weeks. ☐ 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: ☐ Inject 45 mg SC at weeks 0 and 4, then every 12 weeks thereafter. ☐ > 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

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
☐ Steqeyma	☐ 45 mg/0.5 mL prefilled syringe ☐ 90 mg/mL prefilled syringe	PsO Peds patients (6 to 17yo): ☐ < 60 kg: Inject 0.75 mg/kg SC at weeks 0 and 4, then every 12 weeks thereafter. ☐ 60 kg to 100 kg: Inject 45 mg SC at weeks 0 and 4, then every 12 weeks thereafter. ☐ > 100 kg: Inject 90 mg SC at weeks 0 and 4, then every 12 weeks thereafter. PsA Peds patients (6 to 17yo): ☐ < 60 kg: Inject 0.75 mg/kg SC at weeks 0 and 4, then every 12 weeks thereafter. ☐ ≥ 60 kg: Inject 45 mg SC at weeks 0 and 4, then every 12 weeks thereafter. ☐ > 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: ☐ For patients weighing ≤100 kg (220 lbs): Inject 45 mg SC initially and 4 weeks later, followed by 45 mg every 12 weeks. ☐ 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: ☐ Inject 45 mg SC at weeks 0 and 4, then every 12 weeks thereafter. ☐ > 100 kg (220lbs) with co-existent mod-severe PsO: Inject 90 mg SC weeks 0 and 4, then every 12 weeks thereafter.	Quantity: _____ Refills: _____
☐ Taltz	☐ 80 mg/mL PEN ☐ 80 mg/mL PFS ☐ 40 mg/0.5 mL PFS ☐ 20 mg/0.25 mL PFS	**Psoriasis Dosing:** ☐ Starting Dose: Inject two 80 mg SC injections on Day 1, then begin first induction dose 2 weeks later ☐ Induction Dose: Inject one 80 mg injection SC every 2 weeks (weeks 2-10) ☐ Final Induction Dose: Inject one 80 mg injection SC week 12 ☐ Maintenance Dose: Inject one 80 mg injection SC every 4 weeks **Pediatric Psoriasis Dosing (6 years and older):** Patients weighing less than 25 kg: ☐ Inject 40 mg SC at Week 0, followed by 20 mg every 4 weeks Patients weighing 25-50 kg: ☐ Inject 80 mg SC at Week 0, followed by 40 mg every 4 weeks Patients weighing greater than 50 kg: ☐ Inject 160 mg (two 80 mg injections) SC at Week 0, followed by 80 mg every 4 weeks **Psoriatic Arthritis Dosing:** ☐ Starting Dose: Inject SC two 80 mg injections on Day 1 ☐ Maintenance Dose: Inject SC one 80 mg injection every 4 weeks	Quantity: ☐ 28 days ☐ 84 days Refills: _____
☐ Tremfya	☐ 100 mg/mL PEN ☐ 100 mg/mL PFS ☐ 100 mg/mL One-Press patient-controlled injector	☐ Starting Dose: Inject 100 mg SC at weeks 0 and 4, then maintenance dosing ☐ Maintenance Dose: Inject 100 mg SC every 8 weeks	Quantity: _____ Refills: _____
☐ Other	☐ Strength: _____	☐ 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/REFILLS
☐ Ustekinumab	☐ 45 mg/0.5 mL vial ☐ 45 mg/0.5 mL prefilled syringe ☐ 90 mg/mL prefilled syringe	PsO Peds patients (6 to 17yo): ☐ < 60 kg: Inject 0.75 mg/kg SC at weeks 0 and 4, then every 12 weeks thereafter. ☐ 60 kg to 100 kg: Inject 45 mg SC at weeks 0 and 4, then every 12 weeks thereafter. ☐ > 100 kg: Inject 90 mg SC at weeks 0 and 4, then every 12 weeks thereafter. PsA Peds patients (6 to 17yo): ☐ < 60 kg: Inject 0.75 mg/kg SC at weeks 0 and 4, then every 12 weeks thereafter. ☐ ≥ 60 kg: Inject 45 mg SC at weeks 0 and 4, then every 12 weeks thereafter. ☐ > 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: ☐ For patients weighing ≤100 kg (220 lbs): Inject 45 mg SC initially and 4 weeks later, followed by 45 mg every 12 weeks. ☐ 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: ☐ Inject 45 mg SC at weeks 0 and 4, then every 12 weeks thereafter. ☐ > 100 kg (220lbs) with co-existent mod-severe PsO: Inject 90 mg SC weeks 0 and 4, then every 12 weeks thereafter.	Quantity: _____ Refills: _____
☐ Xeljanz	☐ 5 mg tablet ☐ 11 mg XR tablet	☐ Take one 5 mg tablet PO twice daily ☐ Take one 11 mg PO once daily	Quantity: _____ Refills: _____
☐ Other	☐ Strength: _____	☐ 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/REFILLS
☐ Yesintek	☐ 45 mg/0.5 mL vial ☐ 45 mg/0.5 mL prefilled syringe ☐ 90 mg/mL prefilled syringe	PsO Peds patients (6 to 17yo): ☐ < 60 kg: Inject 0.75 mg/kg SC at weeks 0 and 4, then every 12 weeks thereafter. ☐ 60 kg to 100 kg: Inject 45 mg SC at weeks 0 and 4, then every 12 weeks thereafter. ☐ > 100 kg: Inject 90 mg SC at weeks 0 and 4, then every 12 weeks thereafter. PsA Peds patients (6 to 17yo): ☐ < 60 kg: Inject 0.75 mg/kg SC at weeks 0 and 4, then every 12 weeks thereafter. ☐ ≥ 60 kg: Inject 45 mg SC at weeks 0 and 4, then every 12 weeks thereafter. ☐ > 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: ☐ For patients weighing ≤100 kg (220 lbs): Inject 45 mg SC initially and 4 weeks later, followed by 45 mg every 12 weeks. ☐ 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: ☐ Inject 45 mg SC at weeks 0 and 4, then every 12 weeks thereafter. ☐ > 100 kg (220lbs) with co-existent mod-severe PsO: Inject 90 mg SC weeks 0 and 4, then every 12 weeks thereafter.	Quantity: _____ 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 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 ☐ 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 ☐ 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	☐ 28 days ☐ 84 days Refills: _____
☐ Other	☐ Strength: _____	☐ 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
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: ☐ PIV ☐ PORT ☐ 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 & ☐ Heparin 10 units/mL or ☐ 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: ☐ NS ☐ D5W	IV	Pre: ☐ 500 mL ☐ 1000 mL ☐ Other: _____ Concurrent: ☐ 500 mL ☐ 1000 mL ☐ Other: _____ Post: ☐ 500 mL ☐1000 mL ☐ Other: _____	Hydration max infusion rate _____ mL/hr (Adult max rate 250 mL/hr unless otherwise indicated)
☐Epinephrine **nursing requires**	☐ IM ☐ SC	☐ 1:1000, 0.3 mg/0.3 mL (greater than 30 kg/66lbs) ☐ 1:1000, 0.15 mg/0.3 mL (15-30 kg/33-66lbs) ☐ 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: _____
☐ Diphenhydramine Oral	PO	Premedication: ☐ 12.5 mg/kg (0-30 kg) ☐ 25 mg ☐ 50 mg (Over 30 kg)	Quantity: _____ Refills: _____
☐ Diphenhydramine 50 mg/mL vial ***nursing required***	☐ Slow IV ☐ IM	☐ 1 mg/kg (under 15 kg) ☐ 12.5 mg-50 mg (15-30 kg) ☐ 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: _____
☐ Flush Orders:	☐ Peripheral Access ☐ Central Venous Access	☐ 10 mL NS post flush ☐ 50 mL NS post flush (Recommended if no post-hydration) ☐ Other: _____	Send quantity sufficient for medication days supply
☐ Additional Medication: _____	_____ _____ _____	_____ _____	_____ _____

☐ 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.

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.
This document contains references to brand-name prescription drugs that are trademarks or registered trademarks of pharmaceutical manufacturers not affiliated with CVS Specialty and/or one of its affiliates.