

# Rheumatology Oral/Subcutaneous Enrollment Form

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



Fax Referral To: 1-888-280-1191 OR 787-759-4161  
 Phone: 1-888-280-1190 OR 787-759-4162  
 Email Referral To: Customer.ServiceFax@CVSHealth.com  
 Address: 280 Avenida Jesus T. Pinerio Ste B Rio Piedras, PR 00927

### 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
<input type="checkbox"/> Actemra	<input type="checkbox"/> 162 mg/0.9 mL ACTPen <input type="checkbox"/> 162 mg/0.9 mL PFS	<input type="checkbox"/> Inject 162 mg SC every other week <input type="checkbox"/> Inject 162 mg SC every week	<input type="checkbox"/> 28 days <input type="checkbox"/> 84 days	_____
<input type="checkbox"/> Cimzia	<input type="checkbox"/> Cimzia Starter Kit	Loading Dose: <input type="checkbox"/> Inject 400 mg SC on weeks 0, 2 and 4	1 kit	0
	<input type="checkbox"/> 200 mg/mL PFS <input type="checkbox"/> 200 mg/mL vial	Maintenance Dose: <input type="checkbox"/> Inject 200 mg SC every other week <input type="checkbox"/> Inject 400 mg SC every 4 weeks	<input type="checkbox"/> 28 days <input type="checkbox"/> 84 days	_____
<input type="checkbox"/> Cosentyx	<input type="checkbox"/> 150 mg/mL Pen <input type="checkbox"/> 150 mg/mL PFS	PsA Loading Dose (w/o psoriasis): <input type="checkbox"/> Inject 150 mg SC on weeks 0, 1, 2, 3	<input type="checkbox"/> 28 days	0
		PsA Maintenance Dose (w/o psoriasis): <input type="checkbox"/> Inject 150 mg SC on week 4, then every 4 weeks thereafter	<input type="checkbox"/> 28 days <input type="checkbox"/> 84 days	_____
		PsA Loading Dose (with psoriasis): <input type="checkbox"/> Inject 300 mg SC on weeks 0, 1, 2, 3	<input type="checkbox"/> 28 days	0
		PsA Maintenance Dose (with psoriasis): <input type="checkbox"/> Inject 300 mg SC on week 4, then every 4 weeks thereafter	<input type="checkbox"/> 28 days <input type="checkbox"/> 84 days	_____
<input type="checkbox"/> Enbrel	<input type="checkbox"/> 50 mg/mL Pen <input type="checkbox"/> 50 mg/mL PFS <input type="checkbox"/> 50 mg/mL Mini cartridge	<input type="checkbox"/> Inject 50 mg SC once a week	<input type="checkbox"/> 28 days <input type="checkbox"/> 84 days	_____
<input type="checkbox"/> 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.

## 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
<input type="checkbox"/> Humira	<input type="checkbox"/> 40 mg/0.4 mL Pen (citrate free) <input type="checkbox"/> 40 mg/0.4 mL PFS (citrate free) <input type="checkbox"/> 80 mg/0.8 mL Pen (citrate free) <input type="checkbox"/> 80 mg/0.8 mL PFS (citrate free)	<input type="checkbox"/> Inject 40 mg SC every other week <input type="checkbox"/> Inject 40 mg SC every week <input type="checkbox"/> Inject 80 mg SC every other week	<input type="checkbox"/> 28 days <input type="checkbox"/> 84 days	_____
<input type="checkbox"/> Ilaris	150 mg/mL injection SDV	For patients weighing $\geq 7.5$ kg:  Inject _____ mg (4 mg/kg) SC every 4 weeks (*max 300 mg per dose)	<input type="checkbox"/> 28 days <input type="checkbox"/> 84 days	_____
<input type="checkbox"/> Kevzara	<input type="checkbox"/> 200 mg/1.14 mL PFS <input type="checkbox"/> 150 mg/1.14 mL PFS <input type="checkbox"/> 200 mg/1.14 mL PEN <input type="checkbox"/> 150 mg/1.14 mL PEN	<input type="checkbox"/> Inject 200 mg SC once every two weeks <input type="checkbox"/> Inject 150 mg SC once every two weeks	<input type="checkbox"/> 28 days <input type="checkbox"/> 84 days	_____
<input type="checkbox"/> Olumiant	2 mg tablet	Take 2 mg PO once daily	<input type="checkbox"/> 30 days <input type="checkbox"/> 90 days	_____
<input type="checkbox"/> Orencia	<input type="checkbox"/> 125 mg PFS <input type="checkbox"/> 125mg PEN	Inject 125 mg SC every week	<input type="checkbox"/> 28 days <input type="checkbox"/> 84 days	_____
<input type="checkbox"/> Otezla	<input type="checkbox"/> 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
	<input type="checkbox"/> 30 mg tablet <input type="checkbox"/> Sample already provided/no titration needed	Take 30 mg PO twice daily	<input type="checkbox"/> 30 days <input type="checkbox"/> 90 days	_____
<input type="checkbox"/> Rinvoq	15 mg tablet	Take one 15 mg tablet PO once daily	<input type="checkbox"/> 30 days <input type="checkbox"/> 90 days	_____
<input type="checkbox"/> 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 <b>Prescriber's Signature:</b> _____ <b>Date:</b> _____	May Substitute / Product Selection Permitted / Substitution Permissible <b>Prescriber's Signature:</b> _____ <b>Date:</b> _____
---	--

**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.

## 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
<input type="checkbox"/> Simponi	<input type="checkbox"/> 50 mg/0.5 mL PEN <input type="checkbox"/> 50 mg/0.5 mL PFS	Inject 50 mg SC every 4 weeks	<input type="checkbox"/> 28 days <input type="checkbox"/> 84 days	_____
<input type="checkbox"/> Skyrizi	<input type="checkbox"/> 150 mg/mL PFS <input type="checkbox"/> 150 mg/mL PEN	Loading Dose: <input type="checkbox"/> Inject 150 mg SC at week 0	<input type="checkbox"/> 28 days	0
		Maintenance Dose: <input type="checkbox"/> Inject 150 mg SC at week 4, and every 12 weeks thereafter	<input type="checkbox"/> 84 days	_____
<input type="checkbox"/> Taltz	<input type="checkbox"/> 80 mg PEN <input type="checkbox"/> 80 mg PFS	AS Loading Dose: <input type="checkbox"/> Inject 160 mg (two 80 mg injections) SC on week 0	<input type="checkbox"/> 28 days	0
		AS Maintenance Dose: <input type="checkbox"/> Inject 80 mg SC injection every 4 weeks	<input type="checkbox"/> 28 days <input type="checkbox"/> 84 days	_____
		nr-axSpA: <input type="checkbox"/> Inject 80 mg SC every 4 weeks	<input type="checkbox"/> 28 days <input type="checkbox"/> 84 days	_____
		PsA Loading Dose (w/o psoriasis): <input type="checkbox"/> Inject 160 mg (two 80 mg injections) SC on week 0	<input type="checkbox"/> 28 days	0
		PsA Maintenance Dose (w/o psoriasis): <input type="checkbox"/> Inject 80 mg SC every 4 weeks	<input type="checkbox"/> 28 days <input type="checkbox"/> 84 days	_____
		PsA Loading Dose (with psoriasis): <input type="checkbox"/> Inject 160 mg (two 80 mg injections) week 0, then 80 mg week 2	<input type="checkbox"/> 28 days (3-pack)	0
		<input type="checkbox"/> Inject 80 mg week 4, 6, 8, and 10	<input type="checkbox"/> 28 days (2-pack)	1
		PsA Maintenance Dose (with psoriasis): <input type="checkbox"/> Inject 80 mg SC week 12 and every 4 weeks thereafter	<input type="checkbox"/> 28 days (1-pack)	_____
<input type="checkbox"/> Tremfya	<input type="checkbox"/> 100 mg/mL PFS <input type="checkbox"/> 100 mg/mL PEN	Loading Dose: <input type="checkbox"/> Inject 100 mg SC on week 0	<input type="checkbox"/> 28 days	0
		Maintenance Dose: <input type="checkbox"/> Inject 100 mg SC week 4, then every 8 weeks thereafter	<input type="checkbox"/> 56 days	_____
<input type="checkbox"/> Xeljanz	<input type="checkbox"/> 5 mg Tablet <input type="checkbox"/> 11 mg XR Tablet	<input type="checkbox"/> Take one 5 mg tablet PO twice daily	<input type="checkbox"/> 30 days	_____
		<input type="checkbox"/> Take one 11 mg tablet PO once daily	<input type="checkbox"/> 90 days	_____
<input type="checkbox"/> Other	_____	_____	_____	_____

Patient is interested in patient support programs

**STAMP SIGNATURE NOT ALLOWED**

Ancillary supplies and kits provided as needed for administration

### 3 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

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. 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.