Rheumatology Oral/Subcutaneous Enrollment Form

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

CVS specialty®
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. Pinero 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)
☐ L40.50 Arthropathic Psoriasis (PsA)
☐ M35.3 Polymyalgia Rheumatica (PMR)
☐ M45.9 Ankylosing Spondylitis (AS)
☐ 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	_____
☐ Amjevita	☐ 20 mg/0.4 mL PFS ☐ 40 mg/0.8 mL Pen ☐ 40 mg/0.8 mL PFS	☐ Inject 20 mg SC every other week ☐ Inject 40 mg SC every other week ☐ Inject 40 mg SC every week ☐ Inject 80 mg SC every other 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:	_____	_____	_____	_____

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	_____	_____	_____	_____

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

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