

Fax Referral To: 1-855-297-1270

Address: 6020 Ave Roberto Sanchez Vilella Carolina, PR 00982

NCPDP: 4026325 Six Simple Steps to Submitting a Referral PATIENT INFORMATION (Complete or include demographic sheet) DOB: _____ Gender: Male Female _City, State, ZIP Code: _____ Address: 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. _____ Alternate Phone: ___ 2 PRESCRIBER INFORMATION _____ State License #: _____ Prescriber's Name: _____ NPI #: _____ DEA #: ____ Group or Hospital: _____
 Address:
 _____ City, State, ZIP Code: ______

 Phone:
 _____ Contact Person: ______ Contact's Phone: ______
 INSURANCE INFORMATION Please fax copy of prescription and insurance cards (front and back) with this form, if available Is the Patient Insured? 🗌 Yes 🔲 No 🛮 Is the Patient enrolled or eligible for Medicare/Medicaid? 🔲 Yes 🔲 No Check box if patient is enrolled in manufacturer copay assistance

If yes, please provide ID# ______ ☐ DIAGNOSIS (ICD-10) AND PATIENT CLINICAL INFORMATION (Include copy of clinicals)
☐ M06.9 Rheumatoid Arthritis (RA)
☐ L40.50 Arthropathic Psoriasis (PsA)
☐ L40.54 Juvenile Psoriatic Arthritis (JPsA) M45.A0 Non-Radiographic Axial Spondylarthritis (nr-axSpA) M35.3 Polymyalgia Rheumatica (PMR) M08.00 Juvenile Idiopathic Arthritis (JIA) H44.139 Uveitis, unspecified eye Other Code: _____ Description _____ _____ NKDA Weight:____ lb kg Height:____ In Cm Allergies: 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____ PRESCRIPTION INFORMATION Ship to: Patient Office Other: QUANTITY **MEDICATION** STRENGTH DOSE & DIRECTIONS REFILLS 28 days 162 mg/0.9 mL ACTPen ☐ Inject 162 mg SC every other week ☐ Actemra 84 days ☐ 162 mg/0.9 mL PFS ☐ Inject 162 mg SC every week Adalimumab-☐ Inject 40 mg SC every week 40 mg/0.8 mL PEN 28 days aacf ☐ Inject 40 mg SC every other week (unbranded ☐ 40 mg/0.8 mL PFS 84 days ☐ Inject 80 mg SC every other week version of Idacio) Adalimumabaatv 1 x 40 mg/0.4 mL PEN ☐ Inject 40 mg SC every week 28 days 2 x 40 mg/0.4 mL PEN ☐ Inject 40 mg SC every other week (unbranded 84 days Inject 80 mg SC every other week version of Yuflyma) Adalimumab-40 mg/0.4 mL PEN adaz ☐ Inject 40 mg SC every week 40 mg/0.4 mL PFS (with ☐ Inject 40 mg SC every other week (unbranded 28 days needle guard) ☐ Inject 80 mg SC every other week 84 days version of Hyrimoz) Adalimumab-☐ Inject 20 mg SC every other week ☐ 20 mg/0.4 mL PFS ☐ Inject 40 mg SC every week 28 days fkip 40 mg/0.8 mL PFS ☐ Inject 40 mg SC every other week☐ Inject 80 mg SC every other week (unbranded 84 days 40 mg/0.8 mL PEN version of Hulio) Other: 6 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED) "Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / May Substitute / Product Selection Permitted / DAW / May Not Substitute Substitution Permissible Prescriber's Signature: Prescriber's Signature: __ ATTN: New York and Iowa providers, please submit electronic prescription CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "No Substitution" ____

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.

Phone: 1-888-280-1190

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 ☐ Inject 75 mg SC on Week 4, then every 4 weeks thereafter ☐ Inject 75 mg SC on Week 4, then 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 on Week 4, then every 4 weeks thereafter ☐ 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 Prescriber's Si	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:

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		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/_/_ Description of therapy; Date of last treatment/_/_ Pos Description Ne		
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:

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				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				
		IFORMATION 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
			AS Loading Dose:	ng injections) SC on week 0	28 days	0
		☐ 80 mg PEN☐ 80 mg PFS	☐ 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/		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

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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 SC on week 0			
<u> Пеннуа</u>	100 mg/mL PEN	Maintenance Dose:		☐ 56 days	
		☐ Inject 100 mg SC week 4, then every 8 weeks thereafter			
Tyenne (tocilizumab-	☐ 162 mg/0.9 mL PEN		C every other week	28 days	
aazg)	☐ 162 mg/0.9 mL PFS	62 mg/0.9 mL PFS		☐ 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	☐ 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)		
"D:	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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