

Fax Referral To: 1-800-323-2445

Email Referral To: Customer.ServiceFax@CVSHealth.com

Phone: 1-800-237-2767 Six Simple Steps to Submitting a Referral PATIENT INFORMATION (Complete or include demographic sheet) ____ Gender: 🗌 Male 🔲 Female Patient Name: 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: ___ 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: _____ 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 _____Ship to: Patient Office Other: ____ Needs by Date: Diagnosis (ICD-10):

L28.1 Prurigo Nodularis

L40.4 Guttate Psoriasis L40.0 Psoriasis Vulgaris L40.1 Generalized Pustular Psoriasis L40.50 Arthropathic Psoriasis, Unspecified L40.54 Juvenile psoriatic arthritis L40.59 Other Psoriatic Arthropathy L40.8 Other Psoriasis _____ L63.9 Alopecia areata, unspecified Other Code: _____ Description: _____ L40.9 Psoriasis, Unspecified L63.8 Other alopecia areata L73.2 Hidradenitis Suppurativa **Patient Clinical Information:** Allergies: _____ Weight: _____ lb/kg Height: _____ In/cm TB Test Result: _____ 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? \square Yes \square 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** ☐ Inject 40 mg SC every week Adalimumab-☐ Inject 40 mg SC every other week 28 days ☐ 40 mg/0.8 mL PEN aacf (Unbranded ☐ Inject 80 mg SC every other week 84 days ☐ 40 mg/0.8 mL PFS ☐ Inject 80 mg Day 1, followed by 40 mg every other week starting one Idacio) Refills: ____ week after initial dose Adalimumab-☐ Inject 40mg SC every week 1 x 40 mg/0.4 mL aaty (unbranded ☐ Inject 40mg SC every other week 28 days ☐ Inject 80mg SC every other week version of 84 days 2 x 40 mg/0.4 mL Yuflyma) Inject 80 mg Day 1, followed by 40 mg every other week starting one Refills: ____ week after initial dose Strength: Quantity: ___ Other Dose: Patient is interested in patient support programs STAMP SIGNATURE NOT ALLOWED Ancillary supplies and kits provided as needed for administration PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED) Mav Substitute / Product Selection Permitted / "Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute Substitution Permissible Prescriber's Signature: _ Prescriber's Signature: _

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.

atient Name:	Please Complete	_ Patient DOB:	Patient	Phone:
escriber Name: _		Prescriber Pl	hone:	
tient Clinical Inf				
ergies:				
eight:	lb/kg Height:	In/cm TB	Test Result:	Date:
	ON INFORMATION			
IEDICATION	STRENGTH		& DIRECTIONS	QUANTITY/REFILLS
Adalimumabadaz unbranded version of Hyrimoz)	40 mg/0.4 mL PEN 40 mg/0.4 mL PFS (with needle guard)	☐ Inject 40 mg SC every weel☐ Inject 40 mg SC every othe☐ Inject 80 mg SC every othe☐ Inject 80 mg SC on Day 1, for starting one week after initial d☐ Inject 160 mg SC on Day 1 (stays), 80 mg on Day 15, then 4☐ Inject 160 mg SC on Day 1 (stays), 80 mg on Day 15, then 8	r week r week ollowed by 40 mg every ot ose single-dose or split over tv 0 mg every week starting single-dose or split over tv	vo consecutive on Day 29 vo consecutive
Adalimumab- rjp unbranded ersion of Hulio)	☐ 40 mg/0.8 mL PFS ☐ 40 mg/0.8 mL PEN	Inject 40 mg SC every weel Inject 40 mg SC every othe Inject 80 mg SC every othe Inject 80 mg SC on Day 1, for starting one week after initial d Inject 160 mg SC on Day 1 (stays), 80 mg on Day 15, then 4 Inject 160 mg SC on Day 1 (stays), 80 mg on Day 15, then 8	k r week r week ollowed by 40 mg every ot ose single-dose or split over tv 0 mg every week starting single-dose or split over tv	ther week Quantity: 28 days vo consecutive 84 days on Day 29 Refills:
] Amjevita adalimumab-atto)	☐ 40 mg/0.8 mL PFS ☐ 40 mg/0.8 mL PEN	☐ Inject 40 mg SC every weel ☐ Inject 40 mg SC every othe ☐ Inject 80 mg SC every othe ☐ Inject 80 mg Day 1, followed week after initial dose ☐ Inject 160 mg SC on Day 1 (consecutive days), 80 mg on D every other week dosing two w	r week r week d by 40 mg every other we given in one day or split ov ay 15. Begin 40 mg weekl	ver two Refills:
Avsola	100 mg vial	Induction Dose: Infuse IV at 0, 2, 6 and every 8 weeks there Maintenance Dose: Infuse I (Dose =mg) every 8 weeks	5 mg/kg (Dose =mg eafter V at 5 mg/kg	Quantity: # of 100 mg vial(s) Refills:
	☐ 1 x 320 mg/2 mL PEN	PsO Loading Dose: Inject 320 mg (2 x 160 mg/r PsO Maintenance Dose: Inject 320 mg (2 x 160 mg/r thereafter	mL) SC at weeks 0, 4, 8, ar	Quantity: 56 DS ery 8 weeks Refills:
Bimzelx	2 x 160 mg/mL PEN 1 x 320 mg/2 mL PFS 2 x 160 mg/mL PFS	PsO Maintenance Dose for pts Inject 320 mg (2 x 160 mg/r thereafter		Quantity: 28 DS ery 4 weeks Refills:
	L 2 × 100 Hig/Hit PF3	HS Loading Dose: Inject 320 mg (2 x 160 mg/mL) SC at week 0, 2, 4, 6, 8, 10, 12, and 14		
		HS Maintenance Dose: Inject 320 mg (2 x 160 mg/r) thereafter	mL) SC on week 16 and ev	Quantity: 28 DS ery 4 weeks Refills:
Other	Strength:	Dose:		Quantity: Refills:
	patient support programs R SIGNATURE REQUI	STAMP SIGNATURE NOT ALLOWED RED (STAMP SIGNATU		y supplies and kits provided as needed for administration
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Please Complete Patient, Prescriber and Patient Clinical Information					
	atient Name:Patient Phone:Patient DOB:Patient Phone:				
Prescriber Name:		Prescriber Ph	none:		
Patient Clinical Inforr	mation:				
Allergies:					
Weight:		In/cm IB I	Test Result: Date:		
	NINFORMATION	_			
MEDICATION	STRENGTH	Psoriasis Loading Dose	OSE & DIRECTIONS	QUANTITY/REFILLS	
☐ Cimzia	Cimzia Starter Kit (6 prefilled syringes)	☐ 400 mg (given as 2 every other week ☐ Patients (with body 2 subcutaneous injecti 2 and 4, followed by 20 Psoriatic Arthritis Load ☐ 400 mg (given as 2	weight ≤ 90 kg): 400 mg (given as ions of 200 mg each) initially and at weeks 00 mg every other week	Quantity: 1 Kit Refills: 0	
☐ Cimzia	☐ 200 mg/1 mL prefilled syringe ☐ 200 mg vial	every other week 200 mg every other Psoriatic Arthritis Main 200 mg every other 400 mg (given as 2 every 4 weeks	subcutaneous injections of 200 mg each) r week tenance Dose:	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	☐ Inject 75 mg SC even ☐ Inject 150 mg SC or ☐ Inject 150 mg SC even ☐ Inject 150 mg SC even	weeks 0, 1, 2, 3 n Weeks 0, 1, 2, 3 Week 4, then every 4 weeks thereafter ery 4 weeks n Week 4, then every 4 weeks thereafter very 4 weeks n Week 4, then every 4 weeks thereafter very 4 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 SC every 2 we) Maintenance Dose: ☐ Inject 300 mg SC e		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	3 months, then mainte Maintenance Dose: Inject 50 mg SC on	ce weekly	Loading Dose: Quantity: 84 days Refills: 0 Maintenance Dose: Quantity: 28 days	
Other	Strength:	☐ Inject mg S ☐ Dose:	C once weekly	Refills:Refills:	
Patient is interested in patie	•	GIGNATURE NOT ALLOWED		ded as needed for administration	
PRESCRIBER S	SIGNATURE REQUIRED (STAMP SIGNATU	RE NOT ALLOWED)		
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	Please Comp	lete Patient, Prescriber and	d Patient Clinical Information	
		Patient DOB:	Patient Phone:	
	s:			
Prescriber Nam	e:	Prescriber Ph	none:	
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Allergies:	lb/kg Heigh	at: In /am TP T	est Result: Date:	
			est Result: Date: _	
	PTION INFORMATIO			
MEDICATION	STRENGTH		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	one week after initial dose Inject 160 mg SC on Day 1 (singl days), 80 mg on Day 15, then 40 mg Inject 160 mg SC on Day 1 (singl	ek yed by 40 mg every other week starting e-dose or split over two consecutive	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 wee ☐ Inject 80 mg SC every other wee ☐ Inject 80 mg SC on Day 1, follow one week after initial dose ☐ Inject 160 mg SC on Day 1 (single days), 80 mg on Day 15, then 40 mg ☐ Inject 160 mg SC on Day 1 (single days), 80 mg on Day 15, then 80 mg	ek ek red by 40 mg every other week starting e-dose or split over two consecutive	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	subsequent doses Inject 160 mg SC on Day 1 (singled days), 80 mg on Day 15, then 40 mg Inject 160 mg SC on Day 1 (singled)	ek IO mg every other week on day 8 and e-dose or split over two consecutive	28 days 84 days Refills:
☐ Hyrimoz	40 mg/0.4 mL PEN 40 mg/0.4 mL PFS (with needle guard)	one week after initial dose Inject 160 mg SC on Day 1 (singl days), 80 mg on Day 15, then 40 mg Inject 160 mg SC on Day 1 (singl	ek ved by 40 mg every other week starting e-dose or split over two consecutive	28 days 84 days Refills:
□ Ilumya	100 mg/mL prefilled syringe	Psoriasis Induction Dose: Inject (100 mg) SC at weeks 0 and 4, then Psoriasis Maintenance Dose: Inj (100 mg) SC every 12 weeks.	one pre-filled syringe n maintenance dosing.	Quantity: Refills:
Other	Strength:	Dose:		Quantity:
☐ Patient is intereste	ed in patient support programs	STAMP SIGNATURE NOT ALLOWED	Ancillary supplies and kits prov	Refills:ided as needed for administration
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	Please Comp	olete Patient, Prescriber and	d Patient Clinical Information	
		Patient DOB:	Patient Phone:	
Prescriber Name		Prescriber Ph	one:	
Patient Clinical				
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Weight:	lb/kg Heig	ht:In/cm IB I	est Result: Date:	
5 PRESCRIP	TION INFORMATION	ON		
MEDICATION	STRENGTH		& DIRECTIONS	QUANTITY/REFILI
☐ Inflectra		Induction Dose: Infuse IV at 5 mg	· ·	Quantity:
	100 mg vial	(Dose =mg) at weeks 0, 2, 6 and		# of 100 mg vial(s)
☐ Infliximab		Maintenance Dose: Infuse IV at 5	mg/kg (Dose=mg) every 8 weeks	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:
	☐ Titration Starter Pack for 30 mg BID dosage	Adult Patients and Pediatric Patien more: Day 1: 10 mg PO in the morning. Day 2: 10 mg PO in the morning and Day 3: 10 mg PO in the morning and Day 4: 20 mg PO in the morning and Day 5: 20 mg PO in the morning and Day 6 and thereafter: 30 mg PO twice	20 mg PO in the evening. 20 mg PO in the evening. 30 mg PO in the evening.	
Otezla	☐ Titration Starter Pack for 20 mg BID dosage	Pediatric Patients 6 years of age Day 1: 10 mg PO in the morning. Day 2: 10 mg PO in the morning and Day 3: 10 mg PO in the morning and Day 4: 20 mg PO in the morning and Day 5: 20 mg PO in the morning and Day 6 and thereafter: 20 mg PO twice	Quantity: 1 pack Refills: 0	
☐ 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:
	in patient support programs ER SIGNATURE RE	STAMP SIGNATURE NOT ALLOWED QUIRED (STAMP SIGNATURE)	Ancillary supplies and kits provided as RE NOT ALLOWED)	needed for administration
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			l Patient Clinical Information		
Patient Name: _		Patient DOB:	Patient Phone:		
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Allergies:					
		In/cm TB Te	est Result: Date:		
	TION INFORMATION				
MEDICATION	STRENGTH		E & DIRECTIONS	QUANTITY/REFILL	
☐ Pzychiva	45 mg/0.5 mL vial 45 mg/0.5 mL prefilled syringe 90 mg/mL prefilled syringe	thereafter. ☐ 60 kg to 100 kg: Inject 45 mg S 12 weeks thereafter. ☐ > 100 kg: Inject 90 mg SC at w PSA Peds patients (6 to 17yo): ☐ < 60 kg: Inject 0.75 mg/kg SC 12 weeks thereafter. ☐ > 60 kg: Inject 45 mg SC at we ☐ > 100 kg with co-existent mod weeks 0 and 4, then every 12 wee PSO Adult dosing: ☐ For patients weighing ≤100 kg later, followed by 45 mg every 12: ☐ For patients weighing >100 kg weeks later, followed by 90 mg ev PSA Adult dosing: ☐ Inject 45 mg SC at weeks 0 an	eeks 0 and 4, then every 12 weeks thereafter. at weeks 0 and 4, then every eeks 0 and 4, then every 12 weeks thereaftersevere PsO: Inject 90 mg SC at ks thereafter. (220 lbs): Inject 45 mg SC initially and 4 weeks weeks. (220 lbs): Inject 90 mg SC initially and 4 very 12 weeks. d 4, then every 12 weeks thereafter. tent mod-severe PsO: Inject 90 mg	Quantity: Refills:	
Remicade		☐ Induction Dose: Infuse IV at 5 i	mg/kg	Quantity:	
Renflexis	100 mg vial	(Dose =mg) at weeks 0, 2, 6 Maintenance Dose: Infuse IV a	and every 8 weeks thereafter It 5 mg/kg (Dose =mg) every 8 weeks	# of 100 mg vial(s) Refills: Quantity:	
Rinvoq	15 mg	Take one 15 mg tablet PO daily		Refills:	
□ Selarsdi	☐ 45 mg/0.5 mL vial ☐ 45 mg/0.5 mL prefilled syringe ☐ 90 mg/mL prefilled syringe	thereafter. ☐ 60 kg to 100 kg: Inject 45 mg S 12 weeks thereafter. ☐ > 100 kg: Inject 90 mg SC at w PSA Peds patients (6 to 17yo): ☐ < 60 kg: Inject 0.75 mg/kg SC 12 weeks thereafter. ☐ ≥ 60 kg: Inject 45 mg SC at we ☐ > 100 kg with co-existent mod weeks 0 and 4, then every 12 wee PSO Adult dosing: ☐ For patients weighing ≤100 kg later, followed by 45 mg every 12 ☐ For patients weighing >100 kg weeks later, followed by 90 mg ev PSA Adult dosing: ☐ Inject 45 mg SC at weeks 0 an	eeks 0 and 4, then every 12 weeks thereafter. at weeks 0 and 4, then every eks 0 and 4, then every 12 weeks thereaftersevere PsO: Inject 90 mg SC at ks thereafter. (220 lbs): Inject 45 mg SC initially and 4 weeks weeks. (220 lbs): Inject 90 mg SC initially and 4 very 12 weeks. d 4, then every 12 weeks thereafter. tent mod-severe PsO: Inject 90 mg	Quantity: Refills:	
Other	Strength:			Quantity: Refills:	
	ted in patient support programs	STAMP SIGNATURE NOT ALLOWED	Ancillary supplies and kits provided as r		
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CA, MA, NC & PR: II	CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "No Substitution" ATTN: New York and Iowa providers, please submit electronic prescription				

	Please Complet	e Patient, Prescriber and	d Patient Clinical Information	
Patient Name: _ Patient Address		Patient DOB:	Patient Phone:	
Prescriber Nam	s: ne:	Prescriber Phone:		
	al Information:			
Allergies:				
	lb/kg Height:_	In/cm TB Te	est Result: Date:	
	TION INFORMATION			
MEDICATION	STRENGTH		SE& DIRECTIONS	QUANTITY/REFIL
] Siliq	Carton of two 210 mg/1.5 mL single-dose prefilled syringes	prefilled syringe (210 mg) every 2	=	Quantity: Refills:
□ Simlandi adalimumab- yvk)	☐ 40 mg/0.4mL PEN	after initial dose Inject 160 mg SC on Day 1, (giv		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 IRIA	50 mg/4 mL in a single-dose vial	every 8 weeks thereafter	fusion over 30 minutes at weeks 0 and 4, then V 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		t 150 mg SC at Weeks 0 and 4, then	Quantity: Refills:
Sotyktu	6 mg tablet	Take one 6 mg tablet PO once da	ily	Quantity: Refills:
] Stelara	45 mg/0.5 mL vial 45 mg/0.5 mL prefilled syringe 90 mg/mL prefilled syringe	thereafter. ☐ 60 kg to 100 kg: Inject 45 mg \$12 weeks thereafter. ☐ > 100 kg: Inject 90 mg SC at weeks thereafter. ☐ < 60 kg: Inject 0.75 mg/kg SC 12 weeks thereafter. ☐ > 60 kg: Inject 45 mg SC at weeks thereafter. ☐ > 60 kg: Inject 45 mg SC at weeks 0 and 4, then every 12 weeks 0 and 4, then every	veeks 0 and 4, then every 12 weeks thereafter. at weeks 0 and 4, then every eeks 0 and 4, then every 12 weeks thereafter. I-severe PsO: Inject 90 mg SC at eks thereafter. (220 lbs): Inject 45 mg SC initially and 4 weeks weeks. (220 lbs): Inject 90 mg SC initially and 4 very 12 weeks. ad 4, then every 12 weeks thereafter. tent mod-severe PsO: Inject 90 mg	Quantity: Refills:
	ted in patient support programs	STAMP SIGNATURE NOT ALLOWED	Ancillary supplies and kits provided as	needed for administration
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□ Steqeyma	☐ 45 mg/0.5 mL prefilled syringe ☐ 90 mg/mL prefilled syringe	PsO Peds patients (6 to 17yo):	g SC at weeks 0 and 4, then every 12 C at weeks 0 and 4, then every 12 C at weeks 0 and 4, then every 12 D cod-severe PsO: Inject 90 mg D ceks thereafter. Eq (220 lbs): Inject 45 mg SC D every 12 weeks. Eq (220 lbs): Inject 90 mg SC D every 12 weeks. Eq (220 lbs): Inject 90 mg SC D every 12 weeks. Eq (220 lbs): Inject 90 mg SC D every 12 weeks. Eq (220 lbs): Inject 90 mg SC D every 12 weeks. Eq (220 lbs): Inject 90 mg SC D every 12 weeks. Eq (220 lbs): Inject 90 mg SC D every 12 weeks the istent mod-severe PsO: Inject 90 mg SC	every 2 weeks ery weeks SC at initially and 4 initially and 4 mereafter.
□ 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 induction dose 2 weeks later Induction Dose: Inject one 8 Final Induction Dose: Inject or Pediatric Psoriasis Dosing (6 y Patients weighing less than 25 less Inject 40 mg SC at Week 0, Patients weighing 25-50 kg: Inject 40 mg SC at Week 0, Patients weighing greater than Inject 160 mg (two 80 mg inject y 4 weeks) Psoriatic Arthritis Dosing: Starting Dose: Inject SC two Maintenance Dose: Inject SC	0 mg injection SC every 2 we one 80 mg injection SC week ne 80 mg injection SC every 4 years and older): 60: 60: 60: 60: 60: 60: 60: 6	eeks (weeks 2-10) Quantity: 28 days 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 dosing Maintenance Dose: Inject 10	SC at weeks 0 and 4, then n	
Other	Strength:	Dose:		Quantity: Refills:
	in patient support programs ER SIGNATURE REQ	STAMP SIGNATURE NOT ALLOWED UIRED (STAMP SIGNATION STAMP)		ry supplies and kits provided as needed for administrati
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MEDICATION	STRENGTH	DOSE 8	& DIRECTIONS	QUANTITY/REFILLS
		PsO Peds patients (6 to 17yo):		, and the second
		< 60 kg: Inject 0.75 mg/kg SC	at weeks 0 and 4, then every 12 weeks	6
		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 v	weeks 0 and 4, then every 12 weeks	
		thereafter.		
		PsA Peds patients (6 to 17yo):		
		< 60 kg: Inject 0.75 mg/kg S0	C at weeks 0 and 4, then every	
	45 mg/0.5 mL vial 45 mg/0.5 mL prefilled syringe	12 weeks thereafter.		
_			eeks 0 and 4, then every 12 weeks	Quantity:
Ustekinumab		thereafter.		Refills:
	90 mg/mL prefilled		d-severe PsO: Inject 90 mg SC at	Nonto:
	syringe	weeks 0 and 4, then every 12 we	eks thereafter.	
		PsO Adult dosing:		
			g (220 lbs): Inject 45 mg SC initially and	l
		4 weeks later, followed by 45 mg		
			g (220 lbs): Inject 90 mg SC initially and	i
		4 weeks later, followed by 90 mg	g every 12 weeks.	
		PsA Adult dosing:		
			nd 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.		
				O
	5 mg tablet	☐ Take one 5 mg tablet PO twic		Quantity:
·	11 mg XR tablet	Take one 11 mg PO once daily	/	Refills:
Other	Strength:	Dose:		Quantity:
				Refills:
	patient support programs	STAMP SIGNATURE NOT ALLOWED		provided as needed for administra
PRESCRIBE	<u>R SIGNAT</u> URE REQU	IRED (STAMP SIGNATU	RE NOT ALLOWED)	
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PRESCRIPTI	ION 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	thereafter. ☐ 60 kg to 100 kg: Inject 45 mg 12 weeks thereafter. ☐ > 100 kg: Inject 90 mg SC at we thereafter. PsA Peds patients (6 to 17yo): ☐ < 60 kg: Inject 0.75 mg/kg SC 12 weeks thereafter. ☐ > 60 kg: Inject 45 mg SC at we thereafter. ☐ > 100 kg with co-existent mode weeks 0 and 4, then every 12 weeks 0 and 4 weeks later, followed by 90 mg ☐ For patients weighing >100 kg 4 weeks later, followed by 90 mg PsA Adult dosing: ☐ Inject 45 mg SC at weeks 0 and 12 weeks 0 and 13 weeks 0 and 14 weeks 0 and 14 weeks 0 and 15 we	veeks 0 and 4, then every 12 weeks at weeks 0 and 4, then every eeks 0 and 4, then every 12 weeks d-severe PsO: Inject 90 mg SC at eks thereafter. (220 lbs): Inject 45 mg SC initially and every 12 weeks. (220 lbs): Inject 90 mg SC initially and every 12 weeks. at 4, then every 12 weeks thereafter. tent mod-severe PsO: Inject 90 mg	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 w☐ Inject 80 mg SC every other w☐ Inject 80 mg SC on Day 1, follo starting one week after initial dos☐ Inject 160 mg SC on Day 1 (sin days), 80 mg on Day 15, then 40 ☐ Inject 160 mg SC on Day 1 (sin Day 15).	reek reek weed by 40 mg every other week	28 days 84 days Refills:
Other	Strength:	Dose:		Quantity: Refills:
	patient support programs R SIGNATURE REQU	STAMP SIGNATURE NOT ALLOWED		vided as needed for administration
"Dispense As Written' / May Not Substitute Prescriber's Sig	" / Brand Medically Necessary / Do	Not Substitute / No Substitution / DAW	May Substitute / Product Selection Permitted / Substitution Permissible Prescriber's Signature: ATTN: New York and Jowa providers, please	Date:

Dermatology Enrollment Form Nursing Orders

Pl	ease Comi	olete Patient. Prescriber	and Patient Clinical Informati	on
			Patient Phone:	
Patient Address:				
Prescriber Name:		Prescriber	r Phone:	
Patient Clinical Information	<u>on:</u>			
Allergies:	 			
Weight:	lb/kg Heig	jht:In/cm T	B Test Result: Date	e:
			WILL ONLY BE SENT FOR INFUSIONS DOI	
MEDICATION/SUPPLIES	ROUTE	DOSE /STREI	NGTH/ DIRECTIONS	QUANTITY/REFILLS
Catheter: PIV PORT CVC/PICC	IV	IV access and patency PIV: NS 5 mL (Heparin 10 units/ml	n 10 units/mL or 100 units/mL 3-5 mL ss PORT w/ huber needle	Quantity: Refills:
Hydration:	IV	Pre:	nL 🗌 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 ☐ 1:1000, 0.15 mg/0.3 mL (15-30 ☐ 1:1000, 0.01 mg/kg, Max 0.3 m Mild-Moderate Reactions. May re For severe allergic reaction also ca	kg/33-66lbs) g (under 15 kg) peat in 3-5 minutes as needed	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	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 re max dose: 100 mg/day) If severe allergic reaction: call 911	peat in 3-5 minutes as needed (Adult	Quantity: Refills:
☐ Flush Orders:	Peripheral Access Central Venous Access	☐ 10 mL NS post flush ☐ 50 mL NS post flush (Recommended if no post-hydrati ☐ Other:		Send quantity sufficient for medication days supply
Additional Medication:				
Patient is interested in patient supp PRESCRIBER SIGN	. •	STAMP SIGNATURE NOT ALLOWED SQUIRED (STAMP SIGNATION AND SIGNATION AND STAMP SIGNATURE NOT ALLOWED STAMP SIGNATURE NOT ALLOWED STAMP SIGNATION AND STAMP SIGNATION STAMP SIGNATION AND STAMP SIGNATION SIGNATI		provided as needed for administration
DAW / May Not Substitute Prescriber's Signature:		y / Do Not Substitute / No Substitution / Date: escriber writes the words "No Substitution"	May Substitute / Product Selection Permitted / Substitution Permissible Prescriber's Signature: ATTN: New York and Iowa providers, pl	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.

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