

Fax Referral To: 1-800-323-2445 Email Referral To: Customer.ServiceFax@CVSHealth.com Phone: 1-800-237-2767

	\$	ix Simple Steps to Subn	nitting a Refe	rral		
PATIENT INFOR	MATION (Complete or inclu	de demographic sheet)				
Patient Name:			_ DOB:	Gender: [] Male 🔲 Fema	le
	Methods: Phone (to primar					l below)
	es may apply. If unable to cont					
			Alternate Phoi	ne:		
Email:	and Overding Name (Last First)	Last Four of S	SSN:	Primary Language:		
	egal Guardian Name (Last, First):	:Relati	onsnip to patie	nt:		
Prescriber's Name:				State Licen	#*	
Prescriber's Name:	DEA #:	Group or Hospital		State Licer	ise #:	
Address:	DEA #	City State	·			
Phone:	Fax	Contact Person:	ZIF Code	Contact's Phone		
INCLIDANCE INI	FORMATION Please fax copy	of prescription and insurar	noo carde (fron	at and back) with this form	·	
	d? Yes No Is the Pation				i, ii avallable	
	e:					
Medical Insurance:		Telephone:P	olicy ID:	Group #:		
Prescription Insuran	ce:	Presc	ription Plan Tele	ephone:		
Policy ID:	ce: Group :	#: RX	BIN #:	RX PCN #:		
Check box if patient	ent is enrolled in manufacturer c	opay assistance If	yes, please prov	vide ID#		_
	D-10) AND PATIENT CLINIC			linicals)		
	toid Arthritis (RA)					
	athic Psoriasis (PsA)		Arthritis (JPsA))		
_	adiographic Axial Spondylarthi					
_	lgia Rheumatica (PMR)	M08.00 Juvenile Idiopath	ic Arthritis (JIA	.)		
	, unspecified eye					
	Description		A/ - * - 1- 1-			lu 🗆 au
Allergies:		NKDA V	Weight:	lb 🗌 kg Heig	jnt: [_	In ∐ Cm
reatment status: L	New to therapy Continu	lation of therapy; Date of la	ast treatment _	_/_/	1	
	☐ No ☐ Yes, if so, how many ment dates, and reason(s) for		☐ IB Test Da	ite// Pos) Neg	
	INFORMATION Ship to:		 hor:			
	STRENGTH		SE & DIRECTIO)NS	QUANTITY	REFILLS
MEDICATION	☐ 162 mg/0.9 mL ACTPen	☐ Inject 162 mg SC every			28 days	KEITEES
Actemra	☐ 162 mg/0.9 mL PFS	Inject 162 mg SC every			84 days	
Adalimumab-						
aacf	☐ 40 mg/0.8 mL PEN	Inject 40 mg SC every			28 days	
(unbranded	☐ 40 mg/0.8 mL PFS	Inject 40 mg SC every			84 days	
version of Idacio)		Inject 80 mg SC every	other week			
Adalimumab-						
aaty	☐ 1 x 40 mg/0.4 mL PEN	☐ Inject 40 mg SC every	week		28 days	
(unbranded	2 x 40 mg/0.4 mL PEN	Inject 40 mg SC every			84 days	
version of		☐ Inject 80 mg SC every	other week			
Yuflyma)						
Adalimumab-	☐ 40 mg/0.4 mL PEN					
adaz	40 mg/0.4 mL PFS (with	Inject 40 mg SC every				
(unbranded version of	needle guard)	☐ Inject 40 mg SC every ☐ Inject 80 mg SC every			28 days 84 days	
Hyrimoz)		inject 80 mg SC every	other week		□ 64 days	
Adalimumab-		☐ Inject 20 mg SC every	other week			
fkjp	20 mg/0.4 mL PFS	Inject 40 mg SC every			28 days	
(unbranded	40 mg/0.8 mL PFS	☐ Inject 40 mg SC every			84 days	
version of Hulio)	☐ 40 mg/0.8 mL PEN	☐ Inject 80 mg SC every				
Other:		_ , _ ,				
	GNATURE REQUIRED (STAI	MD SIGNATURE NOT AL	I OWED)			
	-		_			
· ·	' / Brand Medically Necessary / Do Not	Substitute / No Substitution /	May Substitute / Substitution Per	/ Product Selection Permitted /		
DAW / May Not Substi		Date:		missible s Signature:	D.	ate:
Frescriber 5 algi	114441 G	vale	FIGSCIDE	. Jigi iatul 5	D	u.e
CA, MA, NC & PR: Inte	rchange is mandated unless Prescriber wr	ites the words "No Substitution"	ATT	N: New York and Iowa provide	s, please submit electro	onic 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.

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 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 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		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:

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.

		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:

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.

				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
			☐ Inject 80 mg SC injectio	n every 4 weeks	☐ 84 days	
		☐ 80 mg PEN	nr-axSpA: Inject 80 mg SC every 4	weeks	28 days 84 days	
		_	PsA Loading Dose (w/o pso			_
☐ Taltz		☐ 80 mg PFS	☐ Inject 160 mg (two 80 m		28 days	0
			PsA Maintenance Dose (w/		28 days 84 days	
			ng 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 (wi	th psoriasis): 2 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

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.

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 S	C on week 0	☐ 56 days		
<u> Пеннуа</u>	100 mg/mL PEN		Maintenance Dose:			
			C week 4, then every 8 weeks thereafte			
Tyenne (tocilizumab-	☐ 162 mg/0.9 mL PEN		C every other week	28 days		
aazg)	☐ 162 mg/0.9 mL PFS	☐ Inject 162 mg S	C every week	☐ 84 days		
□ v-:	5 mg Tablet	☐ Take one 5 mg	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				
	☐ 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:	

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.

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