

Rheumatology Oral/Subcutaneous Enrollment Form

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



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

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)
 M35.3 Polymyalgia Rheumatica (PMR)
 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"/> Amjevita	<input type="checkbox"/> 20 mg/0.4 mL PFS <input type="checkbox"/> 40 mg/0.8 mL Pen <input type="checkbox"/> 40 mg/0.8 mL PFS	<input type="checkbox"/> Inject 20 mg SC every other week <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"/> 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:	_____	_____	_____	_____

Rheumatology Oral/Subcutaneous Enrollment Form

Medications H-R (Humira, Ilaris, Kevzara, Olumiant, 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 ≥ 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"/> Otezla	<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"/> Otezla	<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	_____	_____	_____	_____

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
<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

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

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