Rheumatology Enrollment Form
Medications A
(Actemra®)

CVS specialty™

Fax Referral To: 1-800-323-2445 **Phone:** 1-800-237-2767
Email Referral To: customerservicefax@caremark.com

Coram® CVS specialty infusion services

Six Simple Steps to Submitting a Referral

1 PATIENT INFORMATION *(Complete or include demographic sheet)*

Patient Name: _____ Address: _____ City, State, ZIP: _____

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: _____ DOB: _____ Gender: ☐ Male ☐ Female

Email: _____ Last Four of SSN: _____ Primary Language: _____

2 PRESCRIBER INFORMATION

Prescriber's Name: _____ State License #: _____

NPI #: _____ DEA #: _____ Group or Hospital: _____

Address: _____ City, State, ZIP: _____

Phone: _____ Fax _____ Contact Person: _____ Contact's Phone: _____

3 INSURANCE INFORMATION Please fax copy of prescription and insurance cards with this form, if available (front and back)

4 DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: _____ Ship to: ☐ Patient ☐ Office ☐ Other: _____

Diagnosis (ICD-10):

☐ M06.9 Rheumatoid Arthritis, Unspecified
☐ M45.9 Ankylosing Spondylitis of Unspecified Sites in Spine
☐ L40.50 Arthropathic Psoriasis, Unspecified
☐ L40.59 Other Psoriatic Arthropathy
☐ M08.00 Unspecified Juvenile Rheumatoid Arthritis of Unspecified Site ☐ Other Code: _____ Description _____

For additional ICD-10 information, please visit CVS Specialty Healthcare Professionals Website
https://www.cvsspecialty.com/wps/portal/specialty/healthcare-professionals/about-us

Patient Clinical Information:

Allergies: _____ Weight: _____lb/kg Height: _____in/cm TB Test Result: _____ Date: _____

Nursing:

Specialty pharmacy to coordinate injection training/ home health infusion nurse visit necessary ☐ Yes ☐ No
Site of Care: ☐ MD office ☐ Infusion Clinic ☐ Outpatient Health ☐ Home Health
Injection training not necessary. Date training occurred: _____
Reason: ☐ MD office training patient ☐ Pt already independent ☐ Referred by MD to alternate trainer

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Actemra	☐ 80 mg/4 mL ☐ 200 mg/10 mL ☐ 400 mg/20 mL	☐ Induction Dose: Infuse 4 mg/kg every 4 weeks. ☐ Maintenance Dose: Infuse 8 mg/kg every 4 weeks. ☐ Other: _____	Quantity:_____ Refills:_____
☐ Actemra	162mg/0.9 mL prefilled syringe	☐ For patients weighing <100kg: Inject 162mg SC every other week, followed by an increase to every week based on clinical response ☐ For patients weighing ≥ 100kg: Inject 162mg SC every week.	Quantity:_____ Refills:_____

☐ Patient is interested in patient support programs **STAMP SIGNATURE NOT ALLOWED** Ancillary supplies and kits provided as needed for administration

6 PHYSICIAN SIGNATURE REQUIRED

PRODUCT SUBSTITUTION PERMITTED (Date)
X_____

DISPENSE AS WRITTEN (Date)
X_____

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 below, 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.

Medications A-C
Rheumatology Enrollment Form
(Avsola™Cimzia®,Cosentyx®)

Please complete Patient and Prescriber information

Patient Name: _____ Patient DOB: _____

Prescriber Name: _____ Prescriber Phone: _____

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Avsola	100 mg vial	☐Rheumatoid Arthritis Induction Dose: In conjunction with methotrexate Infuse IV at 3 mg/kg (Dose = _____mg) at weeks 0, week 2, week 6 and every 8 weeks thereafter. ☐ Rheumatoid Arthritis Maintenance Dose: Infuse 3 mg/kg every 8 weeks. ☐ Psoriatic Arthritis Induction Dose: Infuse IV at 5 mg/kg (Dose = _____mg) at weeks 0, week 2, week 6 and every 8 weeks thereafter. ☐ Psoriatic Arthritis Maintenance Dose: Infuse 5 mg/kg every 8 weeks. ☐ Ankylosing Spondylitis Induction Dose: Infuse IV at 5 mg/kg (Dose = _____mg) at weeks 0, week 2, week 6 and every 6 weeks thereafter. ☐ Ankylosing Spondylitis Maintenance Dose: Infuse 5 mg/kg every 6 weeks. ☐ Other:_____	Quantity:_____ # of 100 mg vial Refills:_____
☐ Cimzia	Cimzia Starter Kit (6 prefilled syringes)	Induction Dose: 400 mg initially and at week 2 and 4, (given as 2 SC of 200 mg each) followed by 200 mg every other week;	Quantity: 1 Kit Refills: 0
☐ Cimzia	☐ 200mg/1 mL prefilled syringe ☐ 200mg vial	☐ Maintenance Dose: Inject 200mg SC every OTHER week. ☐ Maintenance Dose: Inject 400mg SC every four weeks. ☐ Other:_____	Quantity:_____ Refills:_____
☐ Cosentyx	☐ Sensoready® pen 150 mg/mL injection ☐ Prefilled syringe 150 mg/mL injection	Psoriatic Arthritis with Coexistent Moderate to Severe Plaque Psoriasis ☐ Loading Dose: Inject 300 mg (two injections) SC at weeks 0, 1, 2, 3 and 4. ☐ Maintenance Dose: Inject 300 mg (two injections) SC every 4 weeks. Other Psoriatic Arthritis or Ankylosing Spondylitis ☐ With Loading Dose: Inject 150 mg (one injection) SC at weeks 0, 1, 2, 3 and 4, and then every 4 weeks thereafter. ☐ Without Loading Dose: Inject 150 mg (one injection) SC every 4 weeks. ☐ Other:_____	Quantity:_____ Refills:_____

☐ Patient is interested in patient support programs **STAMP SIGNATURE NOT ALLOWED** Ancillary supplies and kits provided as needed for administration

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X_____ X_____

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Medications E-I
Rheumatology Enrollment Form
(Enbrel®, Humira®, Ilaris®,Inflectra®)

Please complete Patient and Prescriber information

Patient Name: _____ Patient DOB: _____

Prescriber Name: _____ Prescriber Phone: _____

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Enbrel	☐ 25mg/0.5 mL prefilled syringe ☐ 25mg vial ☐ 50mg/mL Sureclick™ Autoinjector ☐ 50mg/mL prefilled syringe ☐ 50 mg/mL Enbrel Mini™ prefilled cartridge for use with the AutoTouch™ reusable autoinjector only (Prescriber MUST supply). CVS does not order the autoinjector.	☐ Inject 25mg SC TWICE a week (72 – 96 hours apart). ☐ Inject 50mg SC ONCE a week. ☐ Other: _____	Quantity:_____ Refills:_____
☐ Humira	☐ 40 mg/0.4 mL Pen **Citrate Free** ☐ 40 mg/0.4 mL Prefilled Syringe **Citrate Free**	☐ Inject 40mg SC every OTHER week. ☐ Other: _____	Quantity:_____ Refills:_____
☐ Ilaris	150 mg/mL injection solution	For patients weighing ≥ 7.5 kg: Inject 4 mg/kg (with a maximum of 300 mg) SC every 4 weeks. Each single-dose vial of ILARIS (canakinumab) Injection delivers 150 mg/mL sterile, preservative-free, clear to slightly opalescent, colorless to a slight brownish to yellow solution.	Quantity:_____ Refills:_____
☐ Inflectra	100 mg vial	☐ Rheumatoid Arthritis Induction Dose: In conjunction with methotrexate Infuse IV at 3 mg/kg (Dose = _____mg) at weeks 0, week 2, week 6 and every 8 weeks thereafter. ☐ Rheumatoid Arthritis Maintenance Dose: Infuse 3 mg/kg every 8 weeks. ☐ Psoriatic Arthritis Induction Dose: Infuse IV at 5 mg/kg (Dose = _____mg) at weeks 0, week 2, week 6 and every 8 weeks thereafter. ☐ Psoriatic Arthritis Maintenance Dose: Infuse 5 mg/kg every 8 weeks. ☐ Ankylosing Spondylitis Induction Dose: Infuse IV at 5 mg/kg (Dose = _____mg) at weeks 0, week 2, week 6 and every 6 weeks thereafter. ☐ Ankylosing Spondylitis Maintenance Dose: Infuse 5 mg/kg every 6 weeks. ☐ Other: _____	Quantity:_____ # of 100 mg vial Refills:_____

☐ Patient is interested in patient support programs **STAMP SIGNATURE NOT ALLOWED** Ancillary supplies and kits provided as needed for administration

6 PHYSICIAN SIGNATURE REQUIRED

PRODUCT SUBSTITUTION PERMITTED (Date)

X_____

DISPENSE AS WRITTEN (Date)

X_____

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Medications K-O
Rheumatology Enrollment Form
(Kevzara®,Olumiant®,Orencia®, Otezla®)

Please complete Patient and Prescriber information

Patient Name: _____ Patient DOB: _____

Prescriber Name: _____ Prescriber Phone: _____

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Kevzara	☐ 200 mg/1.14 mL prefilled syringe (pk of 2) ☐ 150 mg/1.14 mL prefilled syringe (pk of 2) ☐ 200 mg/1.14 mL prefilled pen (pk of 2) ☐ 150 mg/1.14 mL prefilled pen (pk of 2)	☐ Inject 200 mg SC once every two weeks. ☐ Inject 150 mg SC once every two weeks.	Quantity:_____ Refills:_____
☐ Olumiant	☐ 2 mg tablet ☐ 1 mg tablet	☐ Take 2 mg PO once daily ☐ Other: _____	Quantity:_____ Refills:_____
☐ Orencia	☐ 125mg prefilled syringe ☐ ClickJect Autoinjector 125 mg/mL pack of 4	☐ Inject 125mg SC every week ☐ After Single IV Loading Dose: Inject 125mg SC within a day and 125mg SC every week thereafter. ☐ Patients Unable to Receive an IV Loading Dose: Inject 125 mg SC every week. ☐ Patients Transitioning from IV Infusion Therapy: Inject 125 mg SC instead of the next scheduled IV dose, followed by 125mg SC injections every week thereafter.	Quantity:_____ Refills:_____
☐ Orencia	250 mg vial	☐ Infuse ___ mg at weeks 0, 2 and 4, then every 4 weeks thereafter. ☐ Other: _____	Quantity:_____ Refills:_____
☐ Otezla	Titration Starter Pack	Day 1: 10 mg PO in the morning. Day 2: 10 mg PO in the morning and 10 mg PO in the evening. Day 3: 10 mg PO in the morning and 20 mg PO in the evening. Day 4: 20 mg PO in the morning and 20 mg PO in the evening. Day 5: 20 mg PO in the morning and 30 mg PO in the evening. Day 6 and thereafter: 30 mg PO twice daily.	Quantity: 1 Pack Refills: 0
☐ Otezla	30 mg tablet	☐ Maintenance Dose: 30 mg PO twice daily. ☐ Other: _____	Quantity:_____ Refills:_____

☐ Patient is interested in patient support programs **STAMP SIGNATURE NOT ALLOWED** Ancillary supplies and kits provided as needed for administration

6 PHYSICIAN SIGNATURE REQUIRED

PRODUCT SUBSTITUTION PERMITTED (Date) DISPENSE AS WRITTEN (Date)

X_____ X_____

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Medications R-S
Rheumatology Enrollment Form
(Remicade®, Renflexis®, Rinvoq®, Rituxan®, Simponi®)

Please complete Patient and Prescriber information

Patient Name: _____ Patient DOB: _____

Prescriber Name: _____ Prescriber Phone: _____

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Remicade	100 mg vial	☐ Rheumatoid Arthritis Induction Dose: In conjunction with methotrexate Infuse IV at 3 mg/kg (Dose = _____mg) at weeks 0, week 2, week 6 and every 8 weeks thereafter. ☐ Rheumatoid Arthritis Maintenance Dose: Infuse 3 mg/kg every 8 weeks. ☐ Psoriatic Arthritis Induction Dose: Infuse IV at 5 mg/kg (Dose = _____mg) at weeks 0, week 2, week 6 and every 8 weeks thereafter. ☐ Psoriatic Arthritis Maintenance Dose: Infuse 5 mg/kg every 8 weeks. ☐ Ankylosing Spondylitis Induction Dose: Infuse IV at 5 mg/kg (Dose = _____mg) at weeks 0, week 2, week 6 and every 6 weeks thereafter. ☐ Ankylosing Spondylitis Maintenance Dose: Infuse 5 mg/kg every 6 weeks. ☐ Other: _____	Quantity:_____ Refills:_____
☐ Renflexis	100 mg vial	☐ Rheumatoid Arthritis Induction Dose: In conjunction with methotrexate Infuse IV at 3 mg/kg (Dose = _____mg) at weeks 0, week 2, week 6 and every 8 weeks thereafter. ☐ Rheumatoid Arthritis Maintenance Dose: Infuse 3 mg/kg every 8 weeks. ☐ Psoriatic Arthritis Induction Dose: Infuse IV at 5 mg/kg (Dose = _____mg) at weeks 0, week 2, week 6 and every 8 weeks thereafter. ☐ Psoriatic Arthritis Maintenance Dose: Infuse 5 mg/kg every 8 weeks. ☐ Ankylosing Spondylitis Induction Dose: Infuse IV at 5 mg/kg (Dose = _____mg) at weeks 0, week 2, week 6 and every 6 weeks thereafter. ☐ Ankylosing Spondylitis Maintenance Dose: Infuse 5 mg/kg every 6 weeks. ☐ Other: _____	Quantity:_____ # of 100 mg vial Refills:_____
☐ Rinvoq	15 mg	☐ Take one 15 mg tablet PO once daily. ☐ Other: _____	Quantity:_____ Refills:_____
☐ Rituxan	☐ 100 mg/10 mL vial ☐ 500 mg/50 mL vial	☐ Infuse two doses of 1000 mg separated by 2 weeks. ☐ Other: _____	Quantity:_____ Refills:_____
☐ Simponi	☐ 50mg/0.5mL prefilled SmartJect® Autoinjector ☐ 50mg/0.5mL prefilled syringe	☐ Inject 50mg SC once a month. ☐ Other: _____	Quantity:_____ Refills:_____

☐ Patient is interested in patient support programs **STAMP SIGNATURE NOT ALLOWED** Ancillary supplies and kits provided as needed for administration

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X_____ X_____

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Medications S-Z
Rheumatology Enrollment Form
(Simponi ARIA®, Stelara®, Taltz®,Tremfya® ,Xeljanz®)

Please complete Patient and Prescriber information

Patient Name: _____ Patient DOB: _____

Prescriber Name: _____ Prescriber Phone: _____

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Simponi ARIA	50 mg/4 mL in a single use vial	Infuse 2 mg/kg over 30 minutes at weeks 0 and 4, then every 8 weeks thereafter.	Quantity:_____ # of 50 mg vial Refills:_____
☐ Stelara	☐ 45mg/0.5mL prefilled syringe ☐ 90mg/mL prefilled syringe	☐ For patients weighing ≤100 kg (220 lbs): Inject 45 mg SC initially and 4 weeks later, followed by 45 mg every 12 weeks. ☐ For patients weighing >100 kg (220 lbs): Inject 90 mg SC initially and 4 weeks later, followed by 90 mg every 12 weeks. ☐ Other: _____	Quantity:_____ Refills:_____
☐ Taltz	☐ 80 mg Single Dose Autoinjector ☐ 80 mg Single Dose Prefilled Syringe	Psoriatic Arthritis with Coexistent Moderate to Severe Plaque Psoriasis Dosing: ☐ Starting Dose: Inject SC two 80 mg injections on Day 1, then begin the induction dose 2 weeks later. ☐ Induction Dose: Inject SC one 80 mg injection every 2 weeks (weeks 2, 4, 6, 8, 10, and 12). ☐ Maintenance Dose: Inject SC one 80 mg injection every 4 weeks.	☐ 3 Pens/Syringes ☐ 2 Pens/Syringes ☐1 Pens/Syringes Refills: _____
☐ Taltz	☐ 80 mg Single Dose Autoinjector ☐ 80 mg Single Dose Prefilled Syringe	Psoriatic Arthritis Dosing and Ankylosing Spondylitis Dosing: ☐ Starting Dose: Inject SC two 80 mg injections on Day 1. ☐ Maintenance Dose: Inject SC one 80 mg injection every 4 weeks. Non-radiographic Axial Spondyloarthritis Dosing: ☐ Dose: Inject SC one 80 mg injection every 4 weeks	Quantity: ☐ 2 Pens/Syringes ☐1 Pens/Syringes Refills:_____
☐ Tremfya	100 mg/mL prefilled syringe	Psoriatic Arthritis Dosing: ☐ 100mg administered by SC at Week 0, Week 4 and every 8 weeks thereafter	Quantity:_____ Refills:_____
☐ Xeljanz	☐ 5 mg Tablet ☐ 11 mg XR Tablet	☐ Take one 5 mg tablet PO twice daily ☐ Take one 11 mg PO once daily ☐ Other:_____	Quantity:_____ Refills:_____

Complete Items below, required for Home Infusion/Coram AIS:

MEDICATION/SUPPLIES	ROUTE	DOSE/STRENGTH/DIRECTIONS	QUANTITY/REFILLS
Catheter ☐ PIV ☐ PORT ☐ PICC	☐ IV	Catheter Care/Flush – Only on drug admin days – SASH or PRN to maintain IV access and patency PIV – NS 5ml (Heparin 10 units/ml 3-5ml if multiple days) PORT/PICC – NS 10ml & Heparin 100units/ml 3-5ml, and/or 10ml sterile saline to access port a cath	Quantity:_____ Refills:_____
☐ Epinephrine **nursing requires**	☐ IM ☐	☐ Adult 1:1000, 0.3mL (>30kg/>66lbs) ☐ Peds 1:2000, 0.3mL (15-30kg/33-66lbs) ☐ Infant 0.1mL/0.1mL, 0.1mL (7.5-15kg/16.5-33lbs) PRN severe allergic reaction – Call 911 May repeat in 5-15 minutes as needed	Quantity:_____ Refills:_____

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