Rheumatology Oral/Subcutaneous Enrollment Form

CVS specialty®

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: _____
Parent/Caregiver/Legal Guardian Name (Last, First): _____**Relationship to patient**: _____

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) ☐ 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 _____

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
☐ Actemra	☐ 162 mg/0.9 mL ACTPen ☐ 162 mg/0.9 mL PFS	☐ Inject 162 mg SC every other week ☐ Inject 162 mg SC every week	☐ 28 days ☐ 84 days	_____
☐ Adalimumab-aacf (unbranded version of Idacio)	☐ 40 mg/0.8 mL PEN	☐ Inject 40 mg SC every week ☐ Inject 40 mg SC every other week ☐ Inject 80 mg SC every other week	☐ 28 days ☐ 84 days	_____
☐ Adalimumab-adaz (unbranded version of 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	_____
☐ Adalimumab-fkjp (unbranded version of 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	_____
☐ 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 other week ☐ Inject 20 mg SC every other week ☐ Inject 40 mg SC every other week ☐ Inject 40 mg SC every week ☐ Inject 80 mg SC every other week ☐ Inject 80 mg Day 1, followed by 40 mg every other week starting one week after initial dose	☐ 28 days ☐ 84 days	_____
☐ Other:	_____	_____	_____	_____

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

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.

Rheumatology Oral/Subcutaneous Enrollment Form

Please Complete Patient, Prescriber and Patient Clinical Information

Patient Name: _____ Patient DOB: _____ Patient Phone: _____

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
☐ Bimzelx	☐ 2 x 160 mg/mL PEN ☐ 2 x 160 mg/mL PFS ☐ 160 mg/mL PEN ☐ 160 mg/mL PFS	PsA/nr-axSpA/AS: ☐ Inject 160 mg SC every 4 weeks	☐ 28 days ☐ 84 days	_____
		PsA with Psoriasis: ☐ Inject 320 mg SC every 4 weeks at weeks 0, 4, 8, and 12	☐ 28 days	3
		☐ Inject 320 mg SC at week 16 and then every 8 weeks	☐ 56 days	0
		☐ Inject 320 mg SC at week 16 and then every 4 weeks	☐ 28 days	0
		☐ Inject 320 mg SC every 8 weeks ☐ Inject 320 mg SC every 4 weeks	☐ 28 days ☐ 84 days	_____
☐ Cimzia	☐ Cimzia Starter Kit	☐ Inject 400 mg SC on weeks 0, 2 and 4	1 kit	0
	☐ 200 mg/mL PFS (carton of 1) ☐ 200 mg/mL PFS (carton of 2) ☐ 200 mg/mL vial kit (carton of 2-HCP administration	☐ Inject 50 mg SC every other week ☐ Inject 100 mg SC on weeks 0, 2 and 4 ☐ Inject 100 mg SC every other week ☐ Inject 200 mg SC on weeks 0, 2 and 4 ☐ Inject 200 mg SC every other week ☐ Inject 400 mg SC every 4 weeks *There is no dosage form for Cimzia that allows for patient self-administration for doses below 200 mg. Doses less than 200 mg require administration by a HCP using the vial kit*	☐ 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 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:_____
☐ 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	_____
☐ Other	_____	_____	_____	_____

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Patient Name: _____ Patient DOB: _____ Patient Phone: _____

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Patient Clinical Information:

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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
☐ 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 ☐ 84 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 ☐ 84 days	_____
☐ Hyrimoz	☐ 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 (with needle guard)	☐ 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	☐ 28 days ☐ 84 days	_____
☐ Idacio	☐ 40 mg/0.8 mL PEN ☐ 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	☐ 28 days ☐ 84 days	_____
☐ 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)	☐ 28 days ☐ 84 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 ☐ 84 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 **Adult RA or PsA Dosing:** ☐ Inject 125 mg SC once weekly	☐ 28 days ☐ 84 days	_____
☐ Other	_____	_____	_____	_____

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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
☐ Otezla	☐ Titration Starter Pack for 30 mg BID dosage	Day 1: Take 10 mg PO in the morning. Day 2: Take 10 mg PO in the morning and 10 mg PO in the evening. Day 3: Take 10 mg PO in the morning and 20 mg PO in the evening. Day 4: Take 20 mg PO in the morning and 20 mg PO in the evening. Day 5: Take 20 mg PO in the morning and 30 mg PO in the evening. Day 6 and thereafter: Take 30 mg PO twice daily.	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 once daily	☐ 30 days ☐ 90 days	_____
☐ Rinvoq LQ	☐ 1 mg/ 1 mL	☐ 3 mg (3 mL oral solution) PO twice daily ☐ 4 mg (4 mL oral solution) PO twice daily ☐ 6 mg (6 mL oral solution) PO twice daily	Quantity(ml) _____	_____
☐ Simlandi (adalimumab-ryvk)	☐ 40 mg/0.4 mL PEN	☐ Inject 40mg SC every week ☐ Inject 40mg SC every other week ☐ Inject 80mg SC every other week ☐ Inject 80 mg Day 1, followed by 40 mg every other week starting one week after initial dose	☐ 28 days ☐ 84 days	_____
☐ Simponi	☐ 50 mg/0.5 mL PEN ☐ 50 mg/0.5 mL PFS	Inject 50 mg SC every 4 weeks	☐ 28 days ☐ 84 days	_____
☐ Skyrizi	☐ 150 mg/mL PFS ☐ 150 mg/mL PEN	Loading Dose: ☐ Inject 150 mg SC at week 0	☐ 28 days	0
		Maintenance Dose: ☐ Inject 150 mg SC at week 4, and every 12 weeks thereafter	☐ 84 days	_____
☐ Taltz	☐ 80 mg PEN ☐ 80 mg PFS	AS Loading Dose: ☐ Inject 160 mg (two 80 mg injections) SC on week 0	☐ 28 days	0
		AS Maintenance Dose: ☐ Inject 80 mg SC injection every 4 weeks	☐ 28 days ☐ 84 days	_____
		nr-axSpA: ☐ Inject 80 mg SC every 4 weeks	☐ 28 days ☐ 84 days	_____
		PsA Loading Dose (w/o psoriasis): ☐ Inject 160 mg (two 80 mg injections) SC on week 0	☐ 28 days	0
		PsA Maintenance Dose (w/o psoriasis): ☐ Inject 80 mg SC every 4 weeks	☐ 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, 8, and 10	☐ 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	_____	_____	_____	_____

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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
☐ Tremfya	☐ 100 mg/mL PFS ☐ 100 mg/mL PEN	Loading Dose: ☐ Inject 100 mg SC on week 0	☐ 28 days	0
		Maintenance Dose: ☐ Inject 100 mg SC week 4, then every 8 weeks thereafter	☐ 56 days	_____
☐ Tyenne (tocilizumab-aazg)	☐ 162 mg/0.9 mL PEN ☐ 162 mg/0.9 mL PFS	☐ Inject 162 mg SC every other week ☐ Inject 162 mg SC every week	☐ 28 days ☐ 84 days	_____
☐ Xeljanz	☐ 5 mg Tablet ☐ 11 mg XR Tablet	☐ Take one 5 mg tablet PO twice daily ☐ Take one 11 mg tablet PO once daily	☐ 30 days ☐ 90 days	_____
☐ Yuflyma	☐ 40 mg/0.4 mL PEN ☐ 40 mg/0.4 mL PFS (with safety guard) ☐ 40 mg/0.4 mL PFS ☐ 80 mg/0.8 mL PEN	☐ Inject 40 mg SC every week ☐ Inject 40 mg SC every other week ☐ Inject 80 mg SC every other week	☐ 28 days ☐ 84 days	_____
☐ Other	_____	_____	_____	_____

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

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