

Rheumatology Subcutaneous Enrollment Form

Medications A-C (Actemra, Cimzia)



Fax Referral To: 1-877-232-5455

Address: 500 Ala Moana Blvd., Ste 1-A Honolulu, HI 96813

Phone: 1-800-896-1464

Six Simple Steps to Submitting a Referral

1 PATIENT INFORMATION (Complete or include demographic sheet)

Patient Name: _____ DOB: _____
 Address: _____ City, State, ZIP Code: _____
 Gender: Male Female
 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: _____
 If **Minor**, Parent/Caregiver/Guardian Name (Last, First): _____
Relationship to minor: _____
 Email: _____ Last Four of SSN: _____ Primary Language: _____

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 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.A0 Non-radiographic axial spondyloarthritis of unspecified sites in spine
 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: _____

Patient Clinical Information:

Allergies: _____
 Weight: _____ lb/kg Height: _____ in/cm TB Test Result: _____ Date: _____

Nursing:

Specialty pharmacy to coordinate injection training/home health nurse visit as 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
<input type="checkbox"/> Actemra	162 mg/0.9 mL prefilled syringe	<input type="checkbox"/> For patients weighing <100 kg: Inject 162 mg SC every other week, followed by an increase to every week based on clinical response <input type="checkbox"/> For patients weighing ≥ 100 kg: Inject 162 mg SC every week.	Quantity: _____ Refills: _____
<input type="checkbox"/> Cimzia	Cimzia Starter Kit (6 prefilled syringes)	<input type="checkbox"/> Induction Dose: 400 mg (given as 2 subcutaneous injections of 200 mg each) initially and at weeks 2 and 4, followed by 200 mg every other week <input type="checkbox"/> Other: _____	Quantity: 1 Kit Refills: 0
<input type="checkbox"/> Cimzia	<input type="checkbox"/> 200 mg/1 mL prefilled syringe <input type="checkbox"/> 200 mg vial	<input type="checkbox"/> Maintenance Dose: Inject 200 mg SC every OTHER week. <input type="checkbox"/> Maintenance Dose: Inject 400 mg SC every four weeks. <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____

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	

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 Subcutaneous Enrollment Form

Medications C-K (Cosentyx, Enbrel, Humira, Ilaris, Kevzara)

Please Complete Patient , Prescriber and Patient Clinical Information

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

Patient Clinical Information:

Allergies: _____
 Weight: _____ lb/kg Height: _____ In/cm TB Test Result: _____ Date: _____

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Cosentyx 150 mg	<input type="checkbox"/> Sensoready Pen (1x150 mg/mL) <input type="checkbox"/> Prefilled syringe (1x150 mg/mL)	Adult: <input type="checkbox"/> <u>Loading Dose</u> : Inject 150 mg subcutaneously on Weeks 0, 1, 2, 3 <input type="checkbox"/> <u>Maintenance Dose</u> : Inject 150 mg subcutaneously on Week 4, then every 4 weeks thereafter <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Cosentyx 300 mg	<input type="checkbox"/> Sensoready Pen (2x150 mg/mL) <input type="checkbox"/> Prefilled syringe (2x150 mg/mL)	Adult: <input type="checkbox"/> <u>Loading Dose</u> : Inject 300 mg subcutaneously on Weeks 0, 1, 2, 3 <input type="checkbox"/> <u>Maintenance Dose</u> : Inject 300 mg subcutaneously on Week 4, then every 4 weeks thereafter <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Cosentyx 75 mg (wt ≥ 15 kg and < 50 kg)	Prefilled syringe (1x75 mg/0.5 mL)	Pediatric: <input type="checkbox"/> <u>Loading Dose</u> : Inject 75 mg subcutaneously on Weeks 0, 1, 2, 3 <input type="checkbox"/> <u>Maintenance Dose</u> : Inject 75 mg subcutaneously on Week 4, then every 4 weeks thereafter <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Cosentyx 150 mg (wt ≥ 50 kg)	<input type="checkbox"/> Sensoready Pen (1x150 mg/mL) <input type="checkbox"/> Prefilled syringe (1x150 mg/mL)	Pediatric: <input type="checkbox"/> <u>Loading Dose</u> : Inject 150 mg subcutaneously on Weeks 0, 1, 2, 3 <input type="checkbox"/> <u>Maintenance Dose</u> : Inject 150 mg subcutaneously on Week 4, then every 4 weeks thereafter <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Enbrel	<input type="checkbox"/> 25mg/0.5 mL prefilled syringe <input type="checkbox"/> 25 mg/0.5 mL solution in a single-dose vial <input type="checkbox"/> 50mg/mL Sureclick Autoinjector <input type="checkbox"/> 50mg/mL prefilled syringe <input type="checkbox"/> 50 mg/mL Enbrel Mini prefilled cartridge for use with the <u>AutoTouch reusable autoinjector only</u> (Prescriber MUST supply). CVS does <u>not</u> order the autoinjector.	<input type="checkbox"/> Inject 25mg SC TWICE a week (72 – 96 hours apart). <input type="checkbox"/> Inject 50mg SC ONCE a week. <input type="checkbox"/> Other: _____	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 Prefilled syringe Citrate Free <input type="checkbox"/> 80 mg/0.8 mL Pen Citrate Free <input type="checkbox"/> 80 mg/0.8 mL Prefilled syringe with Citrate Buffer	<input type="checkbox"/> Inject 40 mg SC every OTHER week. <input type="checkbox"/> Other: _____ <input type="checkbox"/> Inject 80 mg SC every OTHER week. <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> 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: _____
<input type="checkbox"/> Kevzara	<input type="checkbox"/> 200 mg/1.14 mL prefilled syringe (pk of 2) <input type="checkbox"/> 150 mg/1.14 mL prefilled syringe (pk of 2) <input type="checkbox"/> 200 mg/1.14 mL prefilled pen (pk of 2) <input type="checkbox"/> 150 mg/1.14 mL prefilled pen (pk of 2)	<input type="checkbox"/> Inject 200 mg SC once every two weeks. <input type="checkbox"/> Inject 150 mg SC once every two weeks.	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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Rheumatology Subcutaneous Enrollment Form

Medications L-Z (Orencia, Simponi, Skyrizi, Stelara, Taltz, Tremfya)

Please Complete Patient, Prescriber and Patient Clinical Information

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

Patient Clinical Information:

Allergies: _____
 Weight: _____ lb/kg Height: _____ In/cm TB Test Result: _____ Date: _____

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Orencia	<input type="checkbox"/> 125 mg prefilled syringe <input type="checkbox"/> ClickJect Autoinjector 125 mg/mL pack of 4	<input type="checkbox"/> Inject 125mg SC every week <input type="checkbox"/> <u>After Single IV Loading Dose:</u> Inject 125 mg SC within a day and 125 mg SC every week thereafter. <input type="checkbox"/> <u>Patients Unable to Receive an IV Loading Dose:</u> Inject 125 mg SC every week. <input type="checkbox"/> <u>Patients Transitioning from IV Infusion Therapy:</u> Inject 125 mg SC instead of the next scheduled IV dose, followed by 125 mg SC injections every week thereafter.	Quantity: _____ Refills: _____
<input type="checkbox"/> Simponi	<input type="checkbox"/> 50 mg/0.5 mL prefilled SmartJect Autoinjector <input type="checkbox"/> 50 mg/0.5 mL prefilled syringe	<input type="checkbox"/> Inject 50 mg SC once a month. <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Skyrizi	<input type="checkbox"/> 150 mg/mL single-dose pen <input type="checkbox"/> 150 mg/mL single-dose prefilled syringe	<input type="checkbox"/> <u>Induction dose:</u> Inject 150 mg SC at weeks 0 and 4, then maintenance dosing <input type="checkbox"/> <u>Maintenance dose:</u> Inject 150 mg SC every 12 weeks <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Stelara	<input type="checkbox"/> 45 mg/0.5 mL prefilled syringe <input type="checkbox"/> 90 mg/mL prefilled syringe	<input type="checkbox"/> <u>For patients weighing ≤100 kg (220 lbs):</u> Inject 45 mg SC initially and 4 weeks later, followed by 45 mg every 12 weeks. <input type="checkbox"/> <u>For patients weighing >100 kg (220 lbs):</u> Inject 90 mg SC initially and 4 weeks later, followed by 90 mg every 12 weeks. <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Taltz	<input type="checkbox"/> 80 mg Single Dose Autoinjector <input type="checkbox"/> 80 mg Single Dose prefilled syringe	Psoriatic Arthritis with Coexistent Moderate to Severe Plaque Psoriasis Dosing: <input type="checkbox"/> <u>Starting Dose:</u> Inject SC two 80 mg injections on Day 1, then begin the induction dose 2 weeks later. <input type="checkbox"/> <u>Induction Dose:</u> Inject SC one 80 mg injection every 2 weeks (weeks 2, 4, 6, 8, 10, and 12). <input type="checkbox"/> <u>Maintenance Dose:</u> Inject SC one 80 mg injection every 4 weeks.	Quantity: <input type="checkbox"/> 3 Pens/Syringes <input type="checkbox"/> 2 Pens/Syringes <input type="checkbox"/> 1 Pens/Syringes Refills: _____
<input type="checkbox"/> Taltz	<input type="checkbox"/> 80 mg Single Dose Autoinjector <input type="checkbox"/> 80 mg Single Dose prefilled syringe	Psoriatic Arthritis Dosing and Ankylosing Spondylitis Dosing: <input type="checkbox"/> <u>Starting Dose:</u> Inject SC two 80 mg injections on Day 1. <input type="checkbox"/> <u>Maintenance Dose:</u> Inject SC one 80 mg injection every 4 weeks. Non-radiographic Axial Spondyloarthritis Dosing: <input type="checkbox"/> <u>Dose:</u> Inject SC one 80 mg injection every 4 weeks	Quantity: <input type="checkbox"/> 2 Pens/Syringes <input type="checkbox"/> 1 Pens/Syringes Refills: _____
<input type="checkbox"/> Tremfya	<input type="checkbox"/> 100 mg/mL prefilled syringe <input type="checkbox"/> 100 mg/mL One-Press patient-controlled injector	Psoriatic Arthritis Dosing: <input type="checkbox"/> <u>Starting Dose:</u> Inject 100 mg SC at weeks 0 and 4, then maintenance dosing <input type="checkbox"/> <u>Maintenance Dose:</u> Inject 100 mg SC every 8 weeks	Quantity: _____ Refills: _____

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