Rheumatology Enrollment Form
Medications A (Actemra, Avsola)

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

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 and Administration:
Place of infusion: ☐ Home Infusion ☐ Coram Ambulatory Infusion Suite ☐ Prescriber's Office
Specialty pharmacy to coordinate home health infusion nurse visit necessary: ☐ Yes ☐ No

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	162 mg/0.9 mL prefilled syringe	☐ For patients weighing <100 kg: Inject 162 mg SC every other week, followed by an increase to every week based on clinical response ☐ For patients weighing ≥ 100 kg: Inject 162 mg SC every week.	Quantity: ______ Refills: ______
☐ Avsola	100 mg vial	☐ Ankylosing Spondylitis Induction Dose: Infuse IV at 5 mg/kg (Dose = ______mg) at weeks 0, 2, 6 and every 6 weeks thereafter ☐ Ankylosing Spondylitis Maintenance Dose: Infuse IV at 5 mg/kg (Dose = _____mg) every 6 weeks ☐ Psoriatic Arthritis Induction Dose: Infuse IV at 5 mg/kg (Dose = _____mg) at weeks 0, 2, 6 and every 8 weeks thereafter ☐ Psoriatic Arthritis Maintenance Dose: Infuse IV at 5 mg/kg (Dose = _____mg) every 8 weeks ☐ Rheumatoid Arthritis Induction Dose: Infuse IV at 3 mg/kg (Dose = _____mg) at weeks 0, 2, 6 and every 8 weeks thereafter ☐ Rheumatoid Arthritis Maintenance Dose: Infuse IV at 3-10 mg/kg (Dose = _____mg) every 4, 6 or 8 weeks (circle one) ☐ Other:______________	Quantity: _____ # of 100 mg vial(s) 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

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Rheumatology Enrollment Form

Medications C-G (Cimzia, Cosentyx, Enbrel)

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
☐ Cimzia	Cimzia Starter Kit (6 prefilled syringes)	☐ 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 ☐ Other: ______________	Quantity: 1 Kit Refills: 0
☐ Cimzia	☐ 200 mg/1 mL prefilled syringe ☐ 200 mg vial	☐ Maintenance Dose: Inject 200 mg SC every OTHER week. ☐ Maintenance Dose: Inject 400 mg SC every four weeks. ☐ Other: ______________	Quantity: ________ Refills: ________
☐ Cosentyx 150 mg	☐ Sensoready Pen (1x150 mg/mL) ☐ Prefilled syringe (1x150 mg/mL)	Adult: ☐ Loading Dose: Inject 150 mg subcutaneously on Weeks 0, 1, 2, 3 ☐ Maintenance Dose: Inject 150 mg subcutaneously on Week 4, then every 4 weeks thereafter ☐ Other:______________	Quantity: ________ Refills: ________
☐ Cosentyx 300 mg	☐ Sensoready Pen (2x150 mg/mL) ☐ Prefilled syringe (2x150 mg/mL)	Adult: ☐ Loading Dose: Inject 300 mg subcutaneously on Weeks 0, 1, 2, 3 ☐ Maintenance Dose: Inject 300 mg subcutaneously on Week 4, then every 4 weeks thereafter ☐ Other:______________	Quantity: ________ Refills: ________
☐ Cosentyx 75 mg (wt ≥ 15 kg and < 50 kg)	Prefilled syringe (1x75 mg/0.5 mL)	Pediatric: ☐ Loading Dose: Inject 75 mg subcutaneously on Weeks 0, 1, 2, 3 ☐ Maintenance Dose: Inject 75 mg subcutaneously on Week 4, then every 4 weeks thereafter ☐ Other:______________	Quantity: ________ Refills: ________
☐ Cosentyx 150 mg (wt ≥ 50 kg)	☐ Sensoready Pen (1x150 mg/mL) ☐ Prefilled syringe (1x150 mg/mL)	Pediatric: ☐ Loading Dose: Inject 150 mg subcutaneously on Weeks 0, 1, 2, 3 ☐ Maintenance Dose: Inject 150 mg subcutaneously on Week 4, then every 4 weeks thereafter ☐ Other:______________	Quantity: ________ Refills: ________
☐ Enbrel	☐ 25 mg/0.5 mL prefilled syringe ☐ 25 mg/0.5 mL solution in a single-dose vial ☐ 50 mg/mL Sureclick Autoinjector ☐ 50 mg/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 25 mg SC TWICE a week (72 – 96 hours apart). ☐ Inject 50 mg SC ONCE a week. ☐ 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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Rheumatology Enrollment Form

Medications H-N (Humira, Ilaris, Inflectra, Infliximab, 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
☐ Humira	☐ 40 mg/0.4 mL Pen **Citrate Free** ☐ 40 mg/0.4 mL prefilled syringe **Citrate Free** ☐ 80 mg/0.8 mL Pen **Citrate Free** ☐ 80 mg/0.8 mL prefilled syringe with **Citrate Buffer**	☐ Inject 40 mg SC every OTHER week. ☐ Other: ____________________ ☐ Inject 80 mg 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 ☐ Infliximab	100 mg vial	☐ Ankylosing Spondylitis Induction Dose: Infuse IV at 5 mg/kg (Dose = _______mg) at weeks 0, 2, 6 and every 6 weeks thereafter ☐ Ankylosing Spondylitis Maintenance Dose: Infuse IV at 5 mg/kg (Dose = ______mg) every 6 weeks ☐ Psoriatic Arthritis Induction Dose: Infuse IV at 5 mg/kg (Dose = ______mg) at weeks 0, 2, 6 and every 8 weeks thereafter ☐ Psoriatic Arthritis Maintenance Dose: Infuse IV at 5 mg/kg (Dose = ______mg) every 8 weeks ☐ Rheumatoid Arthritis Induction Dose: Infuse IV at 3 mg/kg (Dose = ______mg) at weeks 0, 2, 6 and every 8 weeks thereafter ☐ Rheumatoid Arthritis Maintenance Dose: Infuse IV at 3-10 mg/kg (Dose = ______mg) every 4, 6 or 8 weeks (circle one) ☐ Other:________________________	Quantity: _______ # of 100 mg vial(s) 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: _________

☐ 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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Rheumatology Enrollment Form

Medications O-R (Olumiant, Orencia, Otezla, Remicade, Renflexis)

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
☐ Olumiant	☐ 2 mg tablet ☐ 1 mg tablet	☐ Take 2 mg PO once daily ☐ Other: ______________________	Quantity: __________ Refills: __________
☐ Orencia	☐ 125 mg prefilled syringe ☐ ClickJect Autoinjector 125 mg/mL pack of 4	☐ Inject 125 mg SC every week ☐ After Single IV Loading Dose: Inject 125 mg SC within a day and 125 mg 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 125 mg 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: __________
☐ Remicade ☐ Renflexis	100 mg vial	☐ Ankylosing Spondylitis Induction Dose: Infuse IV at 5 mg/kg (Dose = _______mg) at weeks 0, 2, 6 and every 6 weeks thereafter ☐ Ankylosing Spondylitis Maintenance Dose: Infuse IV at 5 mg/kg (Dose = ______mg) every 6 weeks ☐ P soriatic Arthritis Induction Dose: Infuse IV at 5 mg/kg (Dose = ______mg) at weeks 0, 2, 6 and every 8 weeks thereafter ☐ Psoriatic Arthritis Maintenance Dose: Infuse IV at 5 mg/kg (Dose = ______mg) every 8 weeks ☐ Rheumatoid Arthritis Induction Dose: Infuse IV at 3 mg/kg (Dose = ______mg) at weeks 0, 2, 6 and every 8 weeks thereafter ☐ Rheumatoid Arthritis Maintenance Dose: Infuse IV at 3-10 mg/kg (Dose = ______mg) every 4, 6 or 8 weeks (circle one) ☐ Other:______________________	Quantity: _______ # of 100 mg vial(s) 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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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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Rheumatology Enrollment Form

Medications R-T (Rinvoq, Rituxan, Simponi, Simponi ARIA, Skyrizi, Stelara, Taltz)

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
☐ 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	☐ 50 mg/0.5 mL prefilled SmartJect Autoinjector ☐ 50 mg/0.5 mL prefilled syringe	☐ Inject 50 mg SC once a month. ☐ Other: __________	Quantity: __________ Refills: __________
☐ Simponi ARIA	50 mg/4 mL in a single use vial	☐ Adult patients with Rheumatoid Arthritis, Psoriatic Arthritis, and Ankylosing Spondylitis: Infuse 2 mg/kg over 30 minutes at weeks 0 and 4, then every 8 weeks thereafter. ☐ Pediatric patients with polyarticular Juvenile Idiopathic Arthritis and Psoriatic Arthritis: 80 mg/m2 intravenous infusion over 30 minutes at weeks 0 and 4, and every 8 weeks thereafter ☐ Other: __________	Quantity: _______ # of 50 mg vial Refills: _______
☐ Skyrizi	☐ 150 mg/mL single-dose pen ☐ 150 mg/mL single-dose prefilled syringe	☐ Induction dose: Inject 150 mg SC at weeks 0 and 4, then maintenance dosing ☐ Maintenance dose: Inject 150 mg SC every 12 weeks ☐ Other: __________	Quantity: __________ Refills: __________
☐ Stelara	☐ 45 mg/0.5 mL 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: _______

☐ 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 Enrollment Form
Medications T-Z (Tremfya, Xeljanz)
Nursing Medications

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
☐ Tremfya	☐ 100 mg/mL prefilled syringe ☐ 100 mg/mL One-Press patient-controlled injector	Psoriatic Arthritis Dosing: ☐ Starting Dose: Inject 100 mg SC at weeks 0 and 4, then maintenance dosing ☐ Maintenance Dose: Inject 100 mg SC every 8 weeks	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 5 mL (Heparin 10 units/mL 3-5 mL if multiple days) PORT/PICC – NS 10 mL & Heparin 100 units/mL 3-5 mL, and/or 10 mL sterile saline to access port a cath	Quantity: __________ Refills: ____________
☐ Epinephrine **nursing requires**	☐ IM ☐ SC	☐ Adult 1:1000, 0.3 mL (>30 kg/>66 lbs) ☐ Peds 1:2000, 0.3 mL (15-30 kg/33-66 lbs) ☐ Infant 0.1 mL/0.1 mL, 0.1 mL (7.5-15 kg/16.5-33 lbs) PRN severe allergic reaction – Call 911 May repeat in 5-15 minutes as needed	Quantity: __________ Refills: ____________
Premed Antihistamine: ☐ Diphenhydramine ☐ Other: _________	☐ Other: ___________	☐ Other: ____	Dose will be rounded to the nearest vial size
☐ Flush Orders	☐ Peripheral Access ☐ Central Venus Access	☐ 0.9% Sodium Chloride flush with _________ mL IV before and after medication and IVP for Maintenance ☐ Heparin _______ units per mL Flush with __________ units as final flush and as directed	Send quantity sufficient for medication days supply

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

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