Rheumatology Subcutaneous Enrollment Form
Medications A-C (Actemra, Cimzia)

CVS specialty®

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

Coram® CVS specialty® infusion services

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
☐ 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: _____
☐ 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: _____

☐ 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	May Substitute / Product Selection Permitted / Substitution Permissible
Prescriber's Signature: _____ **Date:** _____	**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
☐ 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	☐ 25mg/0.5 mL prefilled syringe ☐ 25 mg/0.5 mL solution in a single-dose 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** ☐ 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: _____
☐ 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

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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
☐ Orencia	☐ 125 mg prefilled syringe ☐ ClickJect Autoinjector 125 mg/mL pack of 4	☐ Inject 125mg 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: _____
☐ 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: _____
☐ 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 ☐ 90 mg/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.	Quantity: ☐ 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 ☐ 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: _____

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