Optum

Rheumatology Enrollment Form

Optum Specialty Phone: 855-427-4682 | Optum Specialty Fax: 877-342-4596

Specialty Pharmacy Enrollment Form

This form is not a valid prescription in Arizona and Virginia

Please detach before submitting to a pharmacy – tear here

PATIENT INFORMATION

Please complete the following or send patient demographic sheet

Patient Name ______
Address ______
Address 2 ______
City, State, Zip ______
Home Phone ______ Alternate Phone ______
DOB ______ Last Four of SS# ______ Gender ______
Language Preference: ☐ English ☐ Spanish ☐ Other ______

PRESCRIBER INFORMATION

Prescriber's Name ______
DEA ______
NPI ______
Group / Hospital ______
Address ______
City, State, ZIP ______
Phone ______ Fax ______
Contact Person ______ Phone ______

INSURANCE INFORMATION (Must fax a copy of patient's insurance card including both sides)

Prior Authorization Reference number: ______

MEDICAL INFORMATION (Section must be completed to process prescription) (Attach separate sheet if needed)

Diagnosis – *Please include diagnosis name with ICD-10 code*

☐ M06.9 Rheumatoid arthritis, unspecified
☐ M08.00 Unspecified juvenile rheumatoid arthritis of unspecified site
☐ M08.3 Juvenile rheumatoid polyarthritis (seronegative)
☐ M45.9 Ankylosing spondylitis of unspecified sites in spine
☐ L40.59 Other Psoriatic Anthropathy
☐ Other Diagnosis: ICD-10 Code ______ Description ______

Date of diagnosis ______
Has a TB test been performed? ☐ Yes ☐ No
Does the patient have an active infection? ☐ Yes ☐ No
Start Date ______ **Review Date** ______

Additional Information Therapy: ☐ New ☐ Reauthorization ☐ Restart

Weight ______kg/lbs Height ______cm/in
Allergies ______
Lab Data ______
Prior Therapies ______
Concomitant Medications ______
Additional Comments ______
Injection Training Required: ☐ Yes ☐ No

PRESCRIPTION INFORMATION

Medication	Strength	Dose & Directions	Qty/Refills
☐ Abrilada™ (tocilizumab)	☐ 20 mg/0.4mL prefilled syringe ☐ 40 mg/0.8mL prefilled syringe ☐ 40 mg/0.8mL pen	☐ Inject 40 mg SQ every other week ☐ Other: ______	Quantity: ______ Refills: ______
☐ Actemra® (tocilizumab)	☐ 80 mg/4 mL Vial ☐ 200 mg/10 mL Vial ☐ 400 mg/20 mL Vial	☐ Induction Dose: Infuse 4 mg/kg IV every 4 weeks. ☐ Maintenance Dose: Infuse 8 mg/kg IV every 4 weeks (please record patient weight at the top of this form). ☐ Other: ______	Quantity: ______ Refills: ______
☐ Actemra® (tocilizumab)	☐ 162 mg/0.9 mL prefilled syringe ☐ 162 mg/0.9 mL ACTPen Autoinjector	☐ 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: ______
☐ Amjevita™ (adalimumab-atto)	☐ 20 mg/0.4 mL Prefilled Syringe **(citrate-free)** ☐ 40 mg/0.8 mL Prefilled Syringe **(citrate-free)** ☐ 40 mg/0.8 mL Prefilled SureClick® autoinjector **(citrate-free)**	☐ Inject 40 mg SC every OTHER week. ☐ Other: ______	Quantity: ______ Refills: ______
☐ Avsola® (infliximab-axxq)	100 mg Vial	☐ Induction Dose: Infuse _____ mg/kg IV at weeks 0, 2 and 6. ☐ Maintenance Dose: Infuse _____ mg/kg IV every 6 weeks. ☐ Maintenance Dose: Infuse _____ mg/kg IV every 8 weeks. ☐ Other: ______	Quantity: ______ # of 100 mg vial Refills: ______
☐ Benlysta® (belimumab)	☐ 120 mg Vial ☐ 400 mg Vial	☐ Induction Dose: 10 mg/kg/dose IV infused over 1 hour every 2 weeks for the first 3 doses (0 refills). ☐ Maintenance Dose: Inject 10 mg/kg/dose IV once every 4 weeks.	Quantity: ______ Refills: ______
☐ Benlysta® (belimumab)	☐ 200 mg/mL Prefilled Syringe ☐ 200 mg/mL Autoinjector	☐ Maintenance Dose: Inject 200 mg SC once every week.	Quantity: ______ Refills: ______

***Prescriber Authorization:** I authorize this pharmacy and its representatives to act as my authorized agent, where permitted by law and benefit plan sponsor, to secure coverage and initiate the insurance prior authorization process for our shared patient, and to sign any necessary forms, including but not limited to, attestations of medical necessity, on my behalf as my authorized agent, including any required prior authorization forms and the receipt and submission of patient lab values and other patient data that support the prior authorization. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

Ship to:
☐ Patient ☐ Office-first fill only ☐ Office-all fills ☐ Other ______ Date: ______ Needs by date: ______

Dispense as Written	Substitution Permitted
Prescriber's Signature ______ Date ______ Electronic or digital signatures not accepted.	Prescriber's Signature ______ Date ______ Electronic or digital signatures not accepted.

Supervising/Collaborative Physician Information (per state requirements) ______

Confidentiality statement: This communication is intended for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential, and exempt from disclosure under applicable law. If the reader of this communication is not the intended recipient or the employee or agent responsible for delivery of the communication, you are hereby notified that any dissemination, distribution, or copying of the communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone. This form is not a valid prescription in Arizona and Virginia.

Optum

Rheumatology Enrollment Form

Optum Specialty Phone: 855-427-4682 | Optum Specialty Fax: 877-342-4596

Specialty Pharmacy Enrollment Form Please detach before submitting to a pharmacy – tear here **This form is not a valid prescription in Arizona and Virginia**

PATIENT INFORMATION

Please complete the following or send patient demographic sheet

Patient Name ___

Address ___

Address 2 ___

City, State, Zip ___

Home Phone ___ Alternate Phone ___

DOB ___ Last Four of SS# ___ Gender ___

Language Preference: ☐ English ☐ Spanish ☐ Other ___

PRESCRIBER INFORMATION

Prescriber's Name ___

DEA ___

NPI ___

Group/Hospital ___

Address ___

City, State, ZIP ___

Phone ___ Fax ___

Contact Person ___ Phone ___

INSURANCE INFORMATION (Must fax a copy of patient's insurance card including both sides)

Prior Authorization Reference number: ___

MEDICAL INFORMATION (Section must be completed to process prescription) (Attach separate sheet if needed)

Diagnosis – *Please include diagnosis name with ICD-10 code*

☐ M06.9 Rheumatoid arthritis, unspecified
☐ M08.00 Unspecified juvenile rheumatoid arthritis of unspecified site
☐ M08.3 Juvenile rheumatoid polyarthritis (seronegative)
☐ M45.9 Ankylosing spondylitis of unspecified sites in spine
☐ L40.59 Other Psoriatic Anthropathy
☐ Other Diagnosis: ICD-10 Code ___ Description ___

Date of diagnosis ___

Has a TB test been performed? ☐ Yes ☐ No

Does the patient have an active infection? ☐ Yes ☐ No

Start Date ___ **Review Date** ___

Additional Information Therapy: ☐ New ☐ Reauthorization ☐ Restart

Weight ___kg/lbs Height ___cm/in

Allergies ___

Lab Data ___

Prior Therapies ___

Concomitant Medications ___

Additional Comments ___

Injection Training Required: ☐ Yes ☐ No

PRESCRIPTION INFORMATION

Medication	Strength	Dose & Directions	Qty/Refills
☐ Cimzia® (certolizumab pegol)	☐ 200 mg/mL Starter Kit (6 prefilled syringes)	Induction Dose: Inject 400mg SC at weeks 0, 2 and 4.	Quantity: 1 Kit Refills: 0
☐ Cimzia® (certolizumab pegol)	☐ 200 mg/ mL Vial Kit ☐ 200 mg/mL Prefilled Syringe	☐ Maintenance Dose: Inject 200 mg SC every OTHER week. ☐ Maintenance Dose: Inject 400 mg SC every four weeks. ☐ Other:___	Quantity:___ Refills: ___
☐ Cosentyx® (secukinumab)	☐ Sensoready® pen 150 mg/mL injection ☐ Prefilled syringe 150 mg/mL injection ☐ UnoReady pen 300 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 (10 pens/syringes, 0 refills). ☐ 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 (5 pens/syringes, 0 refills). ☐ Without Loading Dose: Inject 150 mg (one injection) SC every 4 weeks. ☐ Other:___	Quantity:___ Refills: ___
☐ Cyltezo® (adalimumab-adbm)	☐ 40 mg/0.8ml Pen ☐ 40mg/0.8mL prefilled syringe	☐ Inject 40 mg SQ every other week. ☐ Other:___	Quantity:___ Refills: ___
☐ Enbrel® (etanercept)	☐ 25 mg/0.5 mL prefilled syringe ☐ 25mg/0.5ml 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). Avella/Briova 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: ___

***Prescriber Authorization:** I authorize this pharmacy and its representatives to act as my authorized agent, where permitted by law and benefit plan sponsor, to secure coverage and initiate the insurance prior authorization process for our shared patient, and to sign any necessary forms, including but not limited to, attestations of medical necessity, on my behalf as my authorized agent, including any required prior authorization forms and the receipt and submission of patient lab values and other patient data that support the prior authorization. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

Ship to:

☐ Patient ☐ Office-first fill only ☐ Office-all fills ☐ Other___ Date:___ Needs by date:___

Dispense as Written	Substitution Permitted
Prescriber's Signature___ Date ___ Electronic or digital signatures not accepted.	Prescriber's Signature___ Date ___ Electronic or digital signatures not accepted.

Supervising/Collaborative Physician Information (per state requirements) ___

Confidentiality statement: This communication is intended for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential, and exempt from disclosure under applicable law. If the reader of this communication is not the intended recipient or the employee or agent responsible for delivery of the communication, you are hereby notified that any dissemination, distribution, or copying of the communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone. This form is not a valid prescription in Arizona and Virginia.

Optum Specialty Phone: 855-427-4682 | Optum Specialty Fax: 877-342-4596

Specialty Pharmacy Enrollment Form — Please detach before submitting to a pharmacy – tear here — **This form is not a valid prescription in Arizona and Virginia**

PATIENT INFORMATION

Please complete the following or send patient demographic sheet

Patient Name ____________________
Address ____________________
Address 2 ____________________
City, State, Zip ____________________
Home Phone ____________ Alternate Phone ____________
DOB ________ Last Four of SS# ________ Gender ________
Language Preference: ☐ English ☐ Spanish ☐ Other ____________

PRESCRIBER INFORMATION

Prescriber's Name ____________________
DEA ____________________
NPI ____________________
Group/ Hospital ____________________
Address ____________________
City, State, ZIP ____________________
Phone ____________ Fax ____________
Contact Person ____________ Phone ____________

INSURANCE INFORMATION (Must fax a copy of patient's insurance card including both sides)

Prior Authorization Reference number: ____________________

MEDICAL INFORMATION (Section must be completed to process prescription) (Attach separate sheet if needed)

Diagnosis – *Please include diagnosis name with ICD-10 code*

☐ M06.9 Rheumatoid arthritis, unspecified
☐ M08.00 Unspecified juvenile rheumatoid arthritis of unspecified site
☐ M08.3 Juvenile rheumatoid polyarthritis (seronegative)
☐ M45.9 Ankylosing spondylitis of unspecified sites in spine
☐ L40.59 Other Psoriatic Anthropathy
☐ Other Diagnosis: ICD-10 Code ________ Description ____________
Date of diagnosis ____________
Has a TB test been performed? ☐ Yes ☐ No
Does the patient have an active infection? ☐ Yes ☐ No
Start Date ____________ **Review Date** ____________

Additional Information Therapy: ☐ New ☐ Reauthorization ☐ Restart

Weight ________kg/lbs Height ________cm/in
Allergies ____________________
Lab Data ____________________
Prior Therapies ____________________
Concomitant Medications ____________________
Additional Comments ____________________
Injection Training Required: ☐ Yes ☐ No

PRESCRIPTION INFORMATION

Medication	Strength	Dose & Directions	Qty/Refills
☐ Hadlima™ (adalimumab-bwwd)	☐ 40mg/0.4ml prefilled syringe ☐ 40mg/0.8ml prefilled syringe ☐ 40mg/0.4ml PushTouch auto-injector ☐ 40mg/0.8ml PushTouch auto-injector	☐ Inject 40 mg SQ every other week. ☐ Other: ____________	Quantity: ______ Refills: ______
☐ Hulio® (adalimumab-fkjp)	☐ 20 mg/0.4mL prefilled syringe ☐ 40 mg/0.8mL prefilled syringe ☐ 40 mg/0.8mL pen	☐ Inject 40 mg SQ every other week. ☐ Other: ____________	Quantity: ______ Refills: ______
☐ Humira® (adalimumab)	☐ 10 mg/0.1 mL Prefilled Syringe (citrate-free) ☐ 20 mg/0.2 mL Prefilled Syringe (citrate-free) ☐ 40 mg/0.4 mL Prefilled Syringe (citrate-free) ☐ 40 mg/0.4 mL Pen (citrate-free) ☐ 10 mg/0.2 mL Prefilled Syringe ☐ 20 mg/0.4 mL Prefilled Syringe ☐ 40 mg/0.8 mL Prefilled Syringe ☐ 40 mg/0.8 mL Pen	☐ Inject 40 mg SC every OTHER week. ☐ Other: ____________	Quantity: ______ Refills: ______
☐ Hyrimoz® (adalimumab-adaz)	☐ 10 mg/0.1mL prefilled syringe ☐ 20 mg/0.2mL prefilled syringe ☐ 40 mg/0.4mL prefilled syringe ☐ 40 mg/0.8mL prefilled syringe ☐ 40 mg/0.4mL auto-injector ☐ 80 mg/0.8mL auto-injector	☐ Inject 40 mg SQ every other week. ☐ Other: ____________	Quantity: ______ Refills: ______
☐ Idacio® (adalimumab-aacf)	☐ 40 mg/0.8ml auto-injector ☐ 40 mg/0.8ml prefilled syringe	☐ Inject 40 mg SQ every other week. ☐ Other: ____________	Quantity: ______ Refills: ______

Prescriber Authorization: I authorize this pharmacy and its representatives to act as my authorized agent, where permitted by law and benefit plan sponsor, to secure coverage and initiate the insurance prior authorization process for our shared patient, and to sign any necessary forms, including but not limited to, attestations of medical necessity, on my behalf as my authorized agent, including any required prior authorization forms and the receipt and submission of patient lab values and other patient data that support the prior authorization. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

Ship to:
☐ Patient ☐ Office-first fill only ☐ Office-all fills ☐ Other ____________ Date: ________ Needs by date: ________

Dispense as Written	**Substitution Permitted**
Prescriber's Signature ____________ Date ________ Electronic or digital signatures not accepted.	Prescriber's Signature ____________ Date ________ Electronic or digital signatures not accepted.

Supervising/Collaborative Physician Information (per state requirements) ____________________

Confidentiality statement: This communication is intended for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential, and exempt from disclosure under applicable law. If the reader of this communication is not the intended recipient or the employee or agent responsible for delivery of the communication, you are hereby notified that any dissemination, distribution, or copying of the communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone. This form is not a valid prescription in Arizona and Virginia.

Optum Specialty Phone: 855-427-4682 | Optum Specialty Fax: 877-342-4596

Specialty Pharmacy Enrollment Form

This form is not a valid prescription in Arizona and Virginia

Please detach before submitting to a pharmacy – tear here

PATIENT INFORMATION

Please complete the following or send patient demographic sheet

Patient Name ____

Address ____

Address 2 ____

City, State, Zip ____

Home Phone ____ Alternate Phone ____

DOB ____ Last Four of SS# ____ Gender ____

Language Preference: ☐ English ☐ Spanish ☐ Other ____

PRESCRIBER INFORMATION

Prescriber's Name ____

DEA ____

NPI ____

Group/Hospital ____

Address ____

City, State, ZIP ____

Phone ____ Fax ____

Contact Person ____ Phone ____

INSURANCE INFORMATION (Must fax a copy of patient's insurance card including both sides)

Prior Authorization Reference number: ____

MEDICAL INFORMATION (Section must be completed to process prescription) (Attach separate sheet if needed)

Diagnosis – *Please include diagnosis name with ICD-10 code*

☐ M06.9 Rheumatoid arthritis, unspecified
☐ M08.00 Unspecified juvenile rheumatoid arthritis of unspecified site
☐ M08.3 Juvenile rheumatoid polyarthritis (seronegative)
☐ M45.9 Ankylosing spondylitis of unspecified sites in spine
☐ L40.59 Other Psoriatic Anthropathy
☐ Other Diagnosis: ICD-10 Code ____ Description ____

Date of diagnosis ____

Has a TB test been performed? ☐ Yes ☐ No

Does the patient have an active infection? ☐ Yes ☐ No

Start Date ____ **Review Date** ____

Additional Information Therapy: ☐ New ☐ Reauthorization ☐ Restart

Weight ____kg/lbs Height ____cm/in

Allergies ____

Lab Data ____

Prior Therapies ____

Concomitant Medications ____

Additional Comments ____

Injection Training Required: ☐ Yes ☐ No

PRESCRIPTION INFORMATION

Medication	Strength	Dose & Directions	Qty/Refills
☐ Inflectra® (infliximab-dyyb)	100 mg Vial	☐ Induction Dose: Infuse ____ mg/kg IV at weeks 0, 2 and 6. ☐ Maintenance Dose: Infuse ____ mg/kg IV every 6 weeks. ☐ Maintenance Dose: Infuse ____ mg/kg IV every 8 weeks. ☐ Other: ____	Quantity: ____ # of 100 mg vial Refills: ____
☐ Kevzara® (sarilumab)	☐ 200 mg/1.14 mL Prefilled Syringe ☐ 150 mg/1.14 mL Prefilled Syringe ☐ 200 mg/1.14 mL Prefilled Pen ☐ 150 mg/1.14 mL Prefilled Pen	☐ Inject 200 mg SC once every two weeks. ☐ Inject 150 mg SC once every two weeks.	Quantity: ____ Refills: ____
☐ Olumiant® (baricitinib)	☐ 1 mg Tablet ☐ 2 mg Tablet	☐ Take 2 mg PO once daily. ☐ Other: ____	Quantity: ____ Refills: ____
☐ Orencia® (abatacept)	250 mg vial	☐ Infuse ___ mg IV at weeks 0, 2 and 4, then every 4 weeks thereafter (please record patient weight at the top of the form). ☐ Other: ____	Quantity: ____ Refills: ____
☐ Orencia® (abatacept)	☐ ClickJect Autoinjector 125 mg/mL pack of 4 ☐ 125 mg Prefilled Syringe ☐ 87.5 mg/0.7ml Prefilled Syringe ☐ 50 mg/0.4ml Prefilled Syringe	☐ Inject 125 mg SC every week. ☐ Inject 87.5 mg SC every week. ☐ Inject 50 mg SC every week. ☐ Other: ____	Quantity: ____ Refills: ____
☐ Otezla® (apremilast)	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

Prescriber Authorization: I authorize this pharmacy and its representatives to act as my authorized agent, where permitted by law and benefit plan sponsor, to secure coverage and initiate the insurance prior authorization process for our shared patient, and to sign any necessary forms, including but not limited to, attestations of medical necessity, on my behalf as my authorized agent, including any required prior authorization forms and the receipt and submission of patient lab values and other patient data that support the prior authorization. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

Ship to:

☐ Patient ☐ Office-first fill only ☐ Office-all fills ☐ Other ____ Date: ____ Needs by date: ____

Dispense as Written	Substitution Permitted
Prescriber's Signature ____ Date ____ Electronic or digital signatures not accepted.	Prescriber's Signature ____ Date ____ Electronic or digital signatures not accepted.

Supervising/Collaborative Physician Information (per state requirements) ____

Confidentiality statement: This communication is intended for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential, and exempt from disclosure under applicable law. If the reader of this communication is not the intended recipient or the employee or agent responsible for delivery of the communication, you are hereby notified that any dissemination, distribution, or copying of the communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone. This form is not a valid prescription in Arizona and Virginia.

Optum Specialty Phone: 855-427-4682 | Optum Specialty Fax: 877-342-4596

Specialty Pharmacy Enrollment Form

This form is not a valid prescription in Arizona and Virginia

Please detach before submitting to a pharmacy – tear here

PATIENT INFORMATION

Please complete the following or send patient demographic sheet

Patient Name ______

Address ______

Address 2 ______

City, State, Zip ______

Home Phone ______ Alternate Phone ______

DOB ______ Last Four of SS# ______ Gender ______

Language Preference: ☐ English ☐ Spanish ☐ Other ______

PRESCRIBER INFORMATION

Prescriber's Name ______

DEA ______

NPI ______

Group/ Hospital ______

Address ______

City, State, ZIP ______

Phone ______ Fax ______

Contact Person ______ Phone ______

INSURANCE INFORMATION (Must fax a copy of patient's insurance card including both sides)

Prior Authorization Reference number: ______

MEDICAL INFORMATION (Section must be completed to process prescription) (Attach separate sheet if needed)

Diagnosis – *Please include diagnosis name with ICD-10 code*

☐ M06.9 Rheumatoid arthritis, unspecified

☐ M08.00 Unspecified juvenile rheumatoid arthritis of unspecified site

☐ M08.3 Juvenile rheumatoid polyarthritis (seronegative)

☐ M45.9 Ankylosing spondylitis of unspecified sites in spine

☐ L40.59 Other Psoriatic Anthropathy

☐ Other Diagnosis: ICD-10 Code ______ Description ______

Date of diagnosis ______

Has a TB test been performed? ☐ Yes ☐ No

Does the patient have an active infection? ☐ Yes ☐ No

Start Date ______ **Review Date** ______

Additional Information Therapy: ☐ New ☐ Reauthorization ☐ Restart

Weight ______kg/lbs Height ______cm/in

Allergies ______

Lab Data ______

Prior Therapies ______

Concomitant Medications ______

Additional Comments ______

Injection Training Required: ☐ Yes ☐ No

PRESCRIPTION INFORMATION

Medication	Strength	Dose & Directions	Qty/Refills
☐ Otezla® (apremilast)	30 mg Tablet	☐ Maintenance Dose: 30 mg PO twice daily. ☐ Other: ______	Quantity: ______ Refills: ______
☐ Remicade® (infliximab)	100 mg Vial	☐ Induction Dose: Infuse ____ mg/kg IV at weeks 0, 2 and 6. ☐ Maintenance Dose: Infuse ____ mg/kg IV every 6 weeks. ☐ Maintenance Dose: Infuse ____ mg/kg IV every 8 weeks. ☐ Other: ______	Quantity: ______ # of 100 mg vial Refills: ______
☐ Renflexis® (infliximab-abda)	100 mg Vial	☐ Induction Dose: Infuse ____ mg/kg IV at weeks 0, 2 and 6. ☐ Maintenance Dose: Infuse ____ mg/kg IV every 6 weeks. ☐ Maintenance Dose: Infuse ____ mg/kg IV every 8 weeks. ☐ Other: ______	Quantity: ______ # of 100 mg vial Refills: ______
☐ Rinvoq® (upadacitinib)	15 mg	☐ Take one 15 mg tablet PO once daily. ☐ Other: ______	Quantity: ______ Refills: ______
☐ Simlandi® (adalimumab-ryvk)	40 mg/0.4mL auto-injector	☐ Inject 40 mg SQ every other week. ☐ Other: ______	Quantity: ______ Refills: ______
☐ Simponi Aria® (golimumab)	50 mg/4 mL in a single use vial	Infuse 2 mg/kg IV over 30 minutes at weeks 0 and 4, then every 8 weeks thereafter (please record patient weight in section above).	Quantity: ______ # of 50 mg vial Refills: ______
☐ Simponi® (golimumab)	☐ 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: ______

***Prescriber Authorization:** I authorize this pharmacy and its representatives to act as my authorized agent, where permitted by law and benefit plan sponsor, to secure coverage and initiate the insurance prior authorization process for our shared patient, and to sign any necessary forms, including but not limited to, attestations of medical necessity, on my behalf as my authorized agent, including any required prior authorization forms and the receipt and submission of patient lab values and other patient data that support the prior authorization. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

Ship to:

☐ Patient ☐ Office-first fill only ☐ Office-all fills ☐ Other ______ Date: ______ Needs by date: ______

Dispense as Written	Substitution Permitted
Prescriber's Signature ______ Date ______ Electronic or digital signatures not accepted.	Prescriber's Signature ______ Date ______ Electronic or digital signatures not accepted.

Supervising/Collaborative Physician Information (per state requirements) ______

Confidentiality statement: This communication is intended for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential, and exempt from disclosure under applicable law. If the reader of this communication is not the intended recipient or the employee or agent responsible for delivery of the communication, you are hereby notified that any dissemination, distribution, or copying of the communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone. This form is not a valid prescription in Arizona and Virginia.

Optum

Rheumatology Enrollment Form

Optum Specialty Phone: 855-427-4682 | Optum Specialty Fax: 877-342-4596

Specialty Pharmacy Enrollment Form

This form is not a valid prescription in Arizona and Virginia

Please detach before submitting to a pharmacy – tear here

PATIENT INFORMATION

Please complete the following or send patient demographic sheet

Patient Name ______________________

Address ______________________

Address 2 ______________________

City, State, Zip ______________________

Home Phone ____________ Alternate Phone ____________

DOB ________ Last Four of SS# ________ Gender ________

Language Preference: ☐ English ☐ Spanish ☐ Other ________

PRESCRIBER INFORMATION

Prescriber's Name ______________________

DEA ______________________

NPI ______________________

Group/Hospital ______________________

Address ______________________

City, State, ZIP ______________________

Phone ____________ Fax ____________

Contact Person ____________ Phone ____________

INSURANCE INFORMATION (Must fax a copy of patient's insurance card including both sides)

Prior Authorization Reference number: ______________

MEDICAL INFORMATION (Section must be completed to process prescription) (Attach separate sheet if needed)

Diagnosis – *Please include diagnosis name with ICD-10 code*

☐ M06.9 Rheumatoid arthritis, unspecified

☐ M08.00 Unspecified juvenile rheumatoid arthritis of unspecified site

☐ M08.3 Juvenile rheumatoid polyarthritis (seronegative)

☐ M45.9 Ankylosing spondylitis of unspecified sites in spine

☐ L40.59 Other Psoriatic Anthropathy

☐ Other Diagnosis: ICD-10 Code ________ Description ________

Date of diagnosis ______________

Has a TB test been performed? ☐ Yes ☐ No

Does the patient have an active infection? ☐ Yes ☐ No

Start Date ____________ **Review Date** ____________

Additional Information Therapy: ☐ New ☐ Reauthorization ☐ Restart

Weight ________kg/lbs Height ________cm/in

Allergies ______________________

Lab Data ______________________

Prior Therapies ______________________

Concomitant Medications ______________________

Additional Comments ______________________

Injection Training Required: ☐ Yes ☐ No

PRESCRIPTION INFORMATION

Medication	Strength	Dose & Directions	Qty/Refills
☐ Skyrizi® (risankizumab-rzaa)	☐ 150 mg/mL prefilled syringe ☐ 150 mg/mL prefilled pen	☐ Psoriatic Arthritis Induction Dose: Inject 150 mg SC at Weeks 0 and 4, then maintenance dosing (0 refills). ☐ Psoriatic Arthritis Maintenance Dose: Inject 150mg SC every 12 weeks. ☐ Other: ________	Quantity: ________ Refills: ________
☐ Stelara® (ustekinumab)	☐ 45 mg/0.5 mL Prefilled Syringe ☐ 90 mg/mL Prefilled Syringe	☐ Induction Dose: For patients weighing ≤100 kg (220 lbs): Inject 45 mg SC initially and 4 weeks later, (2 syringes, 0 refills). ☐ Induction Dose: For patients weighing >100 kg (220 lbs): Inject 90 mg SC initially and 4 weeks later, (2 syringes, 0 refills). ☐ Maintenance Dose: Inject 1 syringe SC every 12 weeks. ☐ Other: ________	Quantity: ________ Refills: ________
☐ Taltz® (ixekizumab)	☐ 80 mg Single Dose Autoinjector ☐ 80 mg Single Dose Prefilled Syringe	Ankylosing Spondylitis/Psoriatic Arthritis Dosing: ☐ Starting Dose: Inject SC two 80 mg injections on Day 1. (2 injections, 0 refills). ☐ Maintenance Dose: Inject SC one 80 mg injection every 4 weeks. ☐ Other: ________	Quantity: ________ Refills: ________
☐ Tremfya® (guselkumab)	☐ 100 mg/mL prefilled syringe ☐ 100 mg/ml One-Press Injector	☐ Induction Dose: Inject 100mg SC at week 0 and week 4 (2 syringes/pens, 0 refills). ☐ Maintenance Dose: Inject 100mg SC once every 8 weeks.	Quantity: ________ Refills: ________
☐ Xeljanz® (tofacitinib)	☐ 5 mg Tablet ☐ 11 mg Extended-Release Tablet	☐ Take one 5 mg tablet PO twice daily. ☐ Take one 11 mg tablet PO once daily. ☐ Other: ________	Quantity: ________ Refills: ________
☐ Yuflyma™ (adalimumab-aqvh)	☐ 40 mg/0.4mL prefilled syringe ☐ 40 mg/0.4mL auto-injector	☐ Inject 40 mg SQ every other week. ☐ Other: ________	Quantity: ________ Refills: ________

****Prescriber Authorization:*** I authorize this pharmacy and its representatives to act as my authorized agent, where permitted by law and benefit plan sponsor, to secure coverage and initiate the insurance prior authorization process for our shared patient, and to sign any necessary forms, including but not limited to, attestations of medical necessity, on my behalf as my authorized agent, including any required prior authorization forms and the receipt and submission of patient lab values and other patient data that support the prior authorization. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

Ship to:

☐ Patient ☐ Office-first fill only ☐ Office-all fills ☐ Other ________ Date: ________ Needs by date: ________

Dispense as Written	Substitution Permitted
Prescriber's Signature ________ Date ________ Electronic or digital signatures not accepted.	Prescriber's Signature ________ Date ________ Electronic or digital signatures not accepted.

Supervising/Collaborative Physician Information (per state requirements) ______________________

Confidentiality statement: This communication is intended for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential, and exempt from disclosure under applicable law. If the reader of this communication is not the intended recipient or the employee or agent responsible for delivery of the communication, you are hereby notified that any dissemination, distribution, or copying of the communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone. This form is not a valid prescription in Arizona and Virginia.

Optum

Rheumatology Enrollment Form

Optum Specialty Phone: 855-427-4682 | Optum Specialty Fax: 877-342-4596

Specialty Pharmacy Enrollment Form

Please detach before submitting to a pharmacy – tear here

This form is not a valid prescription in Arizona and Virginia

PATIENT INFORMATION

Please complete the following or send patient demographic sheet

Patient Name ____________________
Address ____________________
Address 2 ____________________
City, State, Zip ____________________
Home Phone ____________ Alternate Phone ____________
DOB ________ Last Four of SS# ________ Gender ________
Language Preference: ☐ English ☐ Spanish ☐ Other ____________

PRESCRIBER INFORMATION

Prescriber's Name ____________________
DEA ____________________
NPI ____________________
Group/ Hospital ____________________
Address ____________________
City, State, ZIP ____________________
Phone ____________ Fax ____________
Contact Person ____________ Phone ____________

INSURANCE INFORMATION (Must fax a copy of patient's insurance card including both sides)

Prior Authorization Reference number: ____________________

MEDICAL INFORMATION (Section must be completed to process prescription) (Attach separate sheet if needed)

Diagnosis — *Please include diagnosis name with ICD-10 code*

☐ M06.9 Rheumatoid arthritis, unspecified
☐ M08.00 Unspecified juvenile rheumatoid arthritis of unspecified site
☐ M08.3 Juvenile rheumatoid polyarthritis (seronegative)
☐ M45.9 Ankylosing spondylitis of unspecified sites in spine
☐ L40.59 Other Psoriatic Anthropathy
☐ Other Diagnosis: ICD-10 Code ________ Description ____________
Date of diagnosis ____________
Has a TB test been performed? ☐ Yes ☐ No
Does the patient have an active infection? ☐ Yes ☐ No
Start Date ____________ **Review Date** ____________

Additional Information Therapy: ☐ New ☐ Reauthorization ☐ Restart

Weight ________kg/lbs Height ________cm/in
Allergies ____________________
Lab Data ____________________
Prior Therapies ____________________
Concomitant Medications ____________________
Additional Comments ____________________
Injection Training Required: ☐ Yes ☐ No

PRESCRIPTION INFORMATION

Medication	Strength	Dose & Directions	Qty/Refills
☐ Yusimry™ (adalimumab-aaty)	☐ 40 mg/0.8mL prefilled syringe ☐ 40 mg/0.8mL auto-injector	☐ Inject 40 mg SQ every other week. ☐ Other: ____________	Quantity: ______ Refills: ______
☐ Other	____________	____________	Quantity: ______ Refills: ______

***Prescriber Authorization:** I authorize this pharmacy and its representatives to act as my authorized agent, where permitted by law and benefit plan sponsor, to secure coverage and initiate the insurance prior authorization process for our shared patient, and to sign any necessary forms, including but not limited to, attestations of medical necessity, on my behalf as my authorized agent, including any required prior authorization forms and the receipt and submission of patient lab values and other patient data that support the prior authorization. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

Ship to:

☐ Patient ☐ Office-first fill only ☐ Office-all fills ☐ Other ____________ Date: ________ Needs by date: ________

Dispense as Written	Substitution Permitted
Prescriber's Signature ____________ Date ________ Electronic or digital signatures not accepted.	Prescriber's Signature ____________ Date ________ Electronic or digital signatures not accepted.

Supervising/Collaborative Physician Information (per state requirements) ____________________

Confidentiality statement: This communication is intended for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential, and exempt from disclosure under applicable law. If the reader of this communication is not the intended recipient or the employee or agent responsible for delivery of the communication, you are hereby notified that any dissemination, distribution, or copying of the communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone. This form is not a valid prescription in Arizona and Virginia.