OPTUM®

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

Rheumatology Enrollment Form

Page 1 (A-E)

Specialty Pharmacy Enrollment Form ✂ 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
☐ Actemra	☐ 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	☐ 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: _____
☐ Benlysta	☐ 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	☐ 200 mg/mL Prefilled Syringe ☐ 200 mg/mL Autoinjector	☐ Maintenance Dose: Inject 200 mg SC once every week.	Quantity: _____ Refills: _____
☐ Cimzia	☐ 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	☐ 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	☐ Sensoready® pen 150 mg/mL injection ☐ Prefilled syringe 150 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: _____
☐ Enbrel	☐ 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 to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. 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 ☐ Other _____ Date _____ Needs by Date _____

☐ Product Substitution permitted ☐ Dispense as Written

Prescriber's Signature _____ Date _____

Supervising Physician Signature: _____ Date _____

Electronic or digital signatures not accepted.

OPTUM®

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

Rheumatology Enrollment Form
Page 2 (H-O)

Specialty Pharmacy Enrollment Form ✂ 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

☐ Humira	☐ 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: _____
☐ Inflectra	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	☐ 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	☐ 1 mg Tablet ☐ 2 mg Tablet	☐ Take 2 mg PO once daily. ☐ Other: _____	Quantity: _____ Refills: _____
☐ Orencia	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	☐ 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	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: _____

***Prescriber Authorization:** I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. 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 ☐ Other _____ Date _____ Needs by Date _____

☐ Product Substitution permitted ☐ Dispense as Written

Prescriber's Signature _____ Date _____

Supervising Physician Signature: _____ Date _____

Electronic or digital signatures not accepted.

OPTUM®

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

Rheumatology Enrollment Form

Page 3 (R-X)

Specialty Pharmacy Enrollment Form ✂ 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

☐ Remicade	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	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	15 mg	☐ Take one 15 mg tablet PO once daily. ☐ Other: _____	Quantity: _____ Refills: _____
☐ Simponi Aria	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	☐ 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: _____
☐ Stelara	☐ 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	☐ 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: _____
☐ Xeljanz	☐ 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: _____
☐ Other	_____	_____	Quantity: _____ Refills: _____
☐ Other	_____	_____	Quantity: _____ Refills: _____

***Prescriber Authorization:** I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. 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 ☐ Other _____ Date _____ Needs by Date _____

☐ Product Substitution permitted ☐ Dispense as Written

Prescriber's Signature _____ Date _____

Supervising Physician Signature: _____ Date _____

Electronic or digital signatures not accepted.