

Page 1 of 5 (A-C)

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

PATIENT INFO	₩ -	se detach before submitting to a pharmacy - tear here PRESCRIBERINEORMATION				
•	the following or send patient demographic sl		Prescriber's Name DEA			
Patient Name		·				
AddressAddress 2						
	Alternate Phone					
	Last Four of SS# Gender					
	ce: English Spanish Other					
	<u> </u>					
INSURANCE I	NFORMATION (Must fax a copy of patie	nt's insurance card including both sides)				
Prior Authorization	Reference number:	<u> </u>				
MEDICAL INF	ORMATION (Section must be complete	d to process prescription) (Attach separate sheet if needed)				
	se include diagnosis name with ICD-10 code	Additional Information Therapy: ☐ New ☐ Reautho	orization Restart			
M069 Pheumato	id arthritis, unspecified	Weightkg/lbs Height	cm/in			
	ied juvenile rheumatoid arthritis of unspecified site	Allergies				
=	neumatoid polyarthritis (seronegative)	Lab Data				
	spondylitis of unspecified sites in spine	Prior Therapies				
L40.59 Other Pso		Concomitant Medications				
	ICD-10 Code Description	Additional Comments				
Date of diagnosis		Injection Training Required: Yes No				
Has a TB test been p						
	ve an active infection?					
	Review Date					
	NINFORMATION					
Medication	Strength	Dose & Directions	Qty/Refills			
☐Abrilada™	20 mg/0.4mL prefilled syringe	Inject 40 mg SQ every other week	Quantity:			
(adalimumab- aaty)	40 mg/0.8mL prefilled syringe 40 mg/0.8mL pen	Other:	,			
aacy)	40 mg/o.amc pen		Refills:			
Actemra*	80 mg/4 mL Vial	Induction Dose: Infuse 4 mg/kg IV every 4 weeks.				
(tocilizumab)	200 mg/10 mL Vial	Maintenance Dose: Infuse 8 mg/kg IV every 4 weeks (please record patient weight at the top				
	☐ 400 mg/20 mL Vial	of this form).	Quantity:			
		Other:	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	ovorv.			
(tocilizumab)	162 mg/0.9 mL ACTPen Autoinjector	week based on clinical response.	Quantity:			
		For patients weighing ≥ 100 kg: Inject 162 mg SC every week.	Refills:			
			iteriiis.			
□ A i eite a TM	Doors (O. 4 and Drofille of Coning on Critical Standards	The best 40 are 60 are see OTHER and be				
Amjevita™ (adalimumab-	20 mg/0.4 mL Prefilled Syringe (citrate-free) 40 mg/0.8 mL Prefilled Syringe (citrate-free)	☐ Inject 40 mg SC every OTHER week. ☐ Other:				
atto)	40 mg/0.8 mL Prefilled SureClick*		Quantity:			
	autoinjector (citrate-free)		Refills:			
Avsola*	100 mg Vial	Induction Dose: Infuse mg/kg IV at weeks 0, 2 and 6.	Quantity:			
(infliximab-axxq)		Maintenance Dose: Infuse mg/kg IV every 6 weeks. Maintenance Dose: Infuse mg/kg IV every 8 weeks.	# of 100 mg vial			
		Other:	Refills:			
Benlysta*	120 mg Vial	Induction Dose: 10 mg/kg/dose IV infused over 1 hour every 2 weeks for the first 3 doses (0 re	fills). Quantity:			
(belimumab)	400 mg Vial	Maintenance Dose: Inject 10 mg/kg/dose IV once every 4 weeks.	Refills:			
			iverilis.			
☐ Benlysta®	200 mg/mL Prefilled Syringe	Maintenance Dose: Inject 200 mg SC once every week.	Quantity:			
(belimumab)	200 mg/mL Autoinjector		Refills:			
		To desting Days Triant 400mm CO standard O one d.4				
Cimzia* (certolizumab	200 mg/mL Starter Kit (6 prefilled syringes)	Induction Dose: Inject 400mg SC at weeks 0, 2 and 4.	Quantity: 1 Kit			
pegol)			Refills: 0			
•						
* Prescriber Authorizati	on. I authorize this pharmacy and its representatives to act as m	authorized agent, where permitted by law and benefit plan sponsor to secure coverage and initiate the insurance pri	or authorization process for our			
*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 Other Date Needs by Date						
☐ Product Substitution permitted ☐ Dispense as Written						
Prescriber's Supervising Signature Date Date Date Date						
Signature Date Physician Signature: Date Date = Electronic or digital signatures not accepted.						



Page 2 of 5 (C-H)

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

	Ple	ease detach before submitting to a pharmacy – tear here				
PATIENT INFO	DRMATION	PRESCRIBER INFORMATION	PRESCRIBER INFORMATION			
Please complete	the following or send patient demographic s	heet Prescriber's Name				
Patient Name		DEA	DEA			
Address		NPI	NPI			
Address 2		Group/Hospital	Group/Hospital			
		Address	Address			
	Alternate Phone		City, State, ZIP			
	Last Four of SS# Gender					
Language Preferer	nce: English Spanish Other	Contact Person Phone	Contact Person Phone			
INSURANCE I	NFORMATION (Must fax a copy of pation	ent's insurance card including both sides)				
Prior Authorization	n Reference number:					
MEDICAL INF	ORMATION (Section must be complete	ed to process prescription) (Attach separate sheet if needed)				
Diagnosis – Plea	ase include diagnosis name with ICD-10 code	Additional Information Therapy: ☐ New ☐ Reauthorization	on Restart			
M069 Rheumat	oid arthritis, unspecified	Weightkg/lbs Height	cm/in			
	ified juvenile rheumatoid arthritis of unspecified site	Allergies				
	rheumatoid polyarthritis (seronegative)		Lab Data			
	g spondylitis of unspecified sites in spine	Prior Therapies				
_ ,	oriatic Anthropathy	Concomitant Medications				
Other Diagnosis	: ICD-10 Code Description	Additional Comments				
Date of diagnosis _		Injection Training Required: Yes No				
Has a TB test been	performed?					
	ave an active infection?					
Start Date	Review Date					
PRESCRIPTIO	N INFORMATION					
Cimzia*	200 mg/mL Vial Kit	Maintenance Dose: Inject 200 mg SC every OTHER week.				
(certolizumab	200 mg/mL Prefilled Syringe	Maintenance Dose: Inject 400 mg SC every four weeks.	Quantity:			
pegol)		Other:	Refills:			
Cosentyx°	Conserved & pop 150 mg/ml injection	Psoriatic Arthritis with Coexistent Moderate to Severe Plaque Psoriasis	+			
(secukinumab)	Sensoready® pen 150 mg/mL injection Prefilled syringe 150 mg/mL injection	Loading Dose: Inject 300 mg (two injections) SC at weeks 0, 1, 2, 3 and 4 (10 pens/syringes, 0 refills).	Quantity:			
,	UnoReady pen 300 mg/mL injection	Maintenance Dose: Inject 300 mg (two injections) SC every 4 weeks.	Refills:			
		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). Mithout Loading Dose: Inject 150 mg (one injection) SC every 4 weeks.				
		Other:				
Cvltezo°	□ 40 mm /0 0mm Pam	☐ Inject 40 mg SQ every other week.	+			
(adalimumab-	40 mg/0.8ml Pen 40mg/0.8mL prefilled syringe	Other:	Quantity:			
adbm)			Refills:			
Enbrel*	25 mg/0.5 mL prefilled syringe	☐ Inject 25 mg SC TWICE a week (72 - 96 hours apart).	Quantity:			
(etanercept)	25mg/0.5ml single-dose vial	Inject 50 mg SC ONCE a week.				
	50 mg/mL Sureclick™ Autoinjector 50 mg/mL prefilled syringe	Other:	Refills:			
	50 mg/mL Enbrel Mini™ prefilled cartridge					
	for use with the <u>AutoTouch™ reusable</u>					
	autoinjector only (prescriber MUST supply). Avella/Briova does not order the autoinjector.					
 ∏Hadlima™	40mg/0.4ml prefilled syringe	☐ Inject 40 mg SQ every other week.	<u> </u>			
(adalimumab-	40mg/0.8ml prefilled syringe	Other:	Quantity:			
bwwd)	40mg/0.4ml PushTouch auto-injector		Refills:			
	40mg/0.8ml PushTouch auto-injector					
Hulio*	20 mg/0.4mL prefilled syringe	☐ Inject 40 mg SQ every other week.	Quantity:			
(adalimumab- fkjp)	40 mg/0.8mL prefilled syringe 40 mg/0.8mL pen	Other:	Refills:			
967						
		ny authorized agent, where permitted by law and benefit plan sponsor, to secure coverage and initiate the insurance prior author				
shared patient, and to s lab values and other pa	sign any necessary forms, including but not limited to, attestatio Itient data that support the prior authorization. In the event that	ns of medical necessity, on my behalf as my authorized agent, including any required prior authorization forms and the receipt a t this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this informatic	nd submission of patient on and any related			
	verage of the product to another pharmacy of the patient's choi		¥			
Ship to:	atient Office Other	Date Needs by Date				
	stitution permitted Dispense as Written	•				
Prescriber's		Supervising				
Signature		e Physician Signature: Da	nte			
Electronic or digital sig	natures not accepted.					



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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

	PPMATION	ase detach before submittir				
PATIENT INFORMATION			PRESCRIBER INFORMATION			
Please complete the following or send patient demographic sheet			Prescriber's Name			
Patient Name			DEA			
			., .			
,						
	Alternate Phone			F		
	Last Four of SS# Gender			Fax		
	ce: English Spanish Other		·	Phone		
INSURANCE I	NFORMATION (Must fax a copy of patic	nt's insurance card i	ncluding both sides)			
Prior Authorization	Reference number:					
	ORMATION (Section must be complete	d to process prescri		·		
Diagnosis – Pleas	se include diagnosis name with ICD-10 code		Additional Information	Therapy: New Reauthorization	n Restart	
M06.9 Rheumato	oid arthritis, unspecified		Weight	_kg/lbs Height	cm/in	
M08.00 Unspecif	fied juvenile rheumatoid arthritis of unspecified site		Allergies			
M08.3 Juvenile rl	neumatoid polyarthritis (seronegative)		Lab Data			
M45.9 Ankylosing	spondylitis of unspecified sites in spine		Prior Therapies			
L40.59 Other Pso			Concomitant Medications			
	ICD-10 Code Description		Additional Comments			
Date of diagnosis _			Injection Training Required: 🔲	′es		
Has a TB test been p	performed? Yes No					
	ve an active infection?					
Start Date	Review Date					
PRESCRIPTIO	N INFORMATION					
Humira*	10 mg/0.1 mL Prefilled Syringe (citrate-free)	Inject 40 mg SC every	OTHER week			
(adalimumab)	20 mg/0.2 mL Prefilled Syringe (citrate-free)		OTTLK Week.		Quantity:	
	40 mg/0.4 mL Prefilled Syringe (citrate-free)				Refills:	
	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					
	10 m = (0.1 m) = m = fills d = min = m		- Alexander			
☐ Hyrimoz° (adalimumab-	10 mg/0.1mL prefilled syringe 20 mg/0.2mL prefilled syringe	Inject 40 mg SQ every	/ otner week.		Quantity:	
adaz)	40 mg/0.4mL prefilled syringe				Refills:	
	40 mg/0.8mL prefilled syringe					
	40 mg/0.4mL auto-injector 80 mg/0.8mL auto-injector					
☐ Idacio° (adalimumab-	40 mg/0.8ml auto-injector 40 mg/0.8ml prefilled syringe	☐ Inject 40 mg SQ every ☐ Other:			Quantity:	
aacf)	+o mg/ o.omi premied syringe				Refills:	
Inflectra*	100 mg Vial	Induction Dose: Infus	e mg/kg IV at weeks 0, 2 and 6.			
(infliximab-dyyb)	100 mg viai		fuse mg/kg IV every 6 weeks.		Quantity:	
			fuse mg/kg IV every 8 weeks.		# of 100 mg vial	
		Other:			Refills:	
☐ Kevzara° (sarilumab)	200 mg/1.14 mL Prefilled Syringe 150 mg/1.14 mL Prefilled Syringe	Inject 200 mg SC onc	,		Quantity:	
(Sariiuiiiab)	200 mg/1.14 mL Prefilled Syringe	Inject 150 mg SC once	e every two weeks.		Refills:	
	150 mg/1.14 mL Prefilled Pen					
Olumiant°	1 mg Tablet	Take 2 mg PO once da	ailv			
(baricitinib)	2 mg Tablet		iny.		Quantity:	
` ,	i v				Refills:	
Orencia*	250 mg vial	Infuse mg IV at we	eeks 0, 2 and 4, then every 4 weeks th	ereafter (please record patient weight	Quantity:	
(abatacept)	3	at the top of the form).	,		-	
		Other:			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 Other Date Needs by Date						
Product Substitution permitted Dispense as Written						
Prescriber's	_	St	pervising	_		
Signature	Date	e Pr	іуысіан ыўнасціе:	Date	e	



Page 4 of 5 (O-S)

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Specialty Pharmacy Enrollment Form

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	·					
Patient Name Address	ICD-10 Code Description	d to process prescrip	Prescriber's Name	eet if needed) Therapy: \(\sum \) New _kg/lbs Height	e Reauthorizatio	n
Has a TB test been p	performed? Yes No					
Does the patient ha	ve an active infection?					
Start Date	Review Date					
PRESCRIPTIO	N INFORMATION					
Orencia*	ClickJect Autoinjector 125 mg/mL pack of 4	☐ Inject 125 mg SC ever				Quantity:
(abatacept)	125 mg Prefilled Syringe	Inject 87.5 mg SC ever	,			Refills:
	87.5 mg/0.7ml Prefilled Syringe 50 mg/0.4ml Prefilled Syringe	☐ Inject 50 mg SC every ☐ Other:				iteriiis.
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
Otezla*	30 mg Tablet	Maintenance Dose: 30) mg PO twice daily.			Quantity:
(apremilast)		Other:				Refills:
Remicade* (infliximab)	100 mg Vial	Maintenance Dose: In	e mg/kg IV at weeks 0, 2 and 6 fuse mg/kg IV every 6 weeks. fuse mg/kg IV every 8 weeks.	j. 		Quantity: # of 100 mg vial Refills:
Renflexis [®]	100 mg Vial	Induction Dose: Infus	e mg/kg IV at weeks 0, 2 and 6	ò.		Quantity:
(infliximab-abda)		Maintenance Dose: In	fuse mg/kg IV every 6 weeks.			# of 100 mg vial
		Maintenance Dose: In	fuse mg/kg IV every 8 weeks.			Refills:
Rinvoq°	15 mg	Take one 15 mg tablet				Quantity:
(upadacitinib)		Other:				Refills:
_						
Simponi Aria° (golimumab)	50 mg/4 mL in a single use vial	Infuse 2 mg/kg IV over 3 patient weight in section	0 minutes at weeks 0 and 4, then ev	ery 8 weeks thereafter (please record	Quantity:
(goiiridinab)		patione weight in occion	42010).			# of 50 mg vial
						Refills:
Simponi* (golimumab)	50 mg/0.5 mL Prefilled SmartJect [®] Autoinjector	Inject 50 mg SC once	a month.			Quantity:
(goiiridinab)	50 mg/0.5 mL Prefilled Syringe					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 Other Date Needs by Date						
Prescriber's Supervising Supervising Physician Signature						
Signature Date Physician Signature: Date Date						



Page 5 of 5 (T-Y)

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

Specialty Pharm	acy Enrollment Form		-	This form is not a valid prescription in	n Arizona and Virginia
Please complete the following or send patient demographic sheet Patient Name Address Address 2			DEANPI		
	Alternate Phone Last Four of SS# Gender		•	Fax	
	ce: English Spanish Other	l l		Phone	
Prior Authorization	Reference number:				
MEDICAL INF	ORMATION (Section must be complete	d to process prescripti	ion) (Attach separate sh	eet if needed)	
Diagnosis – Plea	se include diagnosis name with ICD-10 code		Additional Information	Therapy: New Reauthorizati	on Restart
M06.9 Rheumato	oid arthritis, unspecified		Weight	_kg/lbs Height	cm/in
= :	ied juvenile rheumatoid arthritis of unspecified site		•		
	neumatoid polyarthritis (seronegative) g spondylitis of unspecified sites in spine				
L40.59 Other Pso			·		
	ICD-10 Code Description		Additional Comments		
Date of diagnosis _			Injection Training Required:	Yes No	
Has a TB test been p	ve an active infection? Yes No				
	Review Date				
PRESCRIPTIO	NINFORMATION				
Skyrizi* (risankizumab- rzaa)	☐ 150 mg/mL prefilled syringe ☐ 150 mg/mL prefilled pen	dosing (0 refills). Psoriatic Arthritis Mainte	tion Dose: Inject 150 mg SC at W enance Dose: Inject 150mg SC e	very 12 weeks.	Quantity:
Stelara* (ustekinumab)	45 mg/0.5 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)	Maintenance Dose:		riatic Arthritis Dosing: two 80 mg injections on Day 1. (t ct SC one 80 mg injection every	4 weeks.	Quantity: Refills:
Tremfya° (guselkumab)			00mg SC at week 0 and week 4 (ct 100mg SC once every 8 weeks		Quantity:
Xeljanz° (tofacitinib)	☐ 5 mg Tablet ☐ 11 mg Extended-Release Tablet	Take one 5 mg tablet PO Take one 11 mg tablet PO Other:	O once daily.		Quantity:
Yuflyma™ (adalimumab- aaty)	40 mg/0.4mL prefilled syringe 40 mg/0.4mL auto-injector	☐ Inject 40 mg SQ every of ☐ Other:			Quantity:
☐ Yusimry™ (adalimumab- aqvh)	40 mg/0.8mL prefilled syringe 40 mg/0.8mL auto-injector	☐ Inject 40 mg SQ every of ☐ Other:			Quantity:
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 Other Date Needs by Date Product Substitution permitted Dispense as Written Prescriber's Supervising Signature Date Physician Signature: Date Date					
Signature Electronic or digital sign	Date natures not accepted.	e Phys	sician Signature:	Da	ate