Rheumatology Enrollment Form

Page 1 of 4 (A-C)

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

	Sec Ple	ase detach before submitti			
PATIENT INF	ORMATION		PRESCRIBER INFORM	ATION	
Please complet	e the following or send patient demographic s	heet	Prescriber's Name		
Patient Name					
Address					
	Alternate Phone				
	_ Last Four of SS# Gender			Fax	
	nce: English Spanish Other			Phone	
INSURANCE	INFORMATION (Must fax a copy of patie	ent's insurance card i	including both sides)		
	on Reference number:				
MEDICAL IN	FORMATION (Section must be complete	ed to process prescri	ption) (Attach separate sl	neet if needed)	
Diagnosis – Ple	ase include diagnosis name with ICD-10 code		Additional Information	Therapy: 🗌 New 🗌 Reauthorization	on 🗌 Restart
M06.9 Rheuma	toid arthritis, unspecified		Weight	kg/lbs Height	cm.
	cified juvenile rheumatoid arthritis of unspecified site		-		
	rheumatoid polyarthritis (seronegative)				
	ng spondylitis of unspecified sites in spine				
	soriatic Anthropathy				
	is: ICD-10 Code Description		Additional Comments		
Date of diagnosis			Injection Training Required:		
Has a TB test been					
	nave an active infection?				
	Review Date				
DESCRIPTIO	ON INFORMATION				
Medication	Strength		Dose & Directions		Qty/Refills
Actemra	80 mg/4 mL Vial	Induction Dose: Infus	se 4 mg/kg IV every 4 weeks.		
	200 mg/10 mL Vial			ease record patient weight at the top	Quantity:
	400 mg/20 mL Vial	of this form).			Refills:
		Other:			
Actemra	162 mg/0.9 mL prefilled syringe	For patients weighing	100 kg: Inject 162 mg SC every ot	her week, followed by an increase to every	
	162 mg/0.9 mL ACTPen Autoinjector	week based on clinical response.		· · · · · · · · · · · · · · · · · · ·	Quantity:
		For patients weighing	<u>ı ≥ 100 kg:</u> Inject 162 mg SC every w	eek.	Refills:
Amjevita™	20 mg/0.4 mL Prefilled Syringe (citrate-free)	Inject 40 mg SC every	v OTHER week.		
	40 mg/0.8 mL Prefilled Syringe (citrate-free)				Quantity:
	40 mg/0.8 mL Prefilled SureClick®				Refills:
	autoinjector (citrate-free)				
Avsola	100 mg Vial	Induction Dose: Infus	e mg/kg IV at weeks 0, 2 and	6.	Quantity:
_	_	Maintenance Dose: Infuse mg/kg IV every 6 weeks. Maintenance Dose: Infuse mg/kg IV every 8 weeks.		# of 100 mg vial	
				# 01 100 mg viai	
					Defiller
		Other:			
Benlysta	120 mg Vial	Induction Dose: 10 mg	g/kg/dose IV infused over 1 hour ev	very 2 weeks for the first 3 doses (0 refills).	Quantity:
Benlysta	120 mg Vial 400 mg Vial	Induction Dose: 10 mg			Quantity: Refills:
	☐ 400 mg Vial ☐ 200 mg/mL Prefilled Syringe	<u>Induction Dose:</u> 10 mg <u>Maintenance Dose:</u> In	g/kg/dose IV infused over 1 hour ev		Refills: Quantity:
	400 mg Vial	<u>Induction Dose:</u> 10 mg <u>Maintenance Dose:</u> In	g/kg/dose IV infused over 1 hour ev ject 10 mg/kg/dose IV once every		Quantity: Refills:
Benlysta	☐ 400 mg Vial ☐ 200 mg/mL Prefilled Syringe	Induction Dose: 10 mg Maintenance Dose: In Maintenance Dose: In	g/kg/dose IV infused over 1 hour ev ject 10 mg/kg/dose IV once every		Quantity: Refills: Quantity:
Benlysta	400 mg Vial 200 mg/mL Prefilled Syringe 200 mg/mL Autoinjector	Induction Dose: 10 mg Maintenance Dose: In Maintenance Dose: In	g/kg/dose IV infused over 1 hour ev nject 10 mg/kg/dose IV once every nject 200 mg SC once every week.		Quantity: Refills: Quantity: Refills:
_ Benlysta _ Cimzia	400 mg Vial 200 mg/mL Prefilled Syringe 200 mg/mL Autoinjector	Induction Dose: 10 mg Maintenance Dose: In Maintenance Dose: In Induction Dose: Inject 44	g/kg/dose IV infused over 1 hour ev nject 10 mg/kg/dose IV once every nject 200 mg SC once every week.	4 weeks.	Quantity: Refills: Quantity: Refills: Quantity: 1 Kit Refills: 0
] Benlysta] Cimzia	400 mg Vial 200 mg/mL Prefilled Syringe 200 mg/mL Autoinjector 200 mg/mL Starter Kit (6 prefilled syringes)		g/kg/dose IV infused over 1 hour ev iject 10 mg/kg/dose IV once every iject 200 mg SC once every week. 00mg SC at weeks 0, 2 and 4.	4 weeks.	Quantity: Refills: Quantity: Refills: Quantity: 1 Kit Refills: 0 Quantity:
_ Benlysta _ Cimzia	400 mg Vial 200 mg/mL Prefilled Syringe 200 mg/mL Autoinjector 200 mg/mL Starter Kit (6 prefilled syringes) 200 mg/mL Vial Kit 200 mg/mL Prefilled Syringe	Induction Dose: 10 mg Maintenance Dose: In Maintenance Dose: In Induction Dose: Inject 40 Maintenance Dose: In Maintenance Dose: In Other:	g/kg/dose IV infused over 1 hour ev iject 10 mg/kg/dose IV once every iject 200 mg SC once every week. 00mg SC at weeks 0, 2 and 4. nject 200 mg SC every OTHER week iject 400 mg SC every four weeks.	4 weeks.	Quantity: Refills: Quantity: Refills: Quantity: 1 Kit Refills: 0 Quantity:
] Benlysta] Cimzia] Cimzia	400 mg Vial 200 mg/mL Prefilled Syringe 200 mg/mL Autoinjector 200 mg/mL Starter Kit (6 prefilled syringes) 200 mg/mL Vial Kit 200 mg/mL Prefilled Syringe Sensoready* pen 150 mg/mL injection	Induction Dose: 10 mg Maintenance Dose: In Maintenance Dose: In Induction Dose: Inject 49 Maintenance Dose: In Maintenance Dose: In Maintenance Dose: In Other: Psoriatic Arthritis with C	g/kg/dose IV infused over 1 hour ev iject 10 mg/kg/dose IV once every week. iject 200 mg SC once every week. 00mg SC at weeks 0.2 and 4. iject 200 mg SC every OTHER week iject 400 mg SC every four weeks.	4 weeks.	Quantity: Refills: Quantity: Refills: Quantity: 1 Kit Refills: 0 Quantity: Refills:
_ Benlysta _ Cimzia _ Cimzia	400 mg Vial 200 mg/mL Prefilled Syringe 200 mg/mL Autoinjector 200 mg/mL Starter Kit (6 prefilled syringes) 200 mg/mL Vial Kit 200 mg/mL Prefilled Syringe	Induction Dose: 10 mg Maintenance Dose: In Maintenance Dose: In Induction Dose: Inject 44 Maintenance Dose: In Maintenance Dose: In Other:	g/kg/dose IV infused over 1 hour ev iject 10 mg/kg/dose IV once every v iject 200 mg SC once every week. 00mg SC at weeks 0.2 and 4. iject 200 mg SC every OTHER week iject 400 mg SC every four weeks. Coexistent Moderate to Severe Pla 300 mg (two injections) SC at week	4 weeks. 	Quantity: Refills: Quantity: Refills: Quantity: 1 Kit Refills: Quantity: Refills: Quantity: Quantity: Quantity: Quantity: Quantity: Quantity:
Benlysta Cimzia Cimzia	400 mg Vial 200 mg/mL Prefilled Syringe 200 mg/mL Autoinjector 200 mg/mL Starter Kit (6 prefilled syringes) 200 mg/mL Vial Kit 200 mg/mL Prefilled Syringe Sensoready* pen 150 mg/mL injection	Induction Dose: 10 mg Maintenance Dose: In Maintenance Dose: In Induction Dose: Inject 44 Maintenance Dose: In Maintenance Dose: In Other:	g/kg/dose IV infused over 1 hour ev iject 10 mg/kg/dose IV once every iject 200 mg SC once every week. 00mg SC at weeks 0, 2 and 4. iject 200 mg SC every OTHER week iject 400 mg SC every four weeks. Coexistent Moderate to Severe Pla 300 mg (two injections) SC at week iject 300 mg (two injections) SC ev	4 weeks. 	Quantity: Refills: Quantity: Refills: Quantity: 1 Kit
Benlysta Cimzia Cimzia	400 mg Vial 200 mg/mL Prefilled Syringe 200 mg/mL Autoinjector 200 mg/mL Starter Kit (6 prefilled syringes) 200 mg/mL Vial Kit 200 mg/mL Prefilled Syringe Sensoready* pen 150 mg/mL injection	Induction Dose: 10 mg Maintenance Dose: In Maintenance Dose: In Induction Dose: Inject 44 Maintenance Dose: In Maintenance Dose: In Other:	g/kg/dose IV infused over 1 hour ev nject 10 mg/kg/dose IV once every nject 200 mg SC once every week. 00mg SC at weeks 0.2 and 4. 1 mject 200 mg SC every OTHER week nject 400 mg SC every four weeks. 2 mject 400 mg SC every four set to severe Pla 3 mject 3 mg (two injections) SC at week nject 3 mg (two injections) SC ever 3 or Ankylosing Spondylitis	4 weeks. ique Psoriasis (s 0, 1, 2, 3 and 4 (10 pens/syringes, 0 refills). ery 4 weeks.	Quantity: Refills: Quantity: Refills: Quantity: 1 Kit Refills: Quantity: Refills: Quantity: Quantity: Quantity: Quantity: Quantity: Quantity:
Benlysta	400 mg Vial 200 mg/mL Prefilled Syringe 200 mg/mL Autoinjector 200 mg/mL Starter Kit (6 prefilled syringes) 200 mg/mL Vial Kit 200 mg/mL Prefilled Syringe Sensoready* pen 150 mg/mL injection		g/kg/dose IV infused over 1 hour ev iject 10 mg/kg/dose IV once every - iject 200 mg SC once every week. 00mg SC at weeks 0, 2 and 4. iject 200 mg SC every OTHER week iject 400 mg SC every four weeks. Coexistent Moderate to Severe Pla 300 mg (two injections) SC at week iject 300 mg (two injections) SC ev s or Ankylosing Spondylitis sor ankylosing Spondylitis nject 150 mg (one injection) SC at w r (5 pens/syringes, 0 refills).	4 weeks. 	Quantity: Refills: Quantity: Refills: Quantity: 1 Kit Refills: Quantity: Refills: Quantity: Quantity: Quantity: Quantity: Quantity: Quantity:
Benlysta Benlysta Cimzia Cimzia Cosentyx	400 mg Vial 200 mg/mL Prefilled Syringe 200 mg/mL Autoinjector 200 mg/mL Starter Kit (6 prefilled syringes) 200 mg/mL Vial Kit 200 mg/mL Prefilled Syringe Sensoready* pen 150 mg/mL injection		g/kg/dose IV infused over 1 hour ev nject 10 mg/kg/dose IV once every - nject 200 mg SC once every week. 00mg SC at weeks 0, 2 and 4. nject 200 mg SC every OTHER week nject 400 mg SC every four weeks. Coexistent Moderate to Severe Pla 300 mg (two injections) SC at week nject 300 mg (two injections) SC ev s or Ankylosing Spondylitis nject 150 mg (one injection) SC at week	4 weeks. 	Quantity: Refills: Quantity: Refills: Quantity: 1 Kit Refills: Quantity: Refills: Quantity: Quantity: Quantity: Quantity: Quantity: Quantity:
] Benlysta] Cimzia] Cimzia	400 mg Vial 200 mg/mL Prefilled Syringe 200 mg/mL Autoinjector 200 mg/mL Starter Kit (6 prefilled syringes) 200 mg/mL Vial Kit 200 mg/mL Prefilled Syringe Sensoready* pen 150 mg/mL injection		g/kg/dose IV infused over 1 hour ev iject 10 mg/kg/dose IV once every - iject 200 mg SC once every week. 00mg SC at weeks 0, 2 and 4. iject 200 mg SC every OTHER week iject 400 mg SC every four weeks. Coexistent Moderate to Severe Pla 300 mg (two injections) SC at week iject 300 mg (two injections) SC ev s or Ankylosing Spondylitis sor ankylosing Spondylitis nject 150 mg (one injection) SC at w r (5 pens/syringes, 0 refills).	4 weeks. 	Quantity: Refills: Quantity: Quantity: 1 Kit Refills: 0 Quantity: Refills: Quantity:
Benlysta Cimzia Cimzia	400 mg Vial 200 mg/mL Prefilled Syringe 200 mg/mL Autoinjector 200 mg/mL Starter Kit (6 prefilled syringes) 200 mg/mL Vial Kit 200 mg/mL Prefilled Syringe Sensoready* pen 150 mg/mL injection Prefilled syringe 150 mg/mL injection	Induction Dose: 10 mg Maintenance Dose: In Other:	g/kg/dose IV infused over 1 hour ev nject 10 mg/kg/dose IV once every nject 200 mg SC once every week. 00mg SC at weeks 0.2 and 4. 10ject 200 mg SC every OTHER week nject 400 mg SC every four weeks. Coexistent Moderate to Severe Pla 300 mg (two injections) SC at week nject 300 mg (two injections) SC ev as or Ankylosing Spondylitis nject 150 mg (one injection) SC at we (5 pens/syringes, 0 refills). e: Inject 150 mg (one injection) SC	4 weeks. ique Psoriasis (s 0, 1, 2, 3 and 4 (10 pens/syringes, 0 refills). ery 4 weeks. weeks 0, 1, 2, 3 and 4, and then every 4 weeks.	Quantity: Refills: Quantity: Quantity: 1 Kit Refills: 0 Quantity: Refills: Quantity: Refills:
Benlysta Cimzia Cimzia Cosentyx		Induction Dose: 10 mg Maintenance Dose: In Other:	g/kg/dose IV infused over 1 hour ev nject 10 mg/kg/dose IV once every nject 200 mg SC once every week. 00mg SC at weeks 0.2 and 4. nject 200 mg SC every OTHER week nject 400 mg SC every four weeks. Coexistent Moderate to Severe Pla 300 mg (two injections) SC at week nject 300 mg (two injections) SC ever s or Ankylosing Spondylitis nject 150 mg (one injection) SC at werk (5 pens/syringes, 0 refills). e: Inject 150 mg (one injection) SC werage and initiate the insurance prior aut ission of patient lab values and other patient lab values and patie	4 weeks. ique Psoriasis (s 0, 1, 2, 3 and 4 (10 pens/syringes, 0 refills). ery 4 weeks. veeks 0, 1, 2, 3 and 4, and then every 4 weeks. ————————————————————————————————————	Quantity: Refills: Quantity: Quantity: 1 Kit Refills: 0 Quantity: Refills: Quantity: Refills: Refills: ecessary forms on my
Benlysta Cimzia Cimzia Cosentyx		Induction Dose: 10 mg Maintenance Dose: In Other:	g/kg/dose IV infused over 1 hour ev iject 10 mg/kg/dose IV once every v iject 200 mg SC once every week. 00mg SC at weeks 0.2 and 4. iject 200 mg SC every OTHER week iject 400 mg SC every four weeks. Coexistent Moderate to Severe Pla 300 mg (two injections) SC at week iject 300 mg (two injections) SC ever s or Ankylosing Spondylitis iject 150 mg (one injection) SC at werk iject 150 mg (one in	4 weeks. ique Psoriasis (s 0, 1, 2, 3 and 4 (10 pens/syringes, 0 refills). ery 4 weeks. veeks 0, 1, 2, 3 and 4, and then every 4 weeks. ————————————————————————————————————	Quantity: Refills: Quantity: Quantity: 1 Kit Refills: 0 Quantity: Refills: Quantity: Refills: Refills: ecessary forms on my

Prescriber's		Supervising	
Signature	Date	Physician Signature:	Date _
Electronic on distal size down and seconded			

Electronic or digital signatures not accepted. **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.

Specialty Pharmacy Enrollment Form

Rheumatology Enrollment Form

Page 2 of 4 (E-O)

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

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PATIENT INFORMATION		,	PRESCRIBER INFORMA	ATION	
Please complete the following or send patient demographic sheet		heet	Prescriber's Name		
Patient Name			DEA		
			NPI		
Address 2			Group/Hospital		
City, State, Zip			Address		
	Alternate Phone		City, State, ZIP		
DOB	_ Last Four of SS# Gender		Phone	Fax	
Language Preferer	nce: English Spanish Other		Contact Person	Phone	
INSURANCE 1	INFORMATION (Must fax a copy of patie	nt's insurance card inc	cluding both sides)		
	n Reference number:				
	FORMATION (Section must be complete	d to process prescripti	ion) (Attach senarate sh	peet if peeded)	
	ase include diagnosis name with ICD-10 code	a to process prescript	Additional Information		
Diagnosis - Pier	ase include diagnosis name with ICD-10 code		Additional Information	Therapy: New Reauthorization	
M06.9 Rheumat	oid arthritis, unspecified		Weight	kg/lbs Height	cm/in
M08.00 Unspec	ified juvenile rheumatoid arthritis of unspecified site		Allergies		
M08.3 Juvenile	rheumatoid polyarthritis (seronegative)		Lab Data		
M45.9 Ankylosir	ng spondylitis of unspecified sites in spine		Prior Therapies		
	soriatic Anthropathy		Concomitant Medications		
Other Diagnosis	s: ICD-10 Code Description		Additional Comments		
Date of diagnosis _			Injection Training Required:]Yes 🗌 No	
Has a TB test been	performed? Yes No				
Does the patient h	ave an active infection?				
Start Date	Review Date				
PRESCRIPTIC	ON INFORMATION				
Enbrel	25 mg/0.5 mL prefilled syringe 25 mg/0.5 mL single-dose vial 50 mg/mL Sureclick™ Autoinjector 50 mg/mL prefilled syringe 50 mg/mL Enbrel Mini™ prefilled cartridge for use with the <u>AutoTouch™ reusable</u> <u>autoinjector only</u> (prescriber MUST supply). Avella/Briova does not order the autoinjector.	☐ Inject 25 mg SC TWICE a ☐ Inject 50 mg SC ONCE a ☐ Other:	a week (72 – 96 hours apart). week.		Quantity: Refills:
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) 10 mg/0.2 mL Prefilled Syringe 20 mg/0.4 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.		Quantity: Refills:	
Olumiant	□ 1 mg Tablet □ 2 mg Tablet	Take 2 mg PO once daily.			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 875 mg/0.7ml Prefilled Syringe 50 mg/0.4ml Prefilled Syringe	☐ Inject 125 mg SC every w ☐ Inject 87.5 mg SC every w ☐ Inject 50 mg SC every w ☐ Other:	veek.		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 p	permitted	Dispense as Written		
Prescriber's			Supervising	
Signature		Date	Physician Signature:	Date
Electronic or digital signatures not a	ccented			

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.

Rheumatology Enrollment Form

Page 3 of 4 (O-S)

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

Specialty Pharm	nacy Enrollment Form	ease detach before submitting to a pharmacy - tear here	escription in Arizona
PATIENT INFO	÷ -	PRESCRIBER INFORMATION	
Please complete Patient Name Address City, State, Zip Home Phone DOB Language Preferer INSURANCE Prior Authorizatio MEDICALINE Diagnosis - Plea M06.9 Rheumat M08.00 Unspec M08.3 Juvenile M45.9 Ankylosir L40.59 Other Pse	e the following or send patient demographic s Alternate Phone Last Four of SS# Gender nce:EnglishSpanishOther INFORMATION (Must fax a copy of pati n Reference number:	sheet Prescriber's Name DEA DEA NPI Group/Hospital Address City, State, ZIP Phone Fax Contact Person Phone ient's insurance card including both sides) Person Phone Veight Kg/lbs Aldreise Lab Data Prior Therapies Concomitant Medications	on Restart
Date of diagnosis _ Has a TB test been Does the patient h		Injection Training Required: Yes No	
PRESCRIPTIC	DN INFORMATION 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	<u>Maintenance Dose</u> : 30 mg PO twice daily. Other:	Quantity: Refills:
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:
Skyrizi	☐ 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 150 mg SC every 12 weeks. 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:
behalf as my authorize this prescription, I furt Ship to:	ed agent, including the receipt of any required prior authorizatio	Supervising	that it is unable to fulfill
Signature	Dat		te

Electronic or digital signatures not accepted.

Signature _

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Rheumatology Enrollment Form

Page 4 of 4 (T-X)

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Specialty Pharmacy Enrollment Form

See Please detach before submitting to a pharmacy - tear here

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Please complete the following or send patient demographic sheet	Prescriber's Name
Patient Name	DEA
Address	NPI
Address 2	Group/Hospital
City, State, Zip	Address
Home Phone Alternate Phone	City, State, ZIP
DOB Last Four of SS# Gender	Phone Fax
Language Preference: English Spanish Other	Contact Person Phone

MEDICAL INFORMATION (Section must be completed to process prescription) (Attach separate sheet if needed)					
Diagnosis – Please include diagnosis name with ICD-10 code		Additional Information	Therapy: New Reauthorizati	on Restart	
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		Allergies Lab Data Prior Therapies Concomitant Medications	_kg/lbs Height		
PRESCRIPTION INFORMATION					
Taltz 80 mg Single Dose Autoinjector 80 mg Single Dose Prefilled Syringe	Starting Dose: Inject S	Psoriatic Arthritis Dosing: SC two 80 mg injections on Day 1. (2 iject SC one 80 mg injection every 4	weeks.	Quantity: Refills:	
Tremfya* 100 mg/mL prefilled syringe		t 100mg SC at week 0 and week 4 (2 iject 100mg SC once every 8 weeks.	syringes/pens, 0 refills).	Quantity: Refills:	
Xeljanz 5 mg Tablet 11 mg Extended-Release Tablet	Take one 5 mg tablet Take one 11 mg tablet 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 perm	itted Dispense as Written		
Prescriber's		Supervising	
Signature	Date	Physician Signature:	Date
Electronic or digital signatures not accepted	ed.		

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