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
☐ Abrilada™ (adalimumab-aaty)	☐ 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: _____
☐ 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

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☐ M45.9 Ankylosing spondylitis of unspecified sites in spine

☐ L40.59 Other Psoriatic Anthropathy

☐ Other Diagnosis: ICD-10 Code _____ Description _____

Date of diagnosis _____

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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

☐ 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: _____
☐ 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: _____

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☐ 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® (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: _____
☐ 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: _____

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DOB _____ Last Four of SS# _____ Gender _____

Language Preference: ☐ English ☐ Spanish ☐ Other _____

Prescriber's Name _____

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NPI _____

Group/Hospital _____

Address _____

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Phone _____ Fax _____

Contact Person _____ Phone _____

Prior Authorization Reference number: _____

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

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☐ 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

☐ 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
☐ 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: _____
☐ 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: _____

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Date of diagnosis _____

Has a TB test been performed? ☐ Yes ☐ No

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Start Date _____ **Review Date** _____

Additional Information Therapy: ☐ New ☐ Reauthorization ☐ Restart

Weight _____ kg/lbs Height _____ cm/in

Allergies _____

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Additional Comments _____

Injection Training Required: ☐ Yes ☐ No

PRESCRIPTION INFORMATION

☐ 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-aaty)	☐ 40 mg/0.4mL prefilled syringe ☐ 40 mg/0.4mL auto-injector	☐ Inject 40 mg SQ every other week. ☐ Other: _____	Quantity: _____ Refills: _____
☐ Yusimry™ (adalimumab-aqvh)	☐ 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: _____

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