

Page 1 of 7 (A-B)

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 PRESCRIBER INFORMATION Please complete the following or send patient demographic sheet Prescriber's Name Address NPT Address 2 Group/Hospital_ City, State, Zip _ Address Home Phone ___ City, State, ZIP ___ Phone ___ ___ Last Four of SS# _____ Gender ___ Language Preference: English Spanish Other 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) Therapy: New Reauthorization Restart Diagnosis - Please include diagnosis name with ICD-10 code Additional Information M06.9 Rheumatoid arthritis, unspecified _kg/lbs Height ____ M08.00 Unspecified juvenile rheumatoid arthritis of unspecified site Allergies M08.3 Juvenile rheumatoid polyarthritis (seronegative) Lab Data ___ Prior Therapies _ M45.9 Ankylosing spondylitis of unspecified sites in spine L40.59 Other Psoriatic Anthropathy Concomitant Medications Other Diagnosis: ICD-10 Code ____ Additional Comments _ Description Date of diagnosis Injection Training Required: Yes No Yes No Has a TB test been performed? Yes No Does the patient have an active infection? Start Date PRESCRIPTION INFORMATION Dose & Directions Medication Strength Qty/Refills Abrilada™ 20 mg/0.4mL prefilled syringe Inject 40 mg SQ every other week Quantity: (tocilizumab) 40 mg/0.8mL prefilled syringe 40 mg/0.8mL pen Refills: 80 mg/4 mL Vial ☐ Actemra® Induction Dose: Infuse 4 mg/kg IV every 4 weeks. (tocilizumah)] 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 Other: ☐ 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 every Quantity:__ (tocilizumab) 162 mg/0.9 mL ACTPen Autoinjector week based on clinical response. Refills: For patients weighing ≥ 100 kg: Inject 162 mg SC every week. 20 mg/0.4 mL Prefilled Syringe (citrate-free) Inject 40 mg SC every OTHER week. ∏Amievita™ (adalimumab-40 mg/0.8 mL Prefilled Syringe (citrate-free) Other: 40 mg/0.8 mL Prefilled SureClick* atto) autoinjector (citrate-free) ☐ Avsola⁶ 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. # of 100 mg vial Maintenance Dose: Infuse ____ _ mg/kg IV every 8 weeks. Other ■ Benlysta[®] 120 mg Vial Induction Dose: 10 mg/kg/dose IV infused over 1 hour every 2 weeks for the first 3 doses (0 refills). (belimumab) 400 mg Vial Maintenance Dose: Inject 10 mg/kg/dose IV once every 4 weeks. Refills: 200 mg/mL Prefilled Syringe Benlysta⁶ Maintenance Dose: Inject 200 mg SC once every week. (belimumab) 200 mg/mL Autoiniector *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. Patient Office-first fill only Office-all fills Other_ _ Needs by date:_ Dispense as Written **Substitution Permitted** Prescriber's Prescriber's Signature_ Date _____ Signature_ 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.



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Specialty Pharmacy Enrollment Form

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	9	ase detach before submitting	to a pharmacy - tear here			
PATIENT INFORMATION			PRESCRIBER INFORMATION			
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			
	Alternate Phone Last Four of SS# Gender		City, State, ZIP Phone Fax			
	ce: English Spanish Other		Contact Person Phone			
	NFORMATION (Must fax a copy of patie	ent's insurance card in	cluding both sides)			
	Reference number:					
		d to process prescript	tion) (Attach separate sheet if needed)			
Diagnosis – Plea	se include diagnosis name with ICD-10 code		Additional Information Therapy: New Reauthorization	n Restart		
M06.9 Rheumato	oid arthritis, unspecified		Weightkg/lbs Heightcm/in			
M08.00 Unspecif	fied juvenile rheumatoid arthritis of unspecified site		Allergies			
M08.3 Juvenile r	heumatoid polyarthritis (seronegative)		Lab Data			
M45.9 Ankylosing	g spondylitis of unspecified sites in spine		Prior Therapies			
L40.59 Other Pso	oriatic Anthropathy		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? Yes No Review Date					
	N INFORMATION					
Medication	Strength		Dose & Directions	Qty/Refills		
Cimzia	200 mg/mL Starter Kit (6 prefilled syringes)	Induction Dose: Inject 400	Omg SC at weeks 0, 2 and 4.			
(certolizumab pegol)				Quantity: 1 Kit Refills: 0		
Cimzia* (certolizumab pegol)	☐ 200 mg/mL Vial Kit ☐ 200 mg/mL Prefilled Syringe	Maintenance Dose: Inje Maintenance Dose: Inje Other:	Quantity:			
Cosentyx° (secukinumab)	Sensoready* pen 150 mg/mL injection Prefilled syringe 150 mg/mL injection UnoReady pen 300 mg/mL injection	Psoriatic Arthritis with Co Loading Dose: Inject 30 Maintenance Dose: Inje Other Psoriatic Arthritis o	Quantity:			
		every 4 weeks thereafter (Inject 150 mg (one injection) SC every 4 weeks.			
Cyltezo° (adalimumab- adbm)	40 mg/0.8ml Pen 40mg/0.8mL prefilled syringe	☐ Inject 40 mg SQ every o	Quantity:			
Enbrel® (etanercept)	□ 25 mg/0.5 mL prefilled syringe □ 25mg/0.5ml single-dose vial	☐ Inject 25 mg SC TWICE a week (72 - 96 hours apart). ☐ Inject 50 mg SC ONCE a week.		Quantity:		
	☐ 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.	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-first fill only Office-all fills Other Date: Needs by date:						
Dispense as Written Substitution Permitted						
Prescriber's	21000100 40 111166011		Prescriber's			
Signature		Date	SignatureD	ate		
Electronic or digital s	ignatures not accepted.		Electronic or digital signatures not accepted.			
Supervising/Co	llaborative Physician Information (per state requir	ements)				
	* ******					



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PATIENT INFO	RMATION		PRESCRIBER INFORMA	TION		
Please complete the following or send patient demographic sheet			Prescriber's Name			
Patient Name			DEA			
Address			NPI			
· · · · · · · · · · · · · · · · · · ·						
City, State, Zip			_ Address City, State, ZIP			
Home Phone Alternate Phone DOB Last Four of SS# Gender						
	ce: English Spanish Other		Phone			
					.0	
	NFORMATION (Must fax a copy of patie	ent's insurance card in	cluding both sides)			
	Reference number:					
	ORMATION (Section must be complete	d to process prescript	<u> </u>	· · · · · · · · · · · · · · · · · · ·		
Diagnosis – Plea	se include diagnosis name with ICD-10 code		Additional Information	Therapy: New	Reauthorizatio	n 🔲 Restart
M06.9 Rheumato	oid arthritis, unspecified		Weight	kg/lbs Height		cm/in
	fied juvenile rheumatoid arthritis of unspecified site		Allergies			
	heumatoid polyarthritis (seronegative)		Lab Data			
	g spondylitis of unspecified sites in spine		Prior Therapies Concomitant Medications			
L40.59 Other Pso	ICD-10 Code Description		Additional Comments			
Date of diagnosis _	· ·		Injection Training Required:			
Has a TB test been p			, ,			
,	ve an active infection?					
Start Date	Review Date					
PRESCRIPTIO	N INFORMATION					
Medication	Strength		Dose & Directions			Qty/Refills
☐ Hadlima™	40mg/0.4ml prefilled syringe	Inject 40 mg SQ every				Quantity:
(adalimumab- bwwd)	40mg/0.8ml prefilled syringe 40mg/0.4ml PushTouch auto-injector	Other:			-	Refills:
	40mg/0.8ml PushTouch auto-injector					
☐ Hulio*	20 mg/0.4mL prefilled syringe	Inject 40 mg SQ every	other week.			
(adalimumab-	40 mg/0.8mL prefilled syringe		Other:			Quantity:
fkjp)	☐ 40 mg/0.8mL pen					Refills:
Humira*	10 mg/0.1 mL Prefilled Syringe (citrate-free)	Inject 40 mg SC every (OTHER week.			Overtite:
(adalimumab)	20 mg/0.2 mL Prefilled Syringe (citrate-free) 40 mg/0.4 mL Prefilled Syringe (citrate-free)	Other:			Quantity: Refills:	
	40 mg/0.4 mL Prefilled Syringe (citrate-free)					rterins.
	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					
Hyrimoz°	10 mg/0.1mL prefilled syringe	Inject 40 mg SQ every	other week			
(adalimumab-	20 mg/0.2mL prefilled syringe	Other:			-	Quantity:
adaz)	40 mg/0.4mL prefilled syringe 40 mg/0.8mL prefilled syringe					Refills:
	40 mg/0.4mL auto-injector					
	80 mg/0.8mL auto-injector					
☐ Idacio°	40 mg/0.8ml auto-injector	☐ Inject 40 mg SQ every o				Quantity:
(adalimumab- aacf)	40 mg/0.8ml prefilled syringe	Other:			-	Refills:
						· <u></u>
	norization: I authorize this pharmacy and its re tiate the insurance prior authorization proces:					
	behalf as my authorized agent, including any					
	prior authorization. In the event that this pha					
	any related materials related to coverage of th	ie product to another pha	armacy of the patient's choic	e or in the patient's	insurer s provider i	IELWOFK.
Ship to: Patient Office-first fill only Office-all fills Other				Data	NI- 1 1	
PatientC	office-first fill only Uffice-all fills Uoth	er	Date: Needs by date:			e:
	Dispense as Written			Substitution Pe	ermitted	
Prescriber's		D .	Prescriber's			
	Signature Date Electronic or digital signatures not accepted.			Signature Date Electronic or digital signatures not accepted.		
			Licetronic or digital signatures not acc	леркви.		
Supervising/Co	ollaborative Physician Information (per state requir	ements)				



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PATIENT INFORMATION			g to a pharmacy - tear here PRESCRIBER INFORMATION			
Please complete the following or send patient demographic sheet			Prescriber's Name			
Patient NameAddress			DEANPI			
			NP1Group/Hospital			
Address 2						
	Albamada Dhana		Address			
	Alternate Phone		City, State, ZIP			
	Last Four of SS# Gender		Phone Fax			
Language Preferen	ce: English Spanish Other		Contact Person Phone			
INSURANCE I	NFORMATION (Must fax a copy of patie	ent's insurance card in	cluding both sides)			
	Reference number:		·	_		
			Constitution by a second of the second of th			
	· · · · · · · · · · · · · · · · · · ·	d to process prescript	tion) (Attach separate sheet if needed)			
Diagnosis – Plea	se include diagnosis name with ICD-10 code		Additional Information Therapy: ☐ New ☐ Reauthorization	on Restart		
M069 Rheumato	oid arthritis, unspecified		Weightkg/lbs Height	cm/in		
	fied juvenile rheumatoid arthritis of unspecified site		Allergies			
= '	heumatoid polyarthritis (seronegative)		Lab Data			
_	g spondylitis of unspecified sites in spine		Prior Therapies			
L40.59 Other Pso			Concomitant Medications			
	ICD-10 Code Description		Additional Comments			
			Injection Training Required: Yes No			
Date of diagnosis			Injection training Required: Tes No			
Has a TB test been p						
	ve an active infection? Yes No					
Start Date	Review Date					
PRESCRIPTIO	N INFORMATION					
Medication	Strength		Dose & Directions	Qty/Refills		
Inflectra*	100 mg Vial	Induction Dose: Infuse	mg/kg IV at weeks 0, 2 and 6.	Ougantitus		
(infliximab-dyyb)		Maintenance Dose: Infu	Quantity: # of 100 mg vial			
			use mg/kg IV every 8 weeks.			
		Other:		Refills:		
Пи	Dood as a fill that Destilled Contract					
☐ Kevzara° (sarilumab)	200 mg/1.14 mL Prefilled Syringe 150 mg/1.14 mL Prefilled Syringe	Inject 200 mg SC once		Quantity:		
(surnamab)	200 mg/1.14 mL Prefilled Pen		_Inject 150 mg 50 once every two weeks.			
	150 mg/1.14 mL Prefilled Pen					
Olumiant°	1 mg Tablet	Take 2 mg PO once daily	0			
(baricitinib)	2 mg Tablet	Other:		Quantity:		
` ′				Refills:		
Orencia*	250 mg vial	Infuse mg IV at wee	eks 0, 2 and 4, then every 4 weeks thereafter (please record patient weight	Quantity:		
(abatacept)	3	at the top of the form).	ζ	1		
		Other:		Refills:		
	College to the Australia in the major and and a set of A	□ Inject 10E mg CC overv	week			
Orencia* (abatacept)	ClickJect Autoinjector 125 mg/mL pack of 4	☐ Inject 125 mg SC every		Quantity:		
(ubutuoopt)	87.5 mg/0.7ml Prefilled Syringe	Inject 50 mg SC every w		Refills:		
	50 mg/0.4ml Prefilled Syringe	Other:				
Otezla*	Titration Starter Pack	Day 1: 10 mg PO in the n		Quantity: 1 Pack		
(apremilast)			morning and 10 mg PO in the evening. morning and 20 mg PO in the evening.	1		
			morning and 20 mg PO in the evening.	Refills: 0		
			morning and 30 mg PO in the evening.			
		Day 6 and thereafter: 30				
*Prescriber Auth	norization: I authorize this pharmacy and its re	presentatives to act as m	y authorized agent, where permitted by law and benefit plan spon	sor to secure		
			nd to sign any necessary forms, including but not limited to, attest			
			on forms and the receipt and submission of patient lab values and			
that support the	prior authorization. In the event that this pha	rmacy determines that it i	is unable to fulfill this prescription, I further authorize this pharma	cy to forward this		
information and	any related materials related to coverage of the	ne product to another pha	armacy 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						
	Dispense as Written		Substitution Permitted			
Prescriber's	- -		Prescriber's			
Signature		Date	3)ate		
Electronic or digital si	ignatures not accepted.		Electronic or digital signatures not accepted.			
Supervising/Co	ollaborative Physician Information (per state requir	ements)				
Juper visitig/C0	maborative i riyorcian information (perstate requir	ements)				



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PATIENT INFO	9	ase detach before submitting	to a pharmacy - tear here PRESCRIBER INFORMATION			
Please complete the following or send patient demographic sheet		Prescriber's Name				
Patient Name			DEA			
Address			NPI			
Address 2			Group/Hospital			
	Albamata Dhana		Address			
	Alternate Phone		City, State, ZIP			
	Last Four of SS# Gender		Phone Fax Phone			
Language Preferen	ce: English Spanish Other		Contact Person Phone			
INSURANCE I	NFORMATION (Must fax a copy of patie	ent's insurance card in	cluding both sides)			
Prior Authorization	Reference number:					
	<u> </u>	d to process procesing	tion) (Attack consents shoot if manded)			
	<u> </u>	a to process prescript	tion) (Attach separate sheet if needed)	an Dastant		
Diagnosis – Piea	se include diagnosis name with ICD-10 code		Additional Information Therapy: New Reauthorizati	on Restart		
M06.9 Rheumato	oid arthritis, unspecified		Weightkg/lbs Height	cm/in		
M08.00 Unspeci	fied juvenile rheumatoid arthritis of unspecified site		Allergies			
M08.3 Juvenile r	heumatoid polyarthritis (seronegative)		Lab Data			
M45.9 Ankylosing	g spondylitis of unspecified sites in spine		Prior Therapies			
L40.59 Other Pso	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 p			- · — -			
	ve an active infection?					
	Review Date					
PRESCRIPTION	N INFORMATION					
Medication			Dose & Directions	Oty / Pofills		
	Strength			Qty/Refills		
Otezla* (apremilast)	30 mg Tablet	Maintenance Dose: 30 r	Quantity: Refills:			
Remicade*	100 mg Vial	Induction Dose: Infuse	mg/kg IV at weeks 0, 2 and 6.	<u> </u>		
(infliximab)	100 mg viai		use mg/kg IV every 6 weeks.	Quantity:		
			use mg/kg IV every 8 weeks.	# of 100 mg vial		
		Other:		Refills:		
Renflexis*	100 mg Vial	☐ Induction Dose: Infuse	mg/kg IV at weeks 0, 2 and 6.	Quantity:		
(infliximab-abda)			Maintenance Dose: Infuse mg/kg IV every 6 weeks. Maintenance Dose: Infuse mg/kg IV every 8 weeks.			
Maintenance						
		Other:		Refills:		
Rinvog ^e	15 mg	Take one 15 mg tablet PO once daily.		Ouantitus		
(upadacitinib)			o once duity.	Quantity:		
		_		Refills:		
Simlandi*	40 mg/0.4mL auto-injector	Inject 40 mg SQ every o	other week.	Quantity:		
(adalimumab-	3,	Other:		,		
ryvk)				Refills:		
Simponi Aria®	50 mg/4 mL in a single use vial		minutes at weeks 0 and 4, then every 8 weeks thereafter (please record	Quantity:		
(golimumab)		patient weight in section a	above).	# of 50 mg vial		
			Refills:			
☐ Simponi®	50 mg/0.5 mL Prefilled SmartJect°	☐ Inject 50 mg SC once a		Quantity:		
(golimumab)	Autoinjector	Other:		Refills:		
	50 mg/0.5 mL Prefilled Syringe			ixemis.		
coverage and ini- necessity, on my that support the information and Ship to:	tiate the insurance prior authorization proces behalf as my authorized agent, including any prior authorization. In the event that this pha any related materials related to coverage of the	s for our shared patient, a required prior authorizati rmacy determines that it ne product to another pha	by authorized agent, where permitted by law and benefit plan spor nd to sign any necessary forms, including but not limited to, attes on forms and the receipt and submission of patient lab values and is unable to fulfill this prescription, I further authorize this pharma armacy of the patient's choice or in the patient's insurer's provider	tations of medical d other patient data acy to forward this r network.		
Patient Office-first fill only Office-all fills Other Date:						
	Dispense as Written		Substitution Permitted			
Prescriber's			Prescriber's			
Signature		Date		Date		
Electronic or digital si	ignatures not accepted.		Electronic or digital signatures not accepted.			
Supervisina/Co	llaborative Physician Information (per state requir	ements)				
5555. 1151119/00				·		



Page 6 of 7 (S-Y)

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PATIENT INFORMATION			PRESCRIBER INFORMATION			
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			
	Alternate Phone		City, State, ZIP			
	Last Four of SS# Gender		Phone Fax Contact Person Phone			
	ce: English Spanish Other					
INSURANCE I	NFORMATION (Must fax a copy of pation	ent's insurance card in	cluding both sides)			
Prior Authorization	Reference number:					
MEDICAL INF	ORMATION (Section must be complete	ed to process prescript	tion) (Attach separate sheet if needed)			
	se include diagnosis name with ICD-10 code		Additional Information Therapy: New Reauthorization	on Restart		
	· · · · · · · · · · · · · · · · · · ·		7, 2 2			
	oid arthritis, unspecified		Weightkg/lbs Height			
	fied juvenile rheumatoid arthritis of unspecified site		Allergies			
	heumatoid polyarthritis (seronegative)		Lab Data			
	g spondylitis of unspecified sites in spine		Prior Therapies			
=	oriatic Anthropathy		Concomitant Medications			
	: ICD-10 Code Description		Additional Comments			
Date of diagnosis _ Has a TB test been p			injection framing required: Tes No			
	ave an active infection?					
	Review Date					
	N INFORMATION					
Medication	Strength		Dose & Directions	Qty/Refills		
Skyrizi*	150 mg/mL prefilled syringe	Psoriatic Arthritis Induc	ction Dose: Inject 150 mg SC at Weeks 0 and 4, then maintenance			
(risankizumab-	150 mg/mL prefilled pen	dosing (0 refills).	2000, 2000, 21,000, 200 mg 00 at 1100, a and 1, a an maintenance	Quantity:		
rzaa)			tenance Dose: Inject 150mg SC every 12 weeks.	Refills:		
		Other:				
Stelara*	45 mg/0.5 mL Prefilled Syringe	Induction Dose: For pat	tients weighing ≤100 kg (220 lbs): Inject 45 mg SC initially and 4 weeks later,	Ouantitus		
(ustekinumab)	90 mg/mL Prefilled Syringe	(2 syringes, 0 refills).		Quantity:		
			tients weighing >100 kg (220 lbs): Inject 90 mg SC initially and 4 weeks later,	Refills:		
		(2 syringes, 0 refills). Maintenance Dose: Inje	ect 1 syringe SC every 12 weeks.			
Taltz* (ixekizumab)	80 mg Single Dose Autoinjector 80 mg Single Dose Prefilled Syringe		ndylitis/Psoriatic Arthritis Dosing: <u>e:</u> Inject SC two 80 mg injections on Day 1. (2 injections, 0 refills).			
(ixekizuiliab)			ect SC one 80 mg injection every 4 weeks.	Refills:		
		Other:				
☐ Tremfya®	100 mg/mL prefilled syringe	Induction Dose: Inject 1	100mg SC at week 0 and week 4 (2 syringes/pens, 0 refills).	Quantity:		
(guselkumab)	100 mg/ml One-Press Injector	Maintenance Dose: Inje	ect 100mg SC once every 8 weeks.	Refills:		
		□ - 1 111.8	0.1.1.1			
Xeljanz° (tofacitinib)	5 mg Tablet 11 mg Extended-Release Tablet	Take one 5 mg tablet PC Take one 11 mg tablet P				
(tordoreb)		Other:				
Yuflyma™	40 mg/0.4mL prefilled syringe 40 mg/0.4mL auto-injector	Inject 40 mg SQ every o	Quantity:			
(adalimumab- aqvh)	40 mg/0.4mc auto-injector	Other:				
*5						
			ly authorized agent, where permitted by law and benefit plan spon nd to sign any necessary forms, including but not limited to, attest			
			on forms and the receipt and submission of patient lab values and			
that support the	prior authorization. In the event that this pha	rmacy determines that it	is unable to fulfill this prescription, I further authorize this pharma	cy to forward this		
information and	any related materials related to coverage of the	ne product to another pha	armacy 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:						
Dispanse as Written						
Prescriber's	Dispense as Written		Substitution Permitted Prescriber's			
Signature		Date)ate		
	ignatures not accepted.		Electronic or digital signatures not accepted.			
Supervising/Co	Allahorative Physician Information	aments)				
Supervising/Co	ollaborative Physician Information (per state requir	ements)				



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PATIENT INFO	DRMATION		PRESCRIBER INFORMA	TION		
Please complete the following or send patient demographic sheet			Prescriber's Name			
Patient Name			DEA			
Address		NPI				
Address 2			Group/Hospital			
			Address			
	Alternate Phone		City, State, ZIP			
	Last Four of SS# Gender ce: ☐ English ☐ Spanish ☐ Other		Phone			
	NFORMATION (Must fax a copy of patie	ent s'insurance card in	cluding both sides)			
	Reference number:ORMATION (Section must be complete		ion) (Attack concrete ch	ant if mandad)		
	se include diagnosis name with ICD-10 code	ed to process prescript	Additional Information		Reauthorization	Restart
	-			., .,		
	oid arthritis, unspecified fied juvenile rheumatoid arthritis of unspecified site		Weight			cm/in
_	heumatoid polyarthritis (seronegative)		AllergiesLab Data			
_	g 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? Yes No					
	Review Date					
	N INFORMATION		Dans & Birrations			Obs. (Defille
Medication Yusimry™	Strength 40 mg/0.8mL prefilled syringe	Inject 40 mg SQ every o	Dose & Directions			Qty/Refills
(adalimumab-	40 mg/0.8mL auto-injector	Other:			_	Quantity:
aaty)						Refills:
						Quantity:
Other						Refills:
					_	
	n orization: I authorize this pharmacy and its re tiate the insurance prior authorization proces:					
	behalf as my authorized agent, including any					
that support the	prior authorization. In the event that this pha	rmacy determines that it	is unable to fulfill this prescrip	ption, I further auth	orize this pharmacy	y to forward this
	any related materials related to coverage of th	ne product to another pha	armacy of the patient's choice	e or in the patient's	insurer's provider n	etwork.
Ship to:						
Patient C	Office-first fill only Office-all fills Oth	er		Date:	Needs by date	e:
	Dispense as Written			Substitution Pe	ermitted	
Prescriber's		D .	Prescriber's			
Signature	gnatures not accepted.	Date	Signature Electronic or digital signatures not acc	rented	Da	te
_	·		Electronic or digital signatures flot acc	ьеркви.		
Supervising/Co	llaborative Physician Information (per state requir	ements)				

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