Cimzia

Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-855-330-1720**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-888-877-0518.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____*kg*

Patient Height: _____*cm*

Please indicate the place of service for the requested drug:

❑ *Ambulatory Surgical*	❑ *Home*	❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital*	❑ *Office*	❑ *Pharmacy*

Exception Criteria Questions:

A. Is the product being requested for the treatment of one of the following indications?
- Ankylosing spondylitis
- Crohn's disease
- Plaque psoriasis
- Polyarticular juvenile idiopathic arthritis
- Psoriatic arthritis
- Rheumatoid arthritis

❑ Yes ❑ No *If No, skip to Clinical Criteria Questions*

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

B. These are the preferred products for which coverage is provided for treatment of the following indications:
- Ankylosing spondylitis, psoriatic arthritis, rheumatoid arthritis: **Simponi Aria**
- Plaque psoriasis: **Ilumya**
- Polyarticular juvenile idiopathic arthritis**: Simponi Aria**
- Crohn's disease, ulcerative colitis: **Entyvio and Stelara IV**

Can the patient's treatment be switched to a preferred product?
❑ Yes, *Please obtain Form for preferred product and submit for corresponding PA*.
❑ No

C. What is the diagnosis?
❑ Ankylosing spondylitis ❑ Crohn's disease
❑ Psoriatic arthritis ❑ Rheumatoid arthritis
❑ Polyarticular juvenile idiopathic arthritis, *Skip to letter Q*
❑ Plaque psoriasis, *Skip to letter N* ❑ Other, *Skip to Clinical Criteria Questions*

D. Is the patient currently pregnant or breastfeeding? *If Yes, skip to Clinical Criteria Questions* ❑ Yes ❑ No

E. Is the request for Cimzia vial? *If Yes, skip to letter H* ❑ Yes ❑ No

F. Is this request for continuation of therapy with the requested product? ❑ Yes ❑ No *If No, skip to Question H*

G. Is the patient currently receiving the requested product through samples or a manufacturer's patient assistance program? If unknown, answer Yes. ❑ Yes ❑ No *If No, skip to Clinical Criteria Questions*

H. What is the diagnosis?
❑ Ankylosing spondylitis, *Skip to letter V* ❑ Crohn's disease, *skip to letter L*
❑ Psoriatic arthritis ❑ Rheumatoid arthritis

I. Is the request for an adult patient (18 years of age or older)? ❑ Yes ❑ No *If No, skip to Clinical Criteria Questions*

J. Does the patient have a documented inadequate response or intolerable adverse event to the preferred product indicated for psoriatic arthritis and rheumatoid arthritis (Simponi Aria)? ***ACTION REQUIRED*: *If 'Yes', attach supporting chart note(s)***. ❑ Yes *If Yes, skip to Clinical Criteria Questions* ❑ No

K. Does the patient have one of the following documented clinical reasons to avoid the preferred product that is a TNF inhibitor (Simponi Aria)? ***ACTION REQUIRED: If 'Yes', attach supporting chart note(s).***
❑ Not applicable – Requested medical is a TNF inhibitor, *skip to Clinical Criteria Questions*
❑ Yes – History of demyelinating disorder, *skip to Clinical Criteria Questions*
❑ Yes – History of congestive heart failure, *skip to Clinical Criteria Questions*
❑ Yes – History of hepatitis B virus infection, *skip to Clinical Criteria Questions*
❑ Yes – Autoantibody formation/lupus-like syndrome (attributed to TNF inhibitor), *skip to Clinical Criteria Questions*
❑ Yes – History or risk of lymphoma or other malignancy, *skip to Clinical Criteria Questions*
❑ Yes – History of being a primary non-responder to a TNF inhibitor (i.e., no clinical response with initial treatment), *skip to Clinical Criteria Questions*
❑ No – None of the above, *skip to Clinical Criteria Questions*

L. Is the request for an adult patient (18 years of age or older)? ❑ Yes ❑ No *If No, skip to Clinical Criteria Questions*

M. Does the patient have a documented inadequate response or intolerable adverse event to both of the preferred products indicated for Crohn's disease (Entyvio and Stelara IV)? ***ACTION REQUIRED: If 'Yes', attach supporting chart note(s).*** *If Yes or No, skip to Clinical Criteria Questions* ❑ Yes ❑ No

N. Is the request for an adult patient (18 years of age or older)? ❑ Yes ❑ No *If No, skip to Clinical Criteria Questions*

O. Is the patient currently pregnant or breastfeeding? ❑ Yes, *If Yes, skip to Clinical Criteria Questions* ❑ No

P. Does the patient have a documented inadequate response or intolerable adverse event to the preferred product indicated for plaque psoriasis (Ilumya)? ***ACTION REQUIRED: If 'Yes', attach supporting chart note(s).*** *If Yes or No, skip to Clinical Criteria Questions* ❑ Yes ❑ No

Q. Is the request for a patient 2 years of age or older? ❑ Yes ❑ No *If No, skip to Clinical Criteria Questions*

R. Is the request for continuation of therapy with the requested product? ❑ Yes ❑ No *If No, skip to letter T*

S. Is the patient currently receiving the requested product through samples or a manufacturer's patient assistance program? If unknown, answer 'Yes'. ❑ Yes ❑ No *If No, skip to Clinical Criteria Questions*

T. Does the patient have a documented inadequate response or intolerable adverse event to the preferred product indicated for polyarticular juvenile idiopathic arthritis (Simponi Aria)? ***ACTION REQUIRED: If 'Yes', attach supporting chart note(s).*** ❑ Yes *If Yes, skip to Clinical Criteria Questions* ❑ No

U. Does the patient have one of the following documented clinical reasons to avoid the preferred product that is a TNF inhibitor (Simponi Aria)? ***ACTION REQUIRED: If 'Yes', attach supporting chart note(s).***
❑ Yes – History of demyelinating disorder, *skip to Clinical Criteria Questions*
❑ Yes – History of congestive heart failure, *skip to Clinical Criteria Questions*
❑ Yes – Autoantibody formation/lupus-like syndrome (attributed to TNF inhibitor), *skip to Clinical Criteria Questions*
❑ Yes – History or risk of lymphoma or other malignancy, *skip to Clinical Criteria Questions*
❑ Yes – History of being a primary non-responder to a TNF inhibitor (i.e., no clinical response with initial treatment), *skip to Clinical Criteria Questions*
❑ No – None of the above, *skip to Clinical Criteria Questions*

V. Is the request for an adult patient (18 years of age or older) ❑ Yes ❑ No *If No, skip to Clinical Criteria Questions*

W. Does the patient have a documented inadequate response or intolerable adverse event to the preferred product indicated for ankylosing spondylitis (Simponi Aria)? ***Action Required: If 'Yes', attach supporting chart note(s).*** ❑ Yes ❑ No

Clinical Criteria Questions:

What is the ICD-10 code? _____

1. Will the requested drug be used in combination with any other biologic (e.g., Humira) or targeted synthetic drug (e.g., Olumiant, Otezla, Xeljanz)?
❒ Yes, *Continue to 2*
❒ No, *Continue to 2*

2. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic drug (e.g., Olumiant, Xeljanz) associated with an increased risk of tuberculosis?
❒ Yes, *Continue to 6*
❒ No, *Continue to 3*

3. Has the patient had a tuberculosis (TB) test (e.g., tuberculosis skin test [PPD], interferon-release assay [IGRA], chest x-ray) within 6 months of initiating therapy?

❒ Yes, *Continue to 4*
❒ No, *Continue to 4*

4. What were the results of the tuberculosis (TB) test?

❒ Positive for TB, *Continue to 5*

❒ Negative for TB, *Continue to 6*

❒ Unknown, *No further questions*

5. Which of the following applies to the patient?

❒ Patient has latent TB and treatment for latent TB has been initiated, *Continue to 6*

❒ Patient has latent TB and treatment for latent TB has been completed, *Continue to 6*

❒ Patient has latent TB and treatment for latent TB has not been initiated, *Continue to 6*

❒ Patient has active TB, *Continue to 6*

6. What is the diagnosis?

❒ Rheumatoid arthritis, *Continue to 8*

❒ Psoriatic arthritis WITH co-existent plaque psoriasis, *Continue to 7*

❒ Psoriatic arthritis, *Continue to 22*

❒ Ankylosing spondylitis, *Continue to 37*

❒ Non-radiographic axial spondyloarthritis, *Continue to 37*

❒ Crohn's disease, *Continue to 46*

❒ Plaque psoriasis, *Continue to 53*

❒ Other, please specify. _____, *No further questions*

7. What is the primary diagnosis being treated?

❒ Psoriatic arthritis, *Continue to 22*

❒ Plaque psoriasis, *Continue to 53*

8. Has the patient been diagnosed with moderately to severely active rheumatoid arthritis (RA)?
❒ Yes, *Continue to 9*
❒ No, *Continue to 9*

9. Is the patient an adult (18 years of age or older)?
❒ Yes, *Continue to 10*
❒ No, *Continue to 10*

10. Is the requested drug being prescribed by or in consultation with a rheumatologist?
❒ Yes, *Continue to 11*
❒ No, *Continue to 11*

11. Is this request for continuation of therapy with the requested drug?
❒ Yes, *Continue to 12*
❒ No, *Continue to 15*

12. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program?

❒ Yes, *Continue to 15*

❒ No, *Continue to 13*

❒ Unknown, *Continue to 15*

13. Has the patient achieved or maintained a positive clinical response since starting treatment with the requested drug?
❒ Yes, *Continue to 14*
❒ No, *Continue to 14*

14. Has the patient experienced substantial disease activity improvement (e.g., at least 20% from baseline) in tender joint count, swollen joint count, pain, or disability? ***ACTION REQUIRED***: If Yes, please attach chart notes or medical record documentation supporting positive clinical response and substantial disease activity improvement. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 67*
❒ No, *Continue to 67*

15. Has the patient ever received or is currently receiving a biologic (e.g., Humira) or targeted synthetic drug (e.g., Rinvoq, Xeljanz) indicated for moderately to severely active rheumatoid arthritis (excluding receiving the drug via samples or a manufacturer's patient assistance program)? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 67*
❒ No, *Continue to 16*

16. Does the patient meet either of the following: a) the patient was tested for the rheumatoid factor (RF) biomarker and the RF biomarker test was positive, or b) the patient was tested for the anti-cyclic citrullinated peptide (anti-CCP) biomarker and the anti-CCP biomarker test was positive? ***ACTION REQUIRED***: If Yes, please attach laboratory results, chart notes, or medical record documentation of biomarker testing. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 18*
❒ No, *Continue to 17*

17. Has the patient been tested for all of the following biomarkers: a) rheumatoid factor (RF), b) anti-cyclic citrullinated peptide (anti-CCP), and c) C-reactive protein (CRP) and/or erythrocyte sedimentation rate (ESR)? ***ACTION REQUIRED***: If Yes, please attach laboratory results, chart notes, or medical record documentation of biomarker testing. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 18*
❒ No, *Continue to 18*

18. Has the patient experienced an inadequate response after at least 3 months of treatment with methotrexate at a dose greater than or equal to 15 mg per week? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 67*
❒ No, *Continue to 19*

19. Has the patient experienced an intolerance to methotrexate? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 67*
❒ No, *Continue to 20*

20. Does the patient have a contraindication to methotrexate? ***ACTION REQUIRED***: If Yes, please attach documentation of clinical reason to avoid therapy. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 21*
❒ No, *Continue to 21*

21. Please indicate the contraindication to methotrexate.

❒ Clinical diagnosis of alcohol use disorder, alcoholic liver disease, or other chronic liver disease, *Continue to 67*

❒ Drug interaction, *Continue to 67*

❒ Risk of treatment-related toxicity, *Continue to 67*

❒ Pregnancy or currently planning pregnancy, *Continue to 67*

❒ Breastfeeding, *Continue to 67*
❒ Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension), *Continue to 67*

❒ Hypersensitivity, *Continue to 67*

❒ History of intolerance or adverse event, *Continue to 67*

❒ Other, please specify. _____, *Continue to 67*

22. Is the patient an adult (18 years of age or older)?
❒ Yes, *Continue to 23*
❒ No, *Continue to 23*

23. Is the requested drug being prescribed by or in consultation with a rheumatologist or dermatologist?
❒ Yes, *Continue to 24*
❒ No, *Continue to 24*

24. Is this request for continuation of therapy with the requested drug?
❒ Yes, *Continue to 25*
❒ No, *Continue to 28*

25. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program?

❒ Yes, *Continue to 28*

❒ No, *Continue to 26*

❒ Unknown, *Continue to 28*

26. Has the patient achieved or maintained a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition since starting treatment with the requested drug?
❒ Yes, *Continue to 27*
❒ No, *Continue to 27*

27. Which of the following has the patient experienced an improvement in from baseline? ***ACTION REQUIRED***: Please attach chart notes or medical record documentation supporting positive clinical response.

❒ Number of swollen joints ***ACTION REQUIRED****: Submit supporting documentation, Continue to 67*

❒ Number of tender joints ***ACTION REQUIRED****: Submit supporting documentation, Continue to 67*

❒ Dactylitis ***ACTION REQUIRED****: Submit supporting documentation, Continue to 67*

❒ Enthesitis ***ACTION REQUIRED****: Submit supporting documentation, Continue to 67*

❒ Axial disease ***ACTION REQUIRED****: Submit supporting documentation, Continue to 67*

❒ Skin and/or nail involvement ***ACTION REQUIRED****: Submit supporting documentation, Continue to 67*

❒ None of the above, *Continue to 67*

28. Has the patient been diagnosed with active psoriatic arthritis (PsA)?
❒ Yes, *Continue to 29*
❒ No, *Continue to 29*

29. Has the patient ever received or is currently receiving a biologic or targeted synthetic drug (e.g., Rinvoq, Otezla) indicated for active psoriatic arthritis (excluding receiving the drug via samples or a manufacturer's patient assistance program)? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 67*
❒ No, *Continue to 30*

30. What is the patient's disease severity?

❒ Mild to moderate, *Continue to 31*
❒ Severe, *Continue to 67*

31. Does the patient have enthesitis or predominantly axial disease?
❒ Yes, *Continue to 67*
❒ No, *Continue to 32*

32. Has the patient had an inadequate response to methotrexate, leflunomide, or another conventional synthetic drug (e.g., sulfasalazine) administered at an adequate dose and duration? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 67*
❒ No, *Continue to 33*

33. Has the patient had an intolerance to methotrexate, leflunomide, or another conventional synthetic drug (e.g., sulfasalazine)? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 67*
❒ No, *Continue to 34*

34. Does the patient have a contraindication to methotrexate or leflunomide? ***ACTION REQUIRED***: If Yes, please attach documentation of clinical reason to avoid therapy. ***ACTION REQUIRED***: Submit supporting documentation

❒ Yes, *Continue to 35*
❒ No, *Continue to 36*

35. Please indicate the contraindication to methotrexate or leflunomide.

❒ Clinical diagnosis of alcohol use disorder, alcoholic liver disease, or other chronic liver disease, *Continue to 67*

❒ Drug interaction, *Continue to 67*

❒ Risk of treatment-related toxicity, *Continue to 67*

❒ Pregnancy or currently planning pregnancy, *Continue to 67*

❒ Breastfeeding, *Continue to 67*

❒ Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension), *Continue to 67*

❒ Hypersensitivity, *Continue to 67*

❒ History of intolerance or adverse event, *Continue to 67*

❒ Other, please specify. _____, *Continue to 67*

36. Does the patient have a contraindication to another conventional synthetic drug (e.g., sulfasalazine)? ***ACTION REQUIRED***: If Yes, please attach documentation of clinical reason to avoid therapy. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 67*
❒ No, *Continue to 67*

37. Has the patient been diagnosed with active ankylosing spondylitis (AS) or active non-radiographic axial spondyloarthritis (nr-axSpA)?

❒ Yes - Active ankylosing spondylitis, *Continue to 38*

❒ Yes - Active non-radiographic axial spondyloarthritis, *Continue to 38*

❒ No, *Continue to 38*

38. Is the patient an adult (18 years of age or older)?
❒ Yes, *Continue to 39*
❒ No, *Continue to 39*

39. Is the requested drug being prescribed by or in consultation with a rheumatologist?
❒ Yes, *Continue to 40*
❒ No, *Continue to 40*

40. Is this request for continuation of therapy with the requested drug?
❒ Yes, *Continue to 41*
❒ No, *Continue to 44*

41. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program?

❒ Yes, *Continue to 44*

❒ No, *Continue to 42*

❒ Unknown, *Continue to 44*

42. Has the patient achieved or maintained a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition since starting treatment with the requested drug?
❒ Yes, *Continue to 43*
❒ No, *Continue to 43*

43. Which of the following has the patient experienced an improvement in from baseline? ***ACTION REQUIRED***: Please attach chart notes or medical records supporting positive clinical response.

❒ Functional status ***ACTION REQUIRED****: Submit supporting documentation, Continue to 67*

❒ Total spinal pain ***ACTION REQUIRED****: Submit supporting documentation, Continue to 67*
❒ Inflammation (e.g., morning stiffness) ***ACTION REQUIRED****: Submit supporting documentation, Continue to 67*

❒ None of the above, *Continue to 67*

44. Has the patient ever received or is currently receiving a biologic (e.g., Humira) or targeted synthetic drug (e.g., Rinvoq, Xeljanz) indicated for active ankylosing spondylitis or active non-radiographic axial spondyloarthritis (excluding receiving the drug via samples or a manufacturer's patient assistance program)? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 67*
❒ No, *Continue to 45*

45. Has the patient experienced an inadequate response with at least TWO nonsteroidal anti-inflammatory drugs (NSAIDs), or has an intolerance or contraindication to at least two NSAIDs? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy. If therapy is not advisable, please attach documentation of clinical reason to avoid therapy. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 67*
❒ No, *Continue to 67*

46. Has the patient been diagnosed with moderately to severely active Crohn's disease (CD)?
❒ Yes, *Continue to 47*
❒ No, *Continue to 47*

47. Is the patient an adult (18 years of age or older)?
❒ Yes, *Continue to 48*
❒ No, *Continue to 48*

48. Is the requested drug being prescribed by or in consultation with a gastroenterologist?
❒ Yes, *Continue to 49*
❒ No, *Continue to 49*

49. Is this request for continuation of therapy with the requested drug?
❒ Yes, *Continue to 50*
❒ No, *Continue to 67*

50. Has the patient achieved or maintained remission? ***ACTION REQUIRED***: If Yes, please attach chart notes or medical record documentation of remission. ***ACTION REQUIRED***: Submit supporting documentation

❒ Yes, *Continue to 67*
❒ No, *Continue to 51*

51. Has the patient achieved or maintained a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition since starting treatment with the requested drug?
❒ Yes, *Continue to 52*
❒ No, *Continue to 52*

52. Which of the following has the patient experienced an improvement in from baseline? ***ACTION REQUIRED***: Please attach chart notes or medical record documentation supporting positive clinical response to therapy.

❒ Abdominal pain or tenderness ***ACTION REQUIRED****: Submit supporting documentation, Continue to 67*

❒ Diarrhea ***ACTION REQUIRED****: Submit supporting documentation, Continue to 67*

❒ Body weight ***ACTION REQUIRED****: Submit supporting documentation, Continue to 67*

❒ Abdominal mass ***ACTION REQUIRED****: Submit supporting documentation, Continue to 67*

❒ Hematocrit ***ACTION REQUIRED****: Submit supporting documentation, Continue to 67*
❒ Appearance of the mucosa on endoscopy, computed tomography enterography (CTE), magnetic resonance enterography (MRE), or intestinal ultrasound ***ACTION REQUIRED****: Submit supporting documentation, Continue to 67*
❒ Improvement on a disease activity scoring tool (e.g., Crohn's Disease Activity Index [CDAI] score) ***ACTION REQUIRED****: Submit supporting documentation, Continue to 67*

❒ None of the above, *Continue to 67*

53. Has the patient been diagnosed with moderate to severe plaque psoriasis?
❒ Yes, *Continue to 54*
❒ No, *Continue to 54*

54. Is the patient an adult (18 years of age or older)?
❒ Yes, *Continue to 55*
❒ No, *Continue to 55*

55. Is the requested drug being prescribed by or in consultation with a dermatologist?
❒ Yes, *Continue to 56*
❒ No, *Continue to 56*

56. Is this request for continuation of therapy with the requested drug?
❒ Yes, *Continue to 57*
❒ No, *Continue to 61*

57. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program?

❒ Yes, *Continue to 61*

❒ No, *Continue to 58*

❒ Unknown, *Continue to 61*

58. Has the patient achieved or maintained a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition since starting treatment with the requested drug?

❒ Yes, *Continue to 59*
❒ No, *Continue to 59*

59. Has the patient experienced a reduction in body surface area (BSA) affected from baseline? ***ACTION REQUIRED***: If Yes, please attach chart notes or medical record documentation of decreased body surface area affected. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 67*
❒ No, *Continue to 60*

60. Has the patient experienced an improvement in signs and symptoms of the condition from baseline (e.g., itching, redness, flaking, scaling, burning, cracking, pain)? ***ACTION REQUIRED***: If Yes, please attach chart notes or medical record documentation of improvement in signs and symptoms. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 67*
❒ No, *Continue to 67*

61. Has the patient ever received or is currently receiving a biologic (e.g., Humira) or targeted synthetic drug (e.g., Sotyktu, Otezla) indicated for the treatment of moderate to severe plaque psoriasis (excluding receiving the drug via samples or a manufacturer's patient assistance program)? ***ACTION REQUIRED***: If Yes, attach chart notes, medical record documentation, or claims history supporting previous medications tried. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 67*
❒ No, *Continue to 62*

62. Are crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) affected? ***ACTION REQUIRED***: If Yes, please attach chart notes or medical record documentation of affected areas. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 67*
❒ No, *Continue to 63*

63. What is the percentage of body surface area (BSA) affected (prior to starting the requested medication)? Indicate percentage. ***ACTION REQUIRED***: Please attach chart notes or medical record documentation of body surface area affected.
❒ Greater than or equal to 3% to less than 10% of body surface area (BSA) _____
ACTION REQUIRED*: Submit supporting documentation, Continue to 64*
❒ Greater than or equal to 10% of body surface area (BSA) _____ ***ACTION REQUIRED****: Submit supporting documentation, Continue to 67*
❒ Less than 3% of body surface area (BSA) _____, *No further questions*

64. Has the patient experienced an inadequate response, or has an intolerance to phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 67*
❒ No, *Continue to 65*

65. Does the patient have a clinical reason to avoid pharmacologic treatment with methotrexate, cyclosporine, and acitretin? ***ACTION REQUIRED***: If Yes, please attach documentation of clinical reason to avoid therapy. ***ACTION REQUIRED***: Submit supporting documentation

❒ Yes, *Continue to 66*
❒ No, *Continue to 66*

66. Please indicate the clinical reason to avoid pharmacologic treatment with methotrexate, cyclosporine, and acitretin.

❒ Clinical diagnosis of alcohol use disorder, alcoholic liver disease, or other chronic liver disease, *Continue to 67*

❒ Drug interaction, *Continue to 67*

❒ Risk of treatment-related toxicity, *Continue to 67*

❒ Pregnancy or currently planning pregnancy, *Continue to 67*

❒ Breastfeeding, *Continue to 67*

❒ Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension), *Continue to 67*

❒ Hypersensitivity, *Continue to 67*

❒ History of intolerance or adverse event, *Continue to 67*

❒ Other, please specify. _____, *Continue to 67*

67. What is the diagnosis?

❒ Rheumatoid arthritis, *Continue to 68*

❒ Psoriatic arthritis WITH co-existent plaque psoriasis, *Continue to 78*

❒ Psoriatic arthritis, *Continue to 68*

❒ Ankylosing spondylitis, *Continue to 68*

❒ Non-radiographic axial spondyloarthritis, *Continue to 68*

❒ Crohn's disease, *Continue to 83*

❒ Plaque psoriasis, *Continue to 78*

68. Is the patient currently receiving the requested drug?
❒ Yes, *Continue to 70*
❒ No, *Continue to 69*

69. Is a loading dose prescribed?
❒ Yes, *Continue to 74*
❒ No, *Continue to 70*

70. Does the prescribed maintenance dose exceed 200 mg?
❒ Yes, *Continue to 72*
❒ No, *Continue to 71*

71. Is the prescribed frequency for the maintenance dose more frequent than one dose every other week?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

72. Does the prescribed maintenance dose exceed 400 mg?

❒ Yes, *Continue to 73*
❒ No, *Continue to 73*

73. Is the prescribed frequency for the maintenance dose more frequent than one dose every 4 weeks?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

74. Does the prescribed dose exceed a loading dose of 400 mg at weeks 0, 2, and 4, and a maintenance dose of 200 mg thereafter?
❒ Yes, *Continue to 76*
❒ No, *Continue to 75*

75. Is the prescribed frequency for the maintenance dose more frequent than one dose every other week?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

76. Does the prescribed dose exceed a loading dose of 400 mg at weeks 0, 2, and, 4 and a maintenance dose of 400 mg thereafter?
❒ Yes, *Continue to 77*
❒ No, *Continue to 77*

77. Is the prescribed frequency for the maintenance dose more frequent than one dose every 4 weeks?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

78. Is the patient currently receiving the requested drug?
❒ Yes, *Continue to 79*
❒ No, *Continue to 81*

79. Does the prescribed maintenance dose exceed 400 mg?
❒ Yes, *Continue to 80*
❒ No, *Continue to 80*

80. Is the prescribed frequency for the maintenance dose more frequent than one dose every other week?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

81. Does the prescribed dose exceed 400 mg?
❒ Yes, *Continue to 82*
❒ No, *Continue to 82*

82. Is the prescribed frequency more frequent than one dose every other week?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

83. Is the patient currently receiving the requested drug?

❒ Yes, *Continue to 85*
❒ No, *Continue to 84*

84. Is a loading dose prescribed?
❒ Yes, *Continue to 87*
❒ No, *Continue to 85*

85. Does the prescribed maintenance dose exceed 400 mg?
❒ Yes, *Continue to 86*
❒ No, *Continue to 86*

86. Is the prescribed frequency for the maintenance dose more frequent than one dose every 4 weeks?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

87. Does the prescribed dose exceed a loading dose of 400 mg at weeks 0, 2, and, 4 and a maintenance dose of 400 mg thereafter?
❒ Yes, *Continue to 88*
❒ No, *Continue to 88*

88. Is the prescribed frequency for the maintenance dose more frequent than one dose every 4 weeks?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

Step Therapy Override: Complete if Applicable for the state of Maryland.	Please Circle	
Is the requested drug being used to treat stage four advanced metastatic cancer?	Yes	No
Is the requested drug's use consistent with the FDA-approved indication or the National Comprehensive Cancer Network Drugs & Biologics Compendium indication for the treatment of stage four advanced metastatic cancer and is supported by peer-reviewed medical literature?	Yes	No
Is the requested drug being used for an FDA-approved indication OR an indication supported in the compendia of current literature (examples: AHFS, Lexicomp, Clinical Pharmacology, Micromedex, current accepted guidelines)?	Yes	No
Does the prescribed quantity fall within the manufacturer's published dosing guidelines or within dosing guidelines found in the compendia of current literature (examples: package insert, AHFS, Lexicomp, Clinical Pharmacology, Micromedex, current accepted guidelines)?	Yes	No
Do patient chart notes document the requested drug was ordered with a paid claim at the pharmacy, the pharmacy filled the prescription and delivered to the patient or other documentation that the requested drug was prescribed for the patient in the last 180 days?	Yes	No
Has the prescriber provided proof documented in the patient chart notes that in their opinion the requested drug is effective for the patient's condition?	Yes	No

Step Therapy Override: Complete if Applicable for the state of Virginia.	Please Circle	
Is the requested drug being used for an FDA-approved indication or an indication supported in the compendia of current literature (examples: AHFS, Micromedex, current accepted guidelines)?	Yes	No
Does the prescribed dose and quantity fall within the FDA-approved labeling or within dosing guidelines found in the compendia of current literature?	Yes	No
Is the request for a brand drug that has an AB-rated generic equivalent or interchangeable biological product available?	Yes	No
Has the patient had a trial and failure of the AB-rated generic equivalent or interchangeable biological product due to an adverse event (examples: rash, nausea, vomiting, anaphylaxis) that is thought to be due to an inactive ingredient?	Yes	No
Is the preferred drug contraindicated?	Yes	No
Is the preferred drug expected to be ineffective based on the known clinical characteristics of the patient and the prescription drug regimen?	Yes	No
Has the patient tried the preferred drug while on their current or previous health benefit plan and it was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event?	Yes	No
Is the patient currently receiving a positive therapeutic outcome with the requested drug for their medical condition?	Yes	No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____

Prescriber or Authorized Signature **Date (mm/dd/yy)**

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720