Cosentyx

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*

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 #9*

❒ No, *Continue to #3*

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

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 #9*

❒ Unknown, *No Further Question*

5. Which of the following applies to the patient?

❒ Patient has latent TB and treatment for latent TB has been initiated, *Continue to #9*

❒ Patient has latent TB and treatment for latent TB has been completed, *Continue to #9*

❒ Patient has latent TB and treatment for latent TB has not been initiated, *Continue to #9*

❒ Patient has active TB, *Continue to #9*

9. What is the diagnosis?

❒ Plaque psoriasis, *Continue to #100*

❒ Ankylosing spondylitis, *Continue to #200*

❒ Axial spondyloarthritis, *Continue to #200*

❒ Psoriatic arthritis with co-existent plaque psoriasis, *Continue to #10*

❒ Psoriatic arthritis WITHOUT co-existent plaque psoriasis, *Continue to #300*

❒ Enthesitis-related arthritis (ERA), *Continue to #400*

❒ Other, *No Further Questions*

10. What is the primary diagnosis being treated?

❒ Psoriatic arthritis, *Continue to #300*

❒ Plaque psoriasis, *Continue to #100*

100. Has the patient been diagnosed with moderate to severe plaque psoriasis?

❒ Yes, *Continue to #101*

❒ No, *Continue to #101*

101. Is the patient 6 years of age or older?

❒ Yes, *Continue to #102*

❒ No, *Continue to #102*

102. Is the requested drug being prescribed by or in consultation with a dermatologist?

❒ Yes, *Continue to #103*

❒ No, *Continue to #103*

103. Is this request for continuation of therapy with the requested drug?

❒ Yes, *Continue to #104*

❒ No, *Continue to #108*

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

❒ Yes, *Continue to #108*

❒ No, *Continue to #105*

❒ Unknown, *Continue to #108*

105. 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 #106*

❒ No, *Continue to #106*

106. 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*

❒ Yes, *Continue to #800*

❒ No, *Continue to #107*

107. 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*

❒ Yes, *Continue to #800*

❒ No, *Continue to #800*

108. 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, please attach chart notes, medical record documentation, or claims history supporting previous medications tried*

❒ Yes, *Continue to #800*

❒ No, *Continue to #109*

109. 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*

❒ Yes, *Continue to #800*

❒ No, *Continue to #110*

110. What is the percentage of body surface area (BSA) affected (prior to starting the requested medication)? ***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 BSA, *Continue to #111*

❒ Greater than or equal to 10% of BSA, *Go to #800*

❒ Less than 3% of BSA, *No Further Questions*

111. 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*

❒ Yes, *Continue to #800*

❒ No, *Continue to #112*

112. 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 each therapy*

❒ Yes, *Continue to #113*

❒ No, *No Further Questions*

113. 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 #800*

❒ Drug interaction, *Continue to #800*

❒ Risk of treatment-related toxicity, *Continue to #800*

❒ Pregnancy or currently planning pregnancy, *Continue to #800*

❒ Breastfeeding, *Continue to #800*

❒ Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension), *Continue to #800*

❒ Hypersensitivity, *Continue to #800*

❒ History of intolerance or adverse event, *Continue to #800*

❒ Other, *Continue to #800*

200. Is the patient an adult (18 years of age or older)?

❒ Yes, *Continue to #201*

❒ No, *Continue to #201*

201. Is the requested drug being prescribed by or in consultation with a rheumatologist?

❒ Yes, *Continue to #202*

❒ No, *Continue to #202*

202. Is this request for continuation of therapy with the requested drug?

❒ Yes, *Continue to #203*

❒ No, *Continue to #207*

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

❒ Yes, *Continue to #207*

❒ No, *Continue to #204*

❒ Unknown, *Continue to #207*

204. 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 #205*

❒ No, *Continue to #206*

205. 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*

❒ Functional status, *Continue to #800*

❒ Total spinal pain, *Continue to #800*

❒ Inflammation (e.g., morning stiffness), *Continue to #800*

❒ None of the above, *Continue to #206*

206. Is this a request for an increase in dosing regimen due to the patient not achieving an adequate clinical response at the current dose?

❒ Yes, *Continue to #800*

❒ No, *Continue to #800*

207. Has the patient been diagnosed with active ankylosing spondylitis (AS) or active axial spondyloarthritis?

❒ Yes – Active ankylosing spondylitis, *Continue to #208*

❒ Yes – Active axial spondyloarthritis, *Continue to #208*

❒ No, *Continue to #208*

208. Has the patient ever received or is currently receiving a biologic (e.g., Humira) or targeted synthetic drug (e.g., Rinvoq, Xeljanz) indicated for the treatment of active ankylosing spondylitis or active 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*

❒ Yes, *Continue to #800*

❒ No, *Continue to #209*

209. Has the patient had an inadequate response with at least TWO nonsteroidal anti-inflammatory drugs

❒ If therapy is not advisable, please attach documentation of clinical reason to avoid therapy

❒ Yes, *Continue to #800*

❒ No, *Continue to #800*

300. Is the patient 2 years of age or older?

❒ Yes, *Continue to #301*
❒ No, *Continue to #301*

301. Is the requested drug being prescribed by or in consultation with a rheumatologist or dermatologist?

❒ Yes, *Continue to #302*

❒ No, *Continue to #302*

302. Is this request for continuation of therapy with the requested drug?

❒ Yes, *Continue to #303*

❒ No, *Continue to #307*

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

❒ Yes, *Continue to #307*

❒ No, *Continue to #304*

❒ Unknown, *Continue to #307*

304. 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 #305*

❒ No, *Continue to #306*

305. 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, *Continue to #800*

❒ Number of tender joints, *Continue to #800*

❒ Dactylitis, *Continue to #800*

❒ Enthesitis, *Continue to #800*

❒ Axial disease, *Continue to #800*

❒ Skin and/or nail involvement, *Continue to #800*

❒ None of the above, *Continue to #306*

306. Is this a request for an increase in dosing regimen due to the patient not achieving an adequate clinical response at the current dose?

❒ Yes, *Continue to #800*

❒ No, *Continue to #800*

307. Has the patient been diagnosed with active psoriatic arthritis (PsA)?

❒ Yes, *Continue to #308*

❒ No, *Continue to #308*

308. Has the patient ever received or is currently receiving a biologic (e.g., Humira) or targeted synthetic drug (e.g., Rinvoq, Otezla) indicated for the treatment of 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*

❒ Yes, *Continue to #800*

❒ No, *Continue to #309*

309. Does the patient have mild to moderate disease?

❒ Yes, *Continue to #310*

❒ No, *Continue to #316*

310. Does the patient have enthesitis or predominantly axial disease?

❒ Yes, *Continue to #800*

❒ No, *Continue to #311*

311. 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*

❒ Yes, *Continue to #800*

❒ No, *Continue to #312*

312. 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*

❒ Yes, *Continue to #800*

❒ No, *Continue to #313*

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

❒ Yes, *Continue to #315*

❒ No, *Continue to #314*

314. 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*

❒ Yes, *Continue to #800*

❒ No, *Continue to #800*

315. Please indicate the contraindication to methotrexate or leflunomide

❒ Clinical diagnosis of alcohol use disorder, alcoholic liver disease, or other chronic liver disease, *Continue to #800*

❒ Drug interaction, *Continue to #800*

❒ Risk of treatment-related toxicity, *Continue to #800*

❒ Pregnancy or currently planning pregnancy, *Continue to #800*

❒ Breastfeeding, *Continue to #800*

❒ Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension), *Continue to #800*

❒ Hypersensitivity, *Continue to #800*

❒ History of intolerance or adverse event, *Continue to #800*

❒ Other, *Continue to #800*

316. Does the patient have severe disease?

❒ Yes, *Continue to #800*

❒ No, *Continue to #800*

400. Has the patient been diagnosed with active enthesitis-related arthritis?

❒ Yes, *Continue to #401*

❒ No, *Continue to #401*

401. Is the patient 4 years of age or older?

❒ Yes, *Continue to #402*

❒ No, *Continue to #402*

402. Is the requested drug being prescribed by or in consultation with a rheumatologist?

❒ Yes, *Continue to #403*

❒ No, *Continue to #403*

403. Is this request for continuation of therapy with the requested drug?

❒ Yes, *Continue to #404*

❒ No, *Continue to #407*

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

❒ Yes, *Continue to #407*

❒ No, *Continue to #405*

❒ Unknown, *Continue to #407*

405. 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 #406*

❒ No, *Continue to #406*

406. 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 flares, *Continue to 800*

❒ Number of joints with active arthritis (e.g., swelling, pain), *Continue to #800*

❒ Number of joints with limited movement, *Continue to #800*

❒ Dactylitis, *Continue to #800*

❒ Enthesitis, *Continue to #800*

❒ None of the above, *Continue to #800*

407. Has the patient ever received or is currently receiving a biologic indicated for the treatment of active enthesitis-related 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*

❒ Yes, *Continue to #800*

❒ No, *Continue to #408*

408. Does the patient's disease demonstrate at least three active joints involved and at least one site of active enthesitis at baseline or documented by history?

❒ Yes, *Continue to #409*

❒ No, *Continue to #409*

409. Has the patient experienced an inadequate response to nonsteroidal anti-inflammatory drugs (NSAIDs), sulfasalazine, or methotrexate? ***ACTION REQUIRED****: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy*

❒ Yes, *Continue to #800*

❒ No, *Continue to #410*

410. Has the patient experienced an intolerance or contraindication to nonsteroidal anti-inflammatory drugs (NSAIDs) AND sulfasalazine (e.g., porphyria, intestinal or urinary obstruction)? ***ACTION REQUIRED****: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy.If therapy is not advisable, please attach documentation of clinical reason to avoid therapy*

❒ Yes, *Continue to #411*

❒ No, *Continue to #411*

411. 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*

❒ Yes, *Continue to #800*

❒ No, *Continue to #412*

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

❒ Yes, *Continue to #413*

❒ No, *No Further Questions*

413. Please indicate the contraindication to methotrexate

❒ Clinical diagnosis of alcohol use disorder, alcoholic liver disease, or other chronic liver disease, *Continue to #800*

❒ Drug interaction, *Continue to #800*

❒ Risk of treatment-related toxicity, *Continue to #800*

❒ Pregnancy or currently planning pregnancy, *Continue to #800*

❒ Breastfeeding, *Continue to #800*

❒ Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension), *Continue to #800*

❒ Hypersensitivity, *Continue to #800*

❒ History of intolerance or adverse event, *Continue to #800*

❒ Other, *Continue to #800*

800. What is the diagnosis?

❒ Ankylosing spondylitis, *Continue to #840*

❒ Axial spondyloarthritis, *Continue to #860*

❒ Psoriatic arthritis with co-existent plaque psoriasis, *Continue to #870*

❒ Psoriatic arthritis WITHOUT co-existent plaque psoriasis, *Continue to #900*

❒ Plaque psoriasis, *Continue to #810*

❒ Enthesitis-related arthritis (ERA), *Continue to #930*

810. Is the patient currently receiving Cosentyx?

❒ Yes, *Continue to #811*

❒ No, *Continue to #816*

811. What is the patient's age?

❒ 6 years to less than 18 years of age, *Continue to #814*

❒ 18 years of age or older, *Continue to #812*

812. Does the prescribed dose exceed 300 mg?

❒ Yes, *Continue to #813*

❒ No, *Continue to #813*

813. Is the prescribed frequency for the maintenance dose more frequent than one dose every 4 weeks?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

814. Does the prescribed dose exceed 150 mg?

❒ Yes, *Continue to #815*

❒ No, *Continue to #815*

815. Is the prescribed frequency for the maintenance dose more frequent than one dose every 4 weeks?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

816. What is the patient's age?

❒ 6 years to less than 18 years of age, *Continue to #819*

❒ 18 years of age or older, *Continue to #817*

817. Does the prescribed dose exceed a loading dose of 300 mg at weeks 0, 1, 2, 3, and 4, and a maintenance dose of 300 mg thereafter?

❒ Yes, *Continue to #818*

❒ No, *Continue to #818*

818. Is the prescribed frequency for the maintenance dose more frequent than one dose every 4 weeks?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

819. Does the prescribed dose exceed a loading dose of 150 mg at weeks 0, 1, 2, 3, and 4, and a maintenance dose of 150 mg thereafter?

❒ Yes, *Continue to #820*

❒ No, *Continue to #820*

820. Is the prescribed frequency for the maintenance dose more frequent than one dose every 4 weeks?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

840. Is the patient currently receiving Cosentyx?

❒ Yes, *Continue to #841*

❒ No, *Continue to #846*

841. Does the prescribed dose exceed 150 mg?

❒ Yes, *Continue to #843*

❒ No, *Continue to #842*

842. Is the prescribed frequency for the maintenance dose more frequent than one dose every 4 weeks?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

843. Did the patient continue to have active ankylosing spondylitis at the 150 mg dose?

❒ Yes, *Continue to #844*

❒ No, *Continue to #844*

844. Does the prescribed dose exceed 300 mg?

❒ Yes, *Continue to #845*

❒ No, *Continue to #845*

845. Is the prescribed frequency for the maintenance dose more frequent than one dose every 4 weeks?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

846. Does the prescribed dose exceed a loading dose of 150 mg at weeks 0, 1, 2, 3, and 4, and a maintenance dose of 150 mg thereafter?

❒ Yes, *Continue to #847*

❒ No, *Continue to #847*

847. Is the prescribed frequency for the maintenance dose more frequent than one dose every 4 weeks?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

860. Is the patient currently receiving Cosentyx?

❒ Yes, *Continue to #861*

❒ No, *Continue to #863*

861. Does the prescribed dose exceed 150 mg?

❒ Yes *Continue to #862*

❒ No, *Continue to #862*

862. Is the prescribed frequency for the maintenance dose more frequent than one dose every 4 weeks?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

863. Does the prescribed dose exceed a loading dose of 150 mg at weeks 0, 1, 2, 3, and 4, and a maintenance dose of 150 mg thereafter?

❒ Yes, *Continue to #864*

❒ No, *Continue to #864*

864. Is the prescribed frequency for the maintenance dose more frequent than one dose every 4 weeks?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

870. Is the patient currently receiving Cosentyx?

❒ Yes, *Continue to #871*

❒ No, *Continue to #876*

871. What is the patient's age?

❒ 2 years to less than 18 years of age, *Continue to #874*

❒ 18 years of age or older, *Continue to #872*

872. Does the prescribed dose exceed 300 mg?

❒ Yes, *Continue to #873*

❒ No, *Continue to #873*

873. Is the prescribed frequency for the maintenance dose more frequent than one dose every 4 weeks?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

874. Does the prescribed dose exceed 150 mg?

❒ Yes, *Continue to #875*

❒ No, *Continue to #875*

875. Is the prescribed frequency for the maintenance dose more frequent than one dose every 4 weeks?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

876. What is the patient's age?

❒ 2 years to less than 18 years of age, *Continue to #879*

❒ 18 years of age or older, *Continue to #877*

877. Does the prescribed dose exceed a loading dose of 300 mg at weeks 0, 1, 2, 3, and 4, and a maintenance dose of 300 mg thereafter?

❒ Yes, *Continue to #878*

❒ No, *Continue to #878*

878. Is the prescribed frequency for the maintenance dose more frequent than one dose every 4 weeks?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

879. Does the prescribed dose exceed a loading dose of 150 mg at weeks 0, 1, 2, 3, and 4, and a maintenance dose of 150 mg thereafter?

❒ Yes, *Continue to #880*

❒ No, *Continue to #880*

880. Is the prescribed frequency for the maintenance dose more frequent than one dose every 4 weeks?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

900. Is the patient currently receiving Cosentyx?

❒ Yes, *Continue to #901*

❒ No, *Continue to #910*

901. What is the patient's age?

❒ 2 years to less than 18 years of age, *Continue to #907*

❒ 18 years of age or older, *Continue to #902*

902. Does the prescribed dose exceed 150 mg?

❒ Yes, *Continue to #904*

❒ No, *Continue to #903*

903. Is the prescribed frequency of the maintenance dose more frequent than one dose every 4 weeks?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

904. Did the patient continue to have active psoriatic arthritis at the 150 mg dose?

❒ Yes, *Continue to #905*

❒ No, *Continue to #905*

905. Does the prescribed dose exceed 300 mg?

❒ Yes, *Continue to #906*

❒ No, *Continue to #906*

906. Is the prescribed frequency for the maintenance dose more frequent than one dose every 4 weeks?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

907. What is the patient's weight?

_____kg, *Continue to #908*

908. Does the prescribed dose exceed 150 mg?

❒ Yes, *Continue to #909*

❒ No, *Continue to #909*

909. Is the prescribed frequency for the maintenance dose more frequent than one dose every 4 weeks?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

910. What is the patient's age?

❒ 2 years to less than 18 years of age, *Continue to #911*

❒ 18 years of age or older, *Continue to #912*

911. What is the patient's weight?

_____kg, *Continue to #912*

912. Does the prescribed dose exceed a loading dose of 150 mg at weeks 0, 1, 2, 3, and 4, and a maintenance dose of 150 mg thereafter?

❒ Yes, *Continue to #913*

❒ No, *Continue to #913*

913. Is the prescribed frequency for the maintenance dose more frequent than one dose every 4 weeks?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

930. Is the patient currently receiving Cosentyx?

❒ Yes, *Continue to #931*

❒ No, *Continue to #934*

931. What is the patient's weight?

_____kg, *Continue to #932*

932. Does the prescribed dose exceed 150 mg?

❒ Yes, *Continue to #933*

❒ No, *Continue to #933*

933. Is the prescribed frequency for the maintenance dose more frequent than one dose every 4 weeks?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

934. What is the patient's weight?

_____kg, *Continue to #935*

935. Does the prescribed dose exceed a loading dose of 150 mg at weeks 0, 1, 2, 3, and 4, and a maintenance dose of 150 mg thereafter?

❒ Yes, *Continue to #936*

❒ No, *Continue to #936*

936. Is the prescribed frequency for the maintenance dose more frequent than one dose every 4 weeks?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

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