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 1-866-249-6155**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506.** 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:** _____
Request Initiated For: _____

1. What is the prescribed quantity and frequency?
   a) **Loading dose:**
   - ❑ Cosentyx 75 mg Quantity and Frequency: _____
   - ❑ Cosentyx 150 mg Quantity and Frequency: _____
   - ❑ Cosentyx 300 mg Quantity and Frequency: _____
   - ❑ Other _____

   b) **Maintenance dose:**
   - ❑ Cosentyx 75 mg Quantity and Frequency: _____
   - ❑ Cosentyx 150 mg Quantity and Frequency: _____
   - ❑ Cosentyx 300 mg Quantity and Frequency: _____
   - ❑ Other _____

2. What is the diagnosis?
   - ❑ Moderate to severe plaque psoriasis
   - ❑ Active ankylosing spondylitis
   - ❑ Active axial spondyloarthritis
   - ❑ Active psoriatic arthritis **WITHOUT** co-existent plaque psoriasis
   - ❑ Active psoriatic arthritis **WITH** co-existent plaque psoriasis
     Please indicate primary diagnosis being treated: ❑ Psoriatic arthritis ❑ Plaque psoriasis
   - ❑ Enthesitis related arthritis
   - ❑ Other _____

3. What is the ICD-10 code? _____

4. What is the patient's weight? _____ kg

Send completed form to: Case Review Unit, CVS Caremark Prior Authorization Fax: 1-866-249-6155

 Cosentyx ACSF SGM - 6/2023.

Section A: Preferred Product - *Complete the following section if the **primary** diagnosis is plaque psoriasis*

5. These are the preferred products for which coverage is provided for the treatment of plaque psoriasis: **Humira, Ilumya, Otezla, Remicade, Skyrizi (SC), Stelara (SC), Taltz, Tremfya, Cimzia syringe (secondary)*.** Can the patients treatment be switched to a preferred product?
   Note: Secondary preferred product option only applies to members who have had a documented inadequate response or intolerable adverse event with two primary preferred products.
   ❑ Yes - Please specify: _____ ***If Yes, please call 1-866-814-5506 to have the updated form faxed to your office OR you may complete the PA electronically (ePA). You may sign up online via CoverMyMeds at: www.covermymeds.com/epa/caremark/ or call 1-866-452-5017.***
   ❑ No ❑ Not applicable - Requested for condition not listed above, *skip to Section B: All Requests*

6. Does the patient have a documented inadequate response or intolerable adverse event with any of the following preferred products? ***ACTION REQUIRED: If Yes, attach supporting chart note(s).***
   Indicate ALL that apply.

❑ Humira:	❑ Inadequate response	❑ Intolerable adverse event
❑ Ilumya:	❑ Inadequate response	❑ Intolerable adverse event
❑ Otezla:	❑ Inadequate response	❑ Intolerable adverse event
❑ Skyrizi (SC):	❑ Inadequate response	❑ Intolerable adverse event
❑ Stelara (SC):	❑ Inadequate response	❑ Intolerable adverse event
❑ Taltz:	❑ Inadequate response	❑ Intolerable adverse event
❑ Tremfya:	❑ Inadequate response	❑ Intolerable adverse event
❑ Cimzia syringe:	❑ Inadequate response	❑ Intolerable adverse event

   ❑ No - None of the above

7. Does the patient have one of the following documented clinical reasons to avoid both of the preferred product that is a TNF inhibitor (Humira and Cimzia)? ***ACTION REQUIRED: If Yes, attach supporting chart note(s).***
   ❑ Yes - History of demyelinating disorder ❑ Yes - History of congestive heart failure
   ❑ Yes - History or risk of lymphoma or other malignancy ❑ Yes - History of hepatitis B virus infection
   ❑ Yes - Autoantibody formation/lupus-like syndrome (attributed to TNF inhibitor)
   ❑ Yes - History of being a primary non-responder to a TNF inhibitor (i.e., no clinical response with initial treatment)
   ❑ No - None of the above

Section B: All Requests

8. Is the requested drug being prescribed by or in consultation with a dermatologist or rheumatologist?
   ❑ Dermatologist ❑ Rheumatologist ❑ None of the above

9. 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 ❑ No

10. 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?
    If Yes, skip to #14 ❑ Yes ❑ No

11. 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 ❑ No

12. What were the results of the tuberculosis (TB) test?
    ❑ Positive for TB ❑ Negative for TB, *skip to #14* ❑ Unknown

13. Does the patient have latent or active tuberculosis (TB)?
    ❑ Patient has latent TB and treatment for latent TB has been initiated
    ❑ Patient has latent TB and treatment for latent TB has been completed
    ❑ Patient has latent TB and treatment for latent TB has not been initiated
    ❑ Patient has active TB

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

❑ Yes ❑ No *If No, skip to diagnosis section.*

15. Is the patient currently receiving the requested drug through samples or a manufacturers patient assistance program? ❑ Yes ❑ No ❑ Unknown

16. Has the patient achieved or maintained 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 ❑ No

Complete the following section based on the patient's <u>primary</u> diagnosis, if applicable.

<u>Section C: Plaque Psoriasis</u>

Continuation

17. 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 and no further questions.*** ❑ Yes ❑ No

18. 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 ❑ No

Initiation

19. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic drug (e.g., Sotyktu, Otezla) indicated for the treatment of moderate to severe plaque psoriasis? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried and no further questions.*** ❑ Yes ❑ No

20. 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 and no further questions.*** ❑ Yes ❑ No

21. 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.*** ***_____ %*** *If greater than or equal to 10%, no further questions.*

22. 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 and no further questions.*** ❑ Yes ❑ No

23. 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.*** ❑ Yes ❑ No
If Yes, indicate reason: _____

<u>Section D: Ankylosing Spondylitis and Axial Spondyloarthritis</u>

Continuation

24. Which of the following has the patient experienced an improvement in from baseline? ***ACTION REQUIRED: Please attach chart notes or medical record documentation of positive clinical response.***
❑ Functional status ❑ Total spinal pain
❑ Inflammation (e.g., morning stiffness) ❑ None of the above

25. *If the prescribed dose exceeds 150 mg <u>AND</u> diagnosis is for Ankylosing Spondylitis,* did the patient continue to have active ankylosing spondylitis at the 150 mg dose? ❑ Yes ❑ No ❑ N/A, prescribed dose does not exceed 150mg and/or diagnosis is NOT for Ankylosing Spondylitis

Initiation

26. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic drug (e.g., Rinvoq, Xeljanz) that is indicated for active ankylosing spondylitis or active axial spondyloarthritis? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried and no further questions.*** ❑ Yes ❑ No

27. 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 if not advisable, please attach documentation of clinical reason to avoid therapy.*** ❑ Yes ❑ No

Section E: Psoriatic Arthritis

Continuation

28. Which of the following has the patient experienced an improvement in from baseline? ***ACTION REQUIRED: If Yes, Please attach chart notes or medical record documentation of improvement in signs and symptoms.***
    ❑ Number of swollen joints ❑ Number of tender joints ❑ Dactylitis
    ❑ Enthesitis ❑ Skin and/or nail involvement ❑ None of the above

29. *If the prescribed dose exceeds 150 mg,* did the patient continue to have active psoriatic arthritis at the 150 mg dose? ❑ Yes ❑ No ❑ N/A, prescribed dose does not exceed 150mg

Initiation

30. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic drug (e.g., Rinvoq, Otezla) that is indicated for active psoriatic arthritis? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried and no further questions.*** ❑ Yes ❑ No

31. Does the patient have mild to moderate disease? ❑ Yes ❑ No *If No, skip to #37*

32. Does the patient have enthesitis or predominantly axial disease? *If Yes, no further questions.* ❑ Yes ❑ No

33. 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 and no further questions.*** ❑ Yes ❑ No

34. 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 and no further questions.*** ❑ Yes ❑ No

35. Does the patient have a contraindication to methotrexate or leflunomide? ***ACTION REQUIRED: If Yes, please attach documentation of clinical reason to avoid therapy and no further questions.*** ❑ Yes ❑ No
    If Yes, indicate contraindication: _____

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.***
    ❑ Yes ❑ No *No further questions*.

37. Does the patient have severe disease? ❑ Yes ❑ No

Section F: Enthesitis Related Arthritis (ERA)

Continuation

38. 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 joints with active arthritis (e.g., swelling, pain)
- ❑ Number of joints with limited movement
- ❑ Dactylitis
- ❑ None of the above
- ❑ Enthesitis
- ❑ Number of flares
- ❑ Axial disease

Initiation

39. Has the patient ever received (including current utilizers) a biologic for the treatment of active enthesitis related arthritis? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried.*** ❑ Yes ❑ No

40. Does the patient's disease demonstrate three active joints involved and at least one site of active enthesitis at baseline or documented by history? ❑ Yes ❑ No

41. Has the patient experienced an inadequate response or an intolerance 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 ❑ 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 Prior Authorization Fax: 1-866-249-6155