CVS caremark™ {{PANUMCODE}}

Enbrel

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.

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Patient's Name: {{MEMFIRST}} {{MEMLAST}} **Date**: {{TODAY}}
Patient's ID: {{MEMBERID}} **Patient's Date of Birth:** {{MEMBERDOB}}
Physician's Name: {{PHYFIRST}} {{PHYLAST}}
Specialty: _____, **NPI#:** _____
Physician Office Telephone: {{PHYSICIANPHONE}} **Physician Office Fax:** {{PHYSICIANFAX}}
Request Initiated For: {{DRUGNAME}}

1. What is the prescribed dose and frequency? *Circle formulation being requested.*
   a) **Loading dose:**
   ❑ Enbrel 50 mg PFS/Vials Quantity and Frequency: _____
   ❑ Enbrel 25 mg PFS/Vials Quantity and Frequency: _____
   ❑ Other _____
   b) **Maintenance dose:**
   ❑ Enbrel 50 mg PFS/Vials Quantity and Frequency: _____
   ❑ Enbrel 25 mg PFS/Vials Quantity and Frequency: _____
   ❑ Other _____
2. Is the requested quantity supported by dosing guidelines found in the compendia or current literature (e.g., Micromedex DrugDex, NCCN compendia, current treatment guidelines)? ❑ Yes ❑ No
3. Has the patient been diagnosed with any of the following?
   ❑ Moderately to severely active rheumatoid arthritis (RA)
   ❑ Moderate to severe plaque psoriasis
   ❑ Behcet's disease
   ❑ Graft versus host disease
   ❑ Active non-radiographic axial spondyloarthritis
   ❑ Reactive arthritis
   ❑ Active articular juvenile idiopathic arthritis
   ❑ Active ankylosing spondylitis (AS)
   ❑ Pyoderma gangrenosum
   ❑ Severe, refractory hidradenitis suppurativa
   ❑ Active psoriatic arthritis (PsA) WITH co-existent plaque psoriasis
   ❑ Active psoriatic arthritis (PsA) WITHOUT co-existent plaque psoriasis
   ❑ Moderately to severely active **polyarticular** juvenile idiopathic arthritis (pJIA)
   ❑ Moderately to severely active **oligoarticular** juvenile idiopathic arthritis
   ❑ Other _____
4. What is the ICD-10 code? _____
5. *For pediatric patients with JIA, PsA, or PsO,* what is the patient's weight? _____ kg or lbs ***(circle one)***
6. Does the patient have a latex allergy? ❑ Yes ❑ No

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

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Section A: Preferred Product

7. These are the preferred products for which coverage is provided for the treatment of the following indications:
   a. Non-radiographic axial spondyloarthritis: **Cimzia syringe, Cosentyx**
   b. Plaque psoriasis: **Humira, Otezla, Remicade, Skyrizi, Stelara, Taltz, Tremfya, Cimzia syringe (secondary)***
   Note: Secondary preferred product for Plaque psoriasis is Cimzia syringe. This preferred product option only applies to members who have had a documented inadequate response or intolerable adverse event with primary preferred products.
   Can the patient's treatment be switched to a preferred product?
   ❑ 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 other than plaque psoriasis, *skip to Section B: All Requests*

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

❑ Cymzia syringe:	❑ Inadequate response	❑ Intolerable adverse event
❑ Humira:	❑ Inadequate response	❑ Intolerable adverse event
❑ Otezla:	❑ Inadequate response	❑ Intolerable adverse event
❑ Skyrizi:	❑ Inadequate response	❑ Intolerable adverse event
❑ Stelara SC:	❑ Inadequate response	❑ Intolerable adverse event
❑ Taltz:	❑ Inadequate response	❑ Intolerable adverse event
❑ Tremfya:	❑ Inadequate response	❑ Intolerable adverse event

   ❑ No - none of the above

9. Does the patient have one of the following documented clinical reasons to avoid 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 of hepatitis B virus infection
   ❑ Yes - Autoantibody formation/lupus-like syndrome (attributed to TNF inhibitor)
   ❑ Yes - Risk of lymphoma
   ❑ No - none of the above
   ❑ Not applicable - requested medication is a TNF inhibitor

Section B: All Requests

10. Will the requested drug be used in combination with any other biologic (e.g., Humira) or targeted synthetic disease-modifying anti-rheumatic drug (DMARD) (e.g., Olumiant, Otezla, Xeljanz)? ❑ Yes ❑ No

11. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic DMARD (e.g., Rinvoq, Xeljanz) associated with an increased risk of tuberculosis? *If Yes, skip to #13* ❑ Yes ❑ No

12. 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? *If Yes, skip to #15* ❑ Yes ❑ No

13. Does the patient have risk factors for tuberculosis (TB)? (e.g., persons with close contact to people with infectious TB disease; persons who have recently immigrated from areas of the world with high rates of TB [e.g., Africa, Asia, Eastern Europe, Latin America, Russia]; children less than 5 years of age who have a positive TB test; groups with high rates of TB transmission [e.g., homeless persons, injection drug users, persons with HIV infection], or persons who work or reside with people who are at an increased risk for active TB [e.g., hospitals, long-term care facilities, correctional facilities, homeless shelters])? ❑ Yes ❑ No *If No, skip to #18*

14. Has the patient been tested for tuberculosis (TB) within the previous 12 months? ❑ Yes ❑ No

15. What were the results of the tuberculosis (TB) test?
    ❑ Positive for TB ❑ Negative for TB, *skip to #18* ❑ Unknown

16. Does the patient have latent or active tuberculosis (TB)? ❑ Latent ❑ Active ❑ Unknown

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17. Has treatment for latent tuberculosis (TB) infection been initiated or completed?
❑ Yes - treatment initiated ❑ Yes - treatment completed ❑ No

18. Is this request for continuation of therapy with the requested drug?
❑ Yes ❑ No *If No, skip to diagnosis section*

19. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program? *If Yes, Unknown, or diagnosis is rheumatoid arthritis or reactive arthritis, skip to diagnosis section*
❑ Yes ❑ No ❑ Unknown

20. 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 *If diagnosis is Behcet's disease or Pyoderma Gangrenosum, no further questions*

Complete the following section based on the patient's diagnosis, if applicable.

Section C: Rheumatoid Arthritis and Reactive Arthritis

Continuation

21. *If diagnosis is reactive arthritis*, has the patient achieved or maintained positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition (e.g. tender joint count, swollen joint count, or pain) since starting treatment with the requested drug? ***ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation supporting positive clinical response and no further questions.***
❑ Yes ❑ No

22. *If diagnosis is rheumatoid arthritis,* has the patient achieved or maintained positive clinical response since starting treatment with the requested drug? ❑ Yes ❑ No

23. What is the percent of disease activity improvement from baseline in tender joint count, swollen joint count, pain, or disability? ***ACTION REQUIRED: Please attach chart notes or medical record documentation supporting positive clinical response. _____%***

Initiation

24. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic DMARD (e.g., Rinvoq, Xeljanz) that is indicated for moderately to severely active rheumatoid arthritis or reactive 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

25. Does the patient meet BOTH of the following: a) the patient was tested for the rheumatoid factor (RF) biomarker AND b) the RF biomarker test was positive? ***ACTION REQUIRED: If Yes, please attach laboratory results, chart notes, or medical record documentation of biomarker testing and skip to #32.*** ❑ Yes ❑ No

26. Does the patient meet BOTH of the following: a) the patient was tested for the anti-cyclic citrullinated peptide (anti-CCP) biomarker AND b) the anti-CCP biomarker test was positive? ***ACTION REQUIRED: If Yes, please attach laboratory results, chart notes, or medical record documentation of biomarker testing and skip to #32.***
❑ Yes ❑ No

27. Has the patient been tested for the rheumatoid factor (RF) biomarker? ***ACTION REQUIRED: If Yes, please attach laboratory results, chart notes, or medical record documentation of biomarker testing.*** ❑ Yes ❑ No

28. Has the patient been tested for the anti-cyclic citrullinated peptide (anti-CCP) biomarker?
ACTION REQUIRED: If Yes, please attach laboratory results, chart notes, or medical record documentation of biomarker testing. ❑ Yes ❑ No

29. Has the patient been tested for the C-reactive protein (CRP) and/or erythrocyte sedimentation rate (ESR) biomarker(s)? ***ACTION REQUIRED: If Yes, please attach laboratory results, chart notes, or medical record documentation of biomarker testing.*** ❑ Yes ❑ No

30. Please indicate if the patient tested positive or negative for the C-reactive protein (CRP) biomarker, or if the test was not completed. ❑ Positive for CRP ❑ Negative for CRP ❑ Test for CRP was not completed

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31. Please indicate if the patient tested positive or negative for the erythrocyte sedimentation rate (ESR) biomarker, or if the test was not completed. ❑ Positive for ESR ❑ Negative for ESR ❑ Test for ESR was not completed

32. Has the patient experienced an inadequate response after at least 3 months of treatment with methotrexate at a dose greater than or equal to 20 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 and no further questions.*** ❑ Yes ❑ No

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

34. Does the patient have a contraindication to methotrexate? ***ACTION REQUIRED: If Yes, please attach documentation of clinical reason to avoid therapy.*** ❑ Yes ❑ No
If Yes, indicate the contraindication: _____

Section D: Juvenile Idiopathic Arthritis

Continuation

35. 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, limitation of motion)
❑ Number of joints with limitation of movement
❑ Functional ability
❑ None of the above

Initiation

36. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or a targeted synthetic DMARD indicated for moderately to severely active articular juvenile idiopathic 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

37. Has the patient had an inadequate response to methotrexate or another non-biologic DMARD 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

38. Does the patient have any of the following risk factors?
❑ Positive rheumatoid factor
❑ Positive anti-cyclic citrullinated peptide antibodies
❑ Pre-existing joint damage
❑ None of the above

39. Does the patient meet any of the following?
❑ High-risk joints are involved (e.g., cervical spine, wrist, or hip)
❑ High disease activity
❑ High risk for disabling joint disease
❑ None of the above

Section E: Ankylosing Spondylitis or Axial Spondyloarthritis

Continuation

40. 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
❑ Inflammation (e.g., morning stiffness)
❑ Total spinal pain
❑ None of the above

Initiation

41. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) 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

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42. 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, including response to therapy. If therapy is not advisable, please attach documentation of clinical reason to avoid therapy.*** ❑ Yes ❑ No

Section F: Plaque Psoriasis

Continuation

43. 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

44. 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

Initial Request

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

46. 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 body surface area affected and no further questions.*** ❑ Yes ❑ No

47. 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 affected areas and body surface area affected.*** _____ % *If Greater than or equal to 10% of BSA, no further questions*

48. 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

49. 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 clinical reason: _____

Section G: Psoriatic Arthritis

Continuation

50. 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 ❑ Number of tender joints ❑ Dactylitis
❑ Enthesitis ❑ Skin and/or nail involvement ❑ None of the above

51. Does the patient have psoriatic arthritis WITH co-existent plaque psoriasis? ❑ Yes ❑ No

Initiation

52. Is the requested drug for a pediatric or adult patient? ❑ Pediatric patient ❑ Adult patient

Section H: Hidradenitis Suppurativa

Continuation

53. Which of the following has the patient experienced since starting treatment with the requested drug? ***ACTION REQUIRED: Please attach chart notes or medical records supporting positive clinical response.***
List continues on next page
❑ Reduction in pain from baseline ❑ Reduction in suppuration from baseline
❑ Improvement in quality of life from baseline ❑ Reduced formation of new sinus tracts and scarring

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- ❑ Reduction in abscess and inflammatory nodule count from baseline
- ❑ Decrease in frequency of inflammatory lesions from baseline
- ❑ Improvement in frequency of relapses from baseline
- ❑ Improvement on a disease severity assessment tool from baseline
- ❑ None of the above

Initiation

54. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) indicated for the treatment of severe, refractory hidradenitis suppurativa? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried and no further questions.*** ❑ Yes ❑ No

55. Has the patient experienced an inadequate response after at least 90 days of treatment with oral antibiotics? ***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

56. Has the patient experienced an intolerable adverse effect to oral antibiotics? ***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

57. Does the patient have a contraindication to oral antibiotics? ***ACTION REQUIRED: If Yes, please attach documentation of clinical reason to avoid therapy.*** ❑ Yes ❑ No

Section I: Graft Versus Host Disease

58. Has the patient experienced an inadequate response to systemic corticosteroids? ***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

59. Has the patient experienced an intolerance or contraindication to corticosteroids? ***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 if not advisable, please attach documentation of clinical reason to avoid therapy.*** ❑ Yes ❑ No

Section J: Behcet's Disease

60. Has the patient ever received (including current utilizers) Otezla or a biologic indicated for the treatment of Behcet's disease? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried.*** ❑ Yes ❑ No

61. Has the patient had an inadequate response to at least one nonbiologic medication for Behcet's disease (e.g., apremilast, colchicine, systemic glucocorticoids, azathioprine)? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy.*** ❑ Yes ❑ No

Section K: Pyoderma Gangrenosum

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

63. Has the patient experienced an inadequate response to corticosteroids or immunosuppressive therapy (e.g., cyclosporine, mycophenolate mofetil)? ***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

64. Has the patient experienced an intolerance to corticosteroids and immunosuppressive therapy (e.g., cyclosporine, mycophenolate mofetil)? ***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

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65. Does the patient have a contraindication to corticosteroids and immunosuppressive therapy (e.g., cyclosporine, mycophenolate mofetil)? ***ACTION REQUIRED: If Yes, please attach documentation of clinical reason to avoid 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

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