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.

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 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)
   ❑ Reactive arthritis
   ❑ Moderate to severe plaque psoriasis
   ❑ Systemic juvenile idiopathic arthritis
   ❑ Behcet's disease
   ❑ Active ankylosing spondylitis (AS)
   ❑ Graft versus host disease
   ❑ Severe, refractory hidradenitis suppurativa
   ❑ Immunotherapy-related inflammatory arthritis
   ❑ Active non-radiographic axial spondyloarthritis
   ❑ 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? _____

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

 Enbrel VF, ACSF CHART SGM - 10/2022.

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

Section A: Preferred Product

7. These are the preferred products for which coverage is provided for the treatment of plaque psoriasis: **Humira, Otezla, Skyrizi, Stelara SC, Taltz, Tremfya.** 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 - Continue request for non-preferred, product, Enbrel
   ❑ 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*

❑ 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)? ***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 - History or risk of lymphoma or other malignancy
   ❑ 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
   ❑ 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 #15* ❑ 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? ❑ Yes ❑ No

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

14. Which of the following applies to the patient?
    ❑ 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

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

16. 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

17. 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

18. *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

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

20. 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

21. 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

22. Does the patient meet either of the following? ***ACTION REQUIRED: If Yes, please attach laboratory results, chart notes, or medical record documentation of biomarker testing and skip to #24.***
❑ Yes - the patient was tested for the rheumatoid factor (RF) biomarker and the RF biomarker test was positive
❑ Yes - the patient was tested for the anti-cyclic citrullinated peptide (anti-CCP) biomarker and the anti-CCP biomarker test was positive
❑ No - None of the above

23. 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.*** ❑ Yes ❑ No

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

25. 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

26. 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

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 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

28. 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

29. 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

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

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

Section E: Ankylosing Spondylitis or Axial Spondyloarthritis

Continuation

32. 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
    - ❑ Total spinal pain
    - ❑ Inflammation (e.g., morning stiffness)
    - ❑ None of the above

Initiation

33. 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

34. 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

35. 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

36. 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

37. 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

38. 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

39. 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.*

40. 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

41. 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

42. 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

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

Initiation

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

Section H: Hidradenitis Suppurativa

Continuation

45. 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.***
    - ❑ 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
    - ❑ 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

46. 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

47. 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

48. 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

49. 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

50. 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

51. 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

52. 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

53. 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: Immunotherapy-Related Inflammatory Arthritis

54. Is the disease severe or refractory? ❑ Yes ❑ No

55. Has the patient tried and not responded to corticosteroids and anti-inflammatory agents? ***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