CVS caremark™ {{PANUMCODE}}

Humira

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?
   a) **Loading dose:**
   - ❑ Humira pediatric Crohn's starter pack_____mg Quantity and Frequency:_____
   - ❑ Humira adult Crohn's/UC/HS starter pack _____mg Quantity and Frequency:_____
   - ❑ Humira psoriasis, uveitis, adolescent HS starter pack_____mg Quantity and Frequency:_____
   - ❑ Other _____

   b) **Maintenance dose:**
   - ❑ Humira 10 mg PFS/Pen Quantity and Frequency: _____
   - ❑ Humira 20 mg PFS/Pen Quantity and Frequency: _____
   - ❑ Humira 40 mg PFS/Pen Quantity and Frequency: _____
   - ❑ Humira 80 mg PFS/Pen 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?
   List continues on following page.
   - ❑ Moderately to severely active rheumatoid arthritis (RA)
   - ❑ Moderately to severely active Crohn's disease (CD)
   - ❑ Moderate to severe plaque psoriasis
   - ❑ Moderately to severely active ulcerative colitis (UC)
   - ❑ Active psoriatic arthritis (PsA) WITHOUT co-existent plaque psoriasis
   - ❑ Active psoriatic arthritis (PsA) WITH co-existent plaque psoriasis
   - ❑ Active ankylosing spondylitis (AS)
   - ❑ Active axial spondyloarthritis
   - ❑ Moderately to severely active polyarticular juvenile idiopathic arthritis (pJIA)
   - ❑ Moderately to severely active oligoarticular juvenile idiopathic arthritis
   - ❑ Active systemic juvenile idiopathic arthritis
   - ❑ Moderate to severe hidradenitis suppurativa
   - ❑ Behcet's disease

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

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❑ Pyoderma gangrenosum
❑ Non-infectious intermediate, posterior or panuveitis uveitis
❑ Other _____

4. What is the ICD-10 code? _____
5. What is the patient's weight? _____ kg or lbs ***(circle one)***
6. Will the requested drug be used in combination with any other biologic or targeted synthetic disease-modifying antirheumatic drug (DMARD) (e.g., Olumiant, Xeljanz)? ❑ Yes ❑ No
7. Has the patient ever received (including current utilizers) a biologic or targeted synthetic DMARD (e.g., Rinvoq, Xeljanz) associated with an increased risk of tuberculosis? *If Yes, skip to #9* ❑ Yes ❑ No
8. 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 #11* ❑ Yes ❑ No
9. 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 #14.*
10. Has the patient been tested for tuberculosis (TB) within the previous 12 months? ❑ Yes ❑ No
11. What were the results of the TB test? ❑ Positive for TB ❑ Negative for TB, *skip to #14* ❑ Unknown
12. Does the patient have latent or active tuberculosis (TB)? ❑ Latent ❑ Active ❑ Unknown
13. Has treatment for latent tuberculosis (TB) infection been initiated or completed?
    ❑ Yes - treatment initiated ❑ Yes - treatment completed ❑ No
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 manufacturer's patient assistance program? *If Yes or Unknown, or diagnosis is rheumatoid arthritis,, skip to diagnosis section.*
    ❑ Yes ❑ No ❑ Unknown
16. *If patient's diagnosis is Crohn's Disease or Ulcerative Colitis,* has the patient achieved or maintained remission? ***ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation of remission.***
    ❑ Yes ❑ No
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

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

Section A: Rheumatoid Arthritis

Continuation of Therapy

18. Has the patient achieved or maintained positive clinical response since starting treatment with the requested drug?
    ❑ Yes ❑ No
19. 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._____%***

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Initial Therapy

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

21. 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 #28.*** ❑ Yes ❑ No

22. 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 #28.*** ❑ Yes ❑ No

23. 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

24. 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

25. 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

26. 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

27. 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

28. Has the patient experienced an inadequate response after at least 3 months of treatment with methotrexate 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

29. Has the patient experienced intolerance to methotrexate? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, response to therapy and no further questions.*** ❑ Yes ❑ No

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

Section B: Polyarticular Juvenile Idiopathic Arthritis, Oligoarticular Juvenile Idiopathic Arthritis

Continuation of Therapy

31. 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

Initial Therapy

32. Has the patient ever received (including current utilizers) a biologic or 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

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33. 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

34. Does the patient have any of the following risk factors: a) positive rheumatoid factor, b) positive anti-cyclic citrullinated peptide antibodies, or c) pre-existing joint damage? ❑ Yes ❑ No

35. Does the patient meet any of the following: a) high-risk joints are involved (e.g., cervical spine, wrist, or hip), b) high disease activity, or c) high risk for disabling joint disease? ❑ Yes ❑ No

Section C: Psoriatic Arthritis

36. 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

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

Section D: Ankylosing Spondylitis or Axial Spondyloarthritis

Continuation of Therapy

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

Initial Therapy

39. Has the patient ever received (including current utilizers) a biologic 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

40. 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 E: Crohn's Disease

Continuation of Therapy

41. 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 ❑ Diarrhea ❑ Body weight
❑ Abdominal mass ❑ Hematocrit ❑ Endoscopic appearance of the mucosa
❑ Improvement on a disease activity scoring tool (e.g., Crohn's Disease Activity Index [CDAI] score
❑ No

Initial Therapy

42. Has the patient ever received (including current utilizers) a biologic indicated for Crohn's disease?
ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried and no further questions. ❑ Yes ❑ No

43. Does the patient have fistulizing Crohn's disease? ***ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation supporting diagnosis and no further questions.*** ❑ Yes ❑ No

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44. Has the patient tried and had an inadequate response to at least one conventional therapy option? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy no further questions.***
    - ❑ Yes - Sulfasalazine (Azulfidine, Sulfazine)
    - ❑ Yes - Metronidazole (Flagyl)
    - ❑ Yes - Ciprofloxacin (Cipro)
    - ❑ Yes - Prednisone
    - ❑ Yes - Budesonide (Entocort EC)
    - ❑ Yes - Methotrexate intramuscular (IM) or subcutaneous (SC)
    - ❑ Yes - Mercaptopurine (Purinethol)
    - ❑ Yes - Azathioprine (Azasan, Imuran)
    - ❑ Yes - Methylprednisolone (Solu-Medrol)
    - ❑ Yes - Rifaximin (Xifaxan)
    - ❑ Yes - Tacrolimus
    - ❑ No

45. Does the patient have a contraindication or intolerance to at least one conventional therapy option (e.g., azathioprine [Azasan, Imuran], budesonide [Entocort EC], ciprofloxacin [Cipro], mercaptopurine [Purinethol], methylprednisolone [Solu-Medrol], methotrexate IM or SC, metronidazole [Flagyl], prednisone, sulfasalazine [Azulfidine, Sulfazine], rifaximin [Xifaxan], tacrolimus)? ***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 F: Ulcerative Colitis

Continuation of Therapy

46. *If patient is 18 years old or older,* is this a continuation of a regimen with the requested drug that was started before the patient turned 18 years old? ❑ Yes ❑ No ❑ Not applicable, *skip to #48*

47. Is the patient well-controlled on the requested regimen? ❑ Yes ❑ No

48. 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.***
    - ❑ Stool frequency
    - ❑ Urgency of defecation
    - ❑ Fecal calprotectin (FC)
    - ❑ Rectal bleeding
    - ❑ C-reactive protein (CRP)
    - ❑ Endoscopic appearance of the mucosa
    - ❑ Improvement on a disease activity scoring tool (e.g., Ulcerative Colitis Endoscopic Index of Severity [UCEIS], Mayo Score)
    - ❑ None of the above

Initial Therapy

49. Has the patient ever received (including current utilizers) a biologic or targeted synthetic disease modifying drug (e.g., Xeljanz) indicated for moderately to severely active ulcerative colitis? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried and no further questions.*** ❑ Yes ❑ No

50. Has the patient ever been hospitalized for acute severe ulcerative colitis (e.g., continuous bleeding, severe toxic symptoms, including fever and anorexia)? ***ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation of hospitalization due to acute, severe ulcerative colitis and no further questions.*** ❑ Yes ❑ No

51. Has the patient tried and had an inadequate response to at least one conventional therapy option? ***ACTION REQUIRED: If Yes, please attach patient's chart notes, medical record documentation, or claims history of previous medications tried, including response to therapy and no further questions.***
    List continues on following page.
    - ❑ Yes - Azathioprine (Azasan, Imuran)
    - ❑ Yes - Corticosteroid (e.g., budesonide [Entocort, Uceris], hydrocortisone [Cortifoam, Colocort, Solu-Cortef, Cortef], methylprednisolone [Medrol, Solu-Medrol], prednisone)
    - ❑ Yes - Cyclosporine (Sandimmune)
    - ❑ Yes - Mesalamine (e.g., Asacol, Lialda, Pentasa, Canasa, Rowasa, balsalazide, olsalazine)
    - ❑ Yes - Mercaptopurine (Purinethol)
    - ❑ Yes - Sulfasalazine

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- ❑ Yes - Tacrolimus (Prograf)
- ❑ Yes - Metronidazole (Flagyl) or Ciprofloxacin (Cipro) (for pouchitis only)
- ❑ No

52. Does the patient have a contraindication or intolerance to at least one conventional therapy option (e.g., azathioprine [Azasan, Imuran], corticosteroid [e.g., budesonide, [Entocort, Uceris], hydrocortisone, methylprednisolone, prednisone, cyclosporine [Sandimmune], mesalamine [Asacol, Lialda, Pentasa, Canasa, Rowasa], balsalazide, olsalazine, mercaptopurine [Purinethol], sulfasalazine, tacrolimus [Prograf], metronidazole/ciprofloxacin [for pouchitis only])? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy or clinical reason to avoid therapy.*** ❑ Yes ❑ No

Section G: Plaque Psoriasis

Continuation of Therapy

53. 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 ❑ No

54. 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

55. 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.*** ❑ Yes ❑ No

56. What is the patient's psoriasis involvement in body surface area (BSA) percent? _____ % ***ACTION REQUIRED: Attach supporting chart note(s) or medical record documentation of psoriasis involvement for body surface area (BSA) at the time of diagnosis.***

57. Has the patient ever received (including current utilizers) Otezla or a biologic 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 medication tried and no further questions.*** ❑ Yes ❑ No

58. 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 ❑ No

59. 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: _____

H: Hidradenitis Suppurativa

Continuation of Therapy

60. Which of the following has the patient experienced an improvement in since starting treatment with the requested drug? ***ACTION REQUIRED: Please attach chart notes or medical records supporting positive clinical response.***
List continues on following page.
- ❑ Reduction in abscess and inflammatory nodule count
- ❑ Reduced formation of new sinus tracts and scarring
- ❑ Decrease in frequency of inflammatory lesions from baseline
- ❑ Reduction in pain from baseline
- ❑ Reduction in suppuration from baseline
- ❑ Improvement in frequency of relapses from baseline
- ❑ Improvement in quality of life from baseline

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❑ Improvement on a disease severity assessment tool from baseline
❑ None of the above, *please specify* _____

Initial Request

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

62. 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

63. 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

64. 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: Behcet's Disease

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

66. Has the patient had an inadequate response to at least one nonbiologic medication for Behçet'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 J: Uveitis

Continuation of Therapy

67. 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.***
List continues on following page.
❑ Reduced frequency of disease flares compared to baseline
❑ Stability or improvement in anterior chamber (AC) cell grade compared to baseline
❑ Stability or improvement in vitreous haze (VH) grade compared to baseline
❑ Stability or improvement in visual acuity compared to baseline
❑ Reduction in glucocorticoid requirements from baseline
❑ No new active inflammatory chorioretinal and/or inflammatory retinal vascular lesions relative to baseline
❑ None of the above

Initial Request

68. Has the patient ever received (including current utilizers) a biologic indicated for the treatment of non-infectious intermediate, posterior, and panuveitis? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried and no further questions.*** ❑ Yes ❑ No

69. Has the patient experienced an inadequate response with corticosteroids or immunosuppressive therapy (e.g., azathioprine, cyclosporine, 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

70. Has the patient experienced an intolerance to corticosteroids and immunosuppressive therapy (e.g., azathioprine, cyclosporine, 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

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71. Does the patient have a contraindication to corticosteroids and immunosuppressive therapy (e.g., azathioprine, cyclosporine, methotrexate)? ***ACTION REQUIRED: If Yes, please attach documentation of clinical reason to avoid therapy.*** ❑ Yes ❑ No

Section K: Pyoderma Gangrenosum

72. Has the patient ever received (including current utilizers) 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 and no further questions.*** ❑ Yes ❑ No

73. Has the patient experienced an inadequate response with 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

74. 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

75. 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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