Remicade, Inflectra, Renflexis, Avsola

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*

Exception Criteria Questions:

A. Is the product being requested for the treatment of an ADULT patient (18 years of age or older) with one of the following indications?
- Ankylosing spondylitis
- Crohn's disease
- Plaque psoriasis
- Psoriatic arthritis
- Rheumatoid arthritis
- Ulcerative colitis

❑ Yes ❑ No *If No, skip to Site of Service Questions*

B. These are the preferred products for which coverage is provided for treatment of the following indications:
- Ankylosing spondylitis, psoriatic arthritis, rheumatoid arthritis: **Remicade and Simponi Aria**
- Plaque psoriasis: **Ilumya and Remicade**
- Crohn's disease, ulcerative colitis: **Entyvio and Remicade**
- **Stelara IV** is indicated for a one time induction dose for Crohn's disease and ulcerative colitis.

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

 MR SOC Remicade, Inflectra, Renflexis SGM – 03/2021

Can the patient's treatment be switched to a preferred product?

❑ Yes, *Please obtain Form for preferred product and submit for corresponding PA. If switching to Remicade, Skip to Site of Service Questions*

❑ No

C. Does the patient have a documented intolerable adverse event to the preferred product, Remicade? **Action Required:** ***If 'Yes', attach supporting chart note(s).*** ❑ Yes ❑ No

D. Was the documented intolerable adverse event an expected adverse event attributed to the active ingredient as described in the prescribing information? ❑ Yes ❑ No

E. What is the diagnosis?

❑ Ankylosing spondylitis
❑ Crohn's disease, *skip to Question G*
❑ Plaque Psoriasis, *skip to Question H*
❑ Psoriatic arthritis
❑ Ulcerative colitis, *skip to Question G*
❑ Rheumatoid arthritis
❑ Other_____

F. Does the patient have a documented inadequate response or intolerable adverse event to Simponi Aria? **Action Required:** ***If 'Yes', attach supporting chart note(s).*** ❑ Yes ❑ No *Skip to Site of Service Questions*

G. Does the patient have a documented inadequate response or intolerable adverse event to Entyvio? **Action Required:** ***If 'Yes', attach supporting chart note(s).*** ❑ Yes ❑ No *Skip to Site of Service Questions*

H. Does the patient have a documented inadequate response or intolerable adverse event to Ilumya? **Action Required:** ***If 'Yes', attach supporting chart note(s).*** ❑ Yes ❑ No

Site of Service Questions:

A. Where will this drug be administered?

❑ Ambulatory surgical, *skip to Clinical Questions*
❑ Home infusion, *skip to Clinical Questions*
❑ Off-campus Outpatient Hospital
❑ On-campus Outpatient Hospital
❑ Physician office, *skip to Clinical Questions*
❑ Pharmacy, *skip to Clinical Questions*

B. Is the patient less than 21 years of age or 65 years of age or older?

❑ Yes *skip to Clinical Criteria Questions*

❑ No

C. Is this request to continue previously established treatment with the requested medication?

❑ Yes – This is a continuation of an existing treatment

❑ Yes – This is a continuation request, however a gap in therapy of greater than 2 doses has occurred. *Skip to Clinical Criteria Questions*

❑ No – This is a new therapy request (patient has not received requested medication in the last 6 months). *Skip to Clinical Criteria Questions*

❑ No – This is a request for a different brand infliximab product that the patient has not received previously. *Skip to Clinical Criteria Questions*

D. Has the patient experienced an adverse event with the requested product that has not responded to conventional interventions (eg acetaminophen, steroids, diphenhydramine, fluids, other pre- medications or slowing of infusion rate) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after an infusion? ***ACTION REQUIRED: If Yes, please attach supporting clinical documentation.*** ❑ Yes, *skip to Clinical Criteria Questions* ❑ No

E. Does the patient have laboratory confirmed antibodies to infliximab? ***ACTION REQUIRED: If Yes, please attach supporting clinical documentation.*** ❑ Yes, *skip to Clinical Criteria Questions* ❑ No

F. Is the patient medically unstable which may include respiratory, cardiovascular, or renal conditions that may limit the member's ability to tolerate a large volume or load or predispose the member to a severe adverse event that cannot be managed in an alternate setting without appropriate medical personnel and equipment?
ACTION REQUIRED: If Yes, please attach supporting clinical documentation.
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

G. Does the patient have severe venous access issues that require the use of a special interventions only available in the outpatient hospital setting? ***ACTION REQUIRED: If Yes, please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

H. Does the patient have significant behavioral issues and/or physical or cognitive impairment that would impact the safety of the infusion therapy AND the patient does not have access to a caregiver?
ACTION REQUIRED: If Yes, please attach supporting clinical documentation. ❑ Yes ❑ No

Criteria Questions:

1. What is the prescribed drug? ❑ Remicade ❑ Inflectra ❑ Renflexis ❑ Avsola

2. Has the patient been diagnosed with any of the following?
   - ❑ Moderately to severely active Crohn's disease (CD)
   - ❑ Moderately to severely active ulcerative colitis (UC)
   - ❑ Moderately to severely active rheumatoid arthritis (RA)
   - ❑ Active ankylosing spondylitis (AS)
   - ❑ Active axial spondyloarthritis
   - ❑ Active psoriatic arthritis (PsA)
   - ❑ Moderate to severe plaque psoriasis
   - ❑ Granulomatosis with polyangiitis (Wegener's granulomatosis)
   - ❑ Immune checkpoint inhibitor toxicity
   - ❑ Other _____
   - ❑ Juvenile idiopathic arthritis (JIA)
   - ❑ Behcet's disease
   - ❑ Severe, refractory hidradenitis suppurativa
   - ❑ Pyoderma gangrenosum
   - ❑ Sarcoidosis
   - ❑ refractoryTakayasu's arteritis
   - ❑ Uveitis
   - ❑ Reactive arthritis
   - ❑ Acute graft versus host disease

3. What is the ICD-10 code? _____

4. What is the patient's body weight? _____ kg or lbs ***(circle one)***

Section A: All Requests

5. 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

6. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic DMARD (e.g., Olumiant, Xeljanz) associated with an increased risk of tuberculosis (TB)? *If Yes, skip to #8* ❑ Yes ❑ No

7. 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 *Skip to #10*

8. 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 #13*

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

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

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

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

13. Is this request for continuation of therapy with the requested drug or a biosimilar? ❑ Yes ❑ No *If No, skip to diagnosis section and dosing section*

14. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program? *If Yes or Unknown, skip to diagnosis section and dosing section* ❑ Yes ❑ No ❑ Unknown

15. Has the patient achieved or maintained positive clinical response as evidenced by low disease activity or improvement in signs and symptoms since starting treatment with the requested drug?
❑ Yes ❑ No *Skip to dosing section*

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

Section B: Crohn's Disease

16. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) indicated for moderately to severely active Crohn's disease? *If Yes, skip to #62* ❑ Yes ❑ No

17. Does the patient have fistulizing Crohn's disease? *If Yes, skip to #62* ❑ Yes ❑ No

18. Has the patient tried and had an inadequate response to at least one conventional therapy option?
If Yes, indicate below and skip to #62
❑ Yes - Sulfasalazine (Azulfidine, Sulfazine)
❑ Yes - Mercaptopurine (Purinethol)
❑ Yes - Metronidazole (Flagyl)
❑ Yes - Ciprofloxacin (Cipro)
❑ Yes - Prednisone
❑ Yes - Tacrolimus
❑ Yes - Budesonide (Entocort EC)
❑ Yes - Azathioprine (Azasan, Imuran)
❑ Yes – Methotrexate IM or SC
❑ Yes - Methylprednisolone (Solu-Medrol)
❑ Yes - Rifaximin (Xifaxan)
❑ No

19. 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)? ❑ Yes ❑ No *Skip to #62*

Section C: Ulcerative Colitis

20. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic disease modifying drug (e.g., Xeljanz) indicated for moderately to severely active ulcerative colitis?
If Yes, skip to #64 ❑ Yes ❑ No

21. Has the patient been hospitalized for acute severe ulcerative colitis (e.g., continuous bleeding, severe toxic symptoms, including fever and anorexia)? *If Yes, skip to #64.* ❑ Yes ❑ No

22. Has the patient tried and had an inadequate response to at least one conventional therapy option?
If Yes, indicate below and skip to #64.
❑ 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., Apriso, Asacol, Lialda, Pentasa, Canasa, Rowasa), balsalazide or olsalazine
❑ Yes - Mercaptopurine (Purinethol)
❑ Yes – Sulfasalazine
❑ Yes - Tacrolimus (Prograf)
❑ Yes - Metronidazole (Flagyl) or ciprofloxacin (Cipro) (for pouchitis only)
❑ No

23. 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], balsalzide, olsalazine, mercaptopurine [Purinethol], sulfasalazine, tacrolimus [Prograf], metronidazole/ciprofloxacin [for pouchitis only])? ❑ Yes ❑ No *Skip to #64*

Section D: Rheumatoid Arthritis

24. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic disease modifying drug (e.g., Xeljanz) indicated for moderately to severely active rheumatoid arthritis?
❑ Yes ❑ No

25. Is the requested medication being prescribed in combination with methotrexate or leflunomide? ❑ Yes ❑ No
If No, indicate clinical reason for not using methotrexate or leflunomide:_____
_____

26. 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? *If Yes, skip to #78* ❑ Yes ❑ No

27. Has the patient experienced an intolerance to methotrexate? *If Yes, skip to #78* ❑ Yes ❑ No

28. Does the patient have a contraindication to methotrexate? ❑ Yes ❑ No
If Yes, indicate the contraindication and skip to #78: _____
_____

Section E: Ankylosing Spondylitis or Axial Spondyloarthritis

29. Has the patient ever received (including current utilizers) a biologic (e.g., Cimzia) indicated for active ankylosing spondylitis or active axial spondyloarthritis? *If Yes, skip to #80* ❑ Yes ❑ No

30. 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? ❑ Yes ❑ No *Skip to #80*

Section F: Plaque Psoriasis

31. Has the patient ever received (including current utilizers) Otezla or a biologic (e.g., Humira) indicated for the treatment of moderate to severe plaque psoriasis? *If Yes, skip to #64* ❑ Yes ❑ No

32. Are crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) affected? *If Yes, skip to #64* ❑ Yes ❑ No

33. What is the percentage of body surface area (BSA) affected (prior to starting the requested medication)?
_____ % *If greater than or equal to 10% of BSA, skip to #64*

34. 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?
If Yes, skip to #64 ❑ Yes ❑ No

35. Does the patient have a clinical reason to avoid pharmacologic treatment with methotrexate, cyclosporine and acitretin? ❑ Yes ❑ No
If Yes, indicate the clinical reason and skip to #64: _____
_____

Section G: Juvenile Idiopathic Arthritis

36. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic disease-modifying antirheumatic drug (DMARD) indicated for juvenile idiopathic arthritis?
If Yes, skip to #85 ❑ Yes ❑ No

37. Has the patient experienced an inadequate response to ANY of the following? P*lease indicate and skip to #85*
❑ At least 1 month trial of NSAIDs
❑ At least 2 weeks of treatment with corticosteroids (e.g. prednisone, methylprednisolone)
❑ At least 3 months of treatment with methotrexate
❑ At least 3 months of treatment with leflunomide
❑ No – No history of an inadequate response to any of the above

Section H: Behcet's Disease

38. Has the patient ever received (including current utilizers) Otezla or a biologic (e.g., Humira) indicated for the treatment of Behcet's disease? *If Yes, skip to #85* ❑ Yes ❑ No

39. Has the patient had an inadequate response to at least one nonbiologic medication for Behcet's disease (e.g., apremilast, colchicine, systemic glucocorticoids, azathioprine)? ❑ Yes ❑ No *Skip to #85*

Section I: Granulomatosis with Polyangiitis (Wegener's Granulomatosis), Pyoderma Gangrenosum, Sarcoidosis. Takayasu's Arteritis, and Uveitis

40. *If the diagnosis is Pyoderma Gangrenosum or Uveitis,* has the patient ever received (including current utilizers) a biologic (e.g., Humira) indicated for the treatment of pyoderma gangrenosum or uveitis?
If Yes, skip to #85 ❑ Yes ❑ No

41. Has the patient experienced ANY of the following with corticosteroids or immunosuppressive therapy (e.g., cyclophosphamide, azathioprine, methotrexate, mycophenolate mofetil)? ***Indicate ALL that apply and skip to #85***
❑ Corticosteroids ❑ Inadequate response ❑ Intolerance ❑ Contraindication
❑ Immunosuppressive therapy ❑ Inadequate response ❑ Intolerance ❑ Contraindication
If immunosuppressive therapy, specify therapy: _____
❑ None of the above

Section J: Hidradenitis Suppurativa

42. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) indicated for the treatment of severe, refractory hidradenitis suppurativa? *If Yes, skip to #85* ❑ Yes ❑ No

43. Has the patient experienced an inadequate response after at least 90 days of treatment with oral antibiotics?
If Yes, skip to #85 ❑ Yes ❑ No

44. Has the patient experienced an intolerable adverse effect to oral antibiotics?
If Yes, skip to #85 ❑ Yes ❑ No

45. Does the patient have a contraindication to oral antibiotics? ❑ Yes ❑ No *Skip to #85*

Section K: Reactive Arthritis

46. Has the patient ever received (including current utilizers) a biologic (e.g., Enbrel) indicated for the treatment of reactive arthritis? *If Yes, skip to #85* ❑ Yes ❑ No

47. 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? *If Yes, skip to #85* ❑ Yes ❑ No

48. Has the patient experienced intolerance to methotrexate? *If Yes, skip to #85* ❑ Yes ❑ No

49. Does the patient have a contraindication to methotrexate? ❑ Yes ❑ No
If Yes, indicate the contraindication and skip to #85: _____
_____

Section L: Immune Checkpoint Inhibitor Toxicity

50. Has the patient experienced an inadequate response to corticosteroids?
If Yes, skip to #85. ❑ Yes ❑ No
51. Has the patient experienced an intolerance to corticosteroids? *If Yes, skip to #85* ❑ Yes ❑ No

52. Does the patient have a contraindication to corticosteroids? *If Yes, skip to #85* ❑ Yes ❑ No

53. Does the patient have cardiac toxicity? ❑ Yes ❑ No *Skip to #85*

Section M: Acute Graft Versus Host Disease

54. Has the patient experienced an inadequate response to systemic corticosteroids?
If Yes, skip to #85 ❑ Yes ❑ No

55. Does the patient have an intolerance or contraindication to corticosteroids? ❑ Yes ❑ No *Skip to #85*

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

Section N: Dosing for Crohn's Disease
Continuation of Therapy:

56. Does the prescribed dose exceed 5 mg per kg? *If Yes, skip to #58* ❑ Yes ❑ No

57. Is the prescribed frequency for the maintenance dose more frequent than one dose every 8 weeks? ❑ Yes ❑ No *No further questions*

58. Is the prescribed frequency for the maintenance dose more frequent than one dose every 8 weeks? ❑ Yes ❑ No

59. Does the prescribed dose exceed 10 mg per kg? ❑ Yes ❑ No

60. Is this a request for a change in dosing regimen? ❑ Yes ❑ No *If No, no further questions*

61. Does the patient require a dose above 5 mg per kg due to loss of response at the current dose? ❑ Yes ❑ No *No further questions*

Initiation of Therapy:

62. Is the prescribed frequency for the maintenance dose more frequent than one dose every 8 weeks? ❑ Yes ❑ No

63. Does the prescribed dose exceed an induction dose of 5 mg per kg at week 0, week 2, and week 6, and a maintenance dose of 5 mg per kg thereafter? ❑ Yes ❑ No *No further questions*

Section O: Dosing for Ulcerative Colitis, Psoriatic Arthritis, and Plaque Psoriasis
Continuation and Initiation of Therapy:

64. Is the patient currently receiving Remicade or a biosimilar? ❑ Yes ❑ No *If No, skip to #67*

65. Is the prescribed frequency for the maintenance dose more frequent than one dose every 8 weeks? ❑ Yes ❑ No

66. Does the prescribed dose exceed 5 mg per kg? ❑ Yes ❑ No *No further questions*

67. Is the prescribed frequency for the maintenance dose more frequent than one dose every 8 weeks? ❑ Yes ❑ No

68. Does the prescribed dose exceed an induction dose of 5 mg per kg at week 0, week 2, and week 6, and 5 mg per kg thereafter? ❑ Yes ❑ No *No further questions*

Section P: Dosing for Rheumatoid Arthritis
Continuation of Therapy:

69. Does the prescribed dose exceed 3 mg per kg? *If Yes, skip to #74* ❑ Yes ❑ No

70. Is the prescribed frequency for the maintenance dose more frequent than one dose every 8 weeks? ❑ Yes ❑ No *If No, no further questions*

71. Is the prescribed frequency for the maintenance dose more frequent than one dose every 4 weeks? ❑ Yes ❑ No

72. Is this a request for change in dosing regimen? ❑ Yes ❑ No *If No, no futher questions*

73. Does the patient require dosing more frequent than every 8 weeks due to an incomplete response at the current dosing frequency? ❑ Yes ❑ No *No further questions*

74. Is the prescribed frequency for the maintenance dose more frequent than one dose every 8 weeks? ❑ Yes ❑ No

75. Does the prescribed dose exceed 10 mg per kg? ❑ Yes ❑ No

76. Is this a request for a change in dosing regimen? ❑ Yes ❑ No *If No, no further questions*

77. Does the patient require a dose above 3 mg per kg due to an incomplete response at the current dose? ❑ Yes ❑ No *No further questions*

Initiation of Therapy:

78. Is the prescribed frequency for the maintenance dose more frequent than one dose every 8 weeks? ❑ Yes ❑ No

79. Does the prescribed dose exceed an induction dose of 3 mg per kg at week 0, week 2, and week 6, and a maintenance dose of 3 mg per kg thereafter? ❑ Yes ❑ No

Section Q: Dosing for Ankylosing Spondylitis or Axial Spondyloarthritis
Continuation and Initiation of Therapy:

80. Is the patient currently receiving Remicade or a biosimilar? ❑ Yes ❑ No *If No, skip to #83*

81. Is the prescribed frequency for the maintenance dose more frequent than one dose every 6 weeks? ❑ Yes ❑ No

82. Does the prescribed dose exceed 5 mg per kg? ❑ Yes ❑ No *No further questions*

83. Is the prescribed frequency for the maintenance dose more frequent than one dose every 6 weeks? ❑ Yes ❑ No

84. Does the prescribed dose exceed an induction dose of 5 mg per kg at week 0, week 2, and week 6, and 5 mg per kg thereafter? ❑ Yes ❑ No *No further questions*

Section R: Dosing for Juvinile Idiopathic Arthritis, Behcet's disease, Hidradenitis Suppurativa, Granulomatosis with Polyangiitis (Wegener's Granulomatosis), Pyoderma Gangrenosum, Sarcoidosis, Takayasu's Arteritis, Uveitis, Reactive Arthritis, Immune Checkpoint Inhibitor Toxicity and Acute Graft Versus Host Disease
Continuation and Initiaion of Therapy:

85. 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

86. Is the patient currently receiving Remicade or a biosimilar? ❑ Yes ❑ No

Step Therapy Override: Complete if Applicable.	Please Circle	
Is the requested drug being used to treat stage four advanced metastatic cancer?	Yes	No
Is the requested drug's use consistent with the FDA-approved indication or the National Comprehensive Cancer Network Drugs & Biologics Compendium indication for the treatment of stage four advanced metastatic cancer and is supported by peer-reviewed medical literature?	Yes	No
Is the requested drug being used for an FDA-approved indication OR an indication supported in the compendia of current literature (examples: AHFS, Lexicomp, Clinical Pharmacology, Micromedex, current accepted guidelines)?	Yes	No
Does the prescribed quantity fall within the manufacturer's published dosing guidelines or within dosing guidelines found in the compendia of current literature (examples: package insert, AHFS, Lexicomp, Clinical Pharmacology, Micromedex, current accepted guidelines)?	Yes	No
Do patient chart notes document the requested drug was ordered with a paid claim at the pharmacy, the pharmacy filled the prescription and delivered to the patient or other documentation that the requested drug was prescribed for the patient in the last 180 days?	Yes	No
Has the prescriber provided proof documented in the patient chart notes that in their opinion the requested drug is effective for the patient's condition?	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 Specialty Programs Fax: 1-855-330-1720