Kevzara

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 patient's diagnosis?
   ❑ Moderately to severely active rheumatoid arthritis (RA)
   ❑ Other _____
2. What is the ICD-10 code? _____
3. These are the preferred products for which coverage is provided for the treatment of rheumatoid arthritis: **Enbrel, Humira, Orencia (SC)/Orencia Clickject, Rinvoq, Xeljanz/Xeljanz XR.** Can the patient's treatment be switched to a preferred product? ***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.***
   ❑ Yes - Enbrel ❑ Yes - Humira ❑ Yes - Orencia (SC)/Orencia Clickject ❑ Yes - Rinvoq
   ❑ Yes - Xeljanz/Xeljanz XR ❑ No - Continue request for Kevzara
4. Is this request for continuation of therapy with the requested product? ❑ Yes ❑ No *If No, skip to #6*
5. Is the patient currently receiving the requested product through samples or a manufacturer's patient assistance program? If unknown, answer Yes. ❑ Yes ❑ No *If No, skip to #7*
6. Does the patient have a documented inadequate response or intolerable adverse event with at least two of the preferred products indicated for rheumatoid arthritis (Enbrel, Humira, Orencia SQ/Clickject, Rinvoq, Xeljanz/Xeljanz XR)? ***ACTION REQUIRED: If Yes, attach supporting chart note(s).*** ❑ Yes ❑ No
   If No, complete this form in its entirety and State Step Therapy section.
7. Will the requested drug be used in combination with any other biologic or targeted synthetic disease-modifying antirheumatic drugs (DMARD) (e.g., Rinvoq, Xeljanz)? ❑ Yes ❑ No
8. Has the patient ever received (including current utilizers) a biologic or targeted synthetic DMARD (e.g., Rinvoq, Xeljanz)? *If Yes, skip to #10* ❑ Yes ❑ No
9. Has the patient had a TB test (e.g., a tuberculosis skin test [PPD], an interferon-release assay [IGRA], or a chest x-ray) within 6 months of initiating therapy? *If Yes, skip to #12* ❑ Yes ❑ No

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

 Kevzara State Step, VF, ACSF SGM - 12/2020.

10. Does the patient have risk factors for 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, or persons who work or reside with people who are at an increased risk for active TB)?
    ❑ Yes ❑ No *If No, skip to #15*

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

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

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

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

15. Is this request for continuation of therapy? ❑ Yes ❑ No *If No, skip to #18*

16. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program? *If Yes or Unknown, skip to #18* ❑ Yes ❑ No ❑ Unknown

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

18. Has the patient received a biologic or targeted synthetic DMARD (e.g., Rinvoq, Xeljanz) that is indicated for moderately to severely active rheumatoid arthritis? *If Yes, no further questions* ❑ Yes ❑ No

19. Has the patient experienced an inadequate response after at least 3 months of treatment with the methotrexate dose greater than or equal to 20 mg per week? *If Yes, no further questions* ❑ Yes ❑ No

20. Has the patient experienced intolerance to methotrexate? *If Yes, no further questions* ❑ Yes ❑ No

21. Does the patient have a contraindication to methotrexate? ❑ Yes ❑ No
    If Yes, indicate the contraindication: _____

State Step Therapy

1. 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

2. 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

3. Does the patient reside in Maryland? ❑ Yes ❑ No *If No, skip to #7*

4. Is the alternate drug (Enbrel, Humira, Orencia SQ/Clickject, Rinvoq, Xeljanz/Xeljanz XR) FDA-approved for the medical condition being treated? ❑ Yes ❑ No *If No, please specify:* _____

5. Has the prescriber provided proof, documented in the patient's chart notes, indicating that the requested drug was ordered for the patient in the past 180 days? ❑ Yes ❑ No *If No, skip to #7*

6. 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 *No further questions*

7. Are any of the following conditions met for the alternate drug (Enbrel, Humira, Orencia SQ/Clickject, Rinvoq, Xeljanz/Xeljanz XR)?
   ❑ The alternate drug is contraindicated
   ❑ The alternate drug is likely to cause an adverse reaction, physical or mental harm
   ❑ The alternate drug is expected to be ineffective
   ❑ The alternate drug was previously tried or a drug in the same class or with the same action was previously tried and was stopped due to ineffectiveness or an adverse event
   ❑ The alternate drug is not in the patient's best interest
   ❑ The alternate drug was tried while covered by the current or the previous health benefit plan
   ❑ None of the above
   If Yes, please specify: _____

8. Is the patient stable or currently receiving a positive therapeutic outcome with the requested drug and a change in the prescription drug is expected to be ineffective or cause harm to the patient? ❑ 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