CVS caremark™ {{PANUMCODE}}

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.

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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?
   - ❑ Kevzara 150mg pens/syringes Quantity and Frequency: _____
   - ❑ Kevzara 200mg pens/syringes Quantity and Frequency: _____
   - ❑ Other: _____
2. What is the patient's diagnosis?
   - ❑ Moderately to severely active rheumatoid arthritis (RA)
   - ❑ Polymyalgia rheumatica
   - ❑ Other _____
3. What is the ICD-10 code? _____
4. Will the requested drug be used in combination with any other biologic (e.g., Humira) or targeted synthetic drug (e.g., Olumiant, Otezla, Xeljanz)? ❑ Yes ❑ No
5. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic drug (e.g., Olumiant, Xeljanz) associated with an increased risk of tuberculosis? *If Yes, skip to #9* ❑ Yes ❑ No
6. 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
7. What were the results of the tuberculosis (TB) test?
   ❑ Positive for TB ❑ Negative for TB, *skip to #9* ❑ Unknown
8. 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
9. Is the requested drug being prescribed by or in consultation with a rheumatologist? ❑ Yes ❑ No
10. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program? ❑ Yes ❑ No ❑ Unknown

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

Member Name: {{MEMFIRST}} {{MEMLAST}} **DOB:** {{MEMBERDOB}} **PA Number:** {{PANUMBER}}

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

Section A: Rheumatoid Arthritis

11. Is this request for continuation of therapy with the requested drug? ❑ Yes ❑ No *If No, skip to #14*

12. Has the patient achieved or maintained positive clinical response since starting treatment with the requested drug? ❑ Yes ❑ No

13. Has the patient experienced substantial disease activity improvement (e.g., at least 20% from baseline) in tender joint count, swollen joint count, pain, or disability? ***ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation supporting positive clinical response and substantial disease activity improvement.*** ❑ Yes ❑ No *No further questions.*

14. Has the patient ever received or is currently receiving a biologic (e.g., Humira) or targeted synthetic drug (e.g., Rinvoq, Xeljanz) that is indicated for moderately to severely active rheumatoid arthritis (excluding receiving the drug via samples or a manufacturer's patient assistance program)? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried and no further questions.*** ❑ Yes ❑ No

15. Does the patient meet either of the following: a) the patient was tested for the rheumatoid factor (RF) biomarker and the RF biomarker test was positive, or b) the patient was tested for the anti-cyclic citrullinated peptide (anti-CCP) biomarker and 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 #17.*** ❑ Yes ❑ No

16. 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

17. 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

18. 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

19. 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 B: Polymyalgia Rheumatica

20. Is this request for continuation of therapy with the requested drug? ❑ Yes ❑ No *If No, skip to #23*

21. Has the patient achieved or maintained a 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 No, no further questions*

22. 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.***
❑ Morning stiffness
❑ Hip or shoulder pain
❑ Hip or shoulder range of motion
❑ C-reactive protein (CRP) and/or erythrocyte sedimentation rate (ESR)
❑ None of the above

23. 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

24. Has the patient experienced a disease flare during taper with 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

25. Has the patient experienced an inadequate response 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 an intolerance or contraindication to systemic corticosteroids? ***ACTION REQUIRED: If Yes, please attach documentation of clinical reason to avoid therapy.*** ❑ Yes ❑ No
    If Yes, indicate the contraindication:_____

27. 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:_____

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