CVS caremark™ {{PANUMCODE}}

Olumiant

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 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?
   - ❑ Olumiant 1 mg Quantity and Frequency: _____
   - ❑ Olumiant 2 mg Quantity and Frequency: _____
   - ❑ Other: _____

2. What is the diagnosis?
   - ❑ Rheumatoid arthritis
   - ❑ Other _____

3. What is the ICD-10 code? _____

4. These are the preferred products for which coverage is provided for the treatment of rheumatoid arthritis: **Enbrel, Humira, Kevzara, Orencia (SC)/Orencia Clickject, Remicade, Rinvoq, Simponi Aria, Xeljanz/Xeljanz XR, Cimzia syringe (secondary)*.** Can the patient's treatment be switched to a preferred product?
   Note: Secondary preferred product for RA is Cimzia syringe. The secondary preferred product option only applies to members who have had a documented inadequate response or intolerable adverse event with two primary preferred products.
   ❑ 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 ❑ Not applicable - Requested for condition not listed above, *skip to #9*

5. Is this request for continuation of therapy with the requested product? ❑ Yes ❑ No *If No, skip to #7*

6. 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 #9*

7. Does the patient have a documented inadequate response or intolerable adverse event to any of the following preferred products indicated for rheumatoid arthritis? ***ACTION REQUIRED: If Yes, attach supporting chart note(s).*** *Indicate ALL that apply. List continues on following page.*
   - ❑ Cimzia syringe: ❑ Inadequate response ❑ Intolerable adverse event
   - ❑ Enbrel: ❑ Inadequate response ❑ Intolerable adverse event

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❑ Humira:	❑ Inadequate response	❑ Intolerable adverse event
❑ Kevzara:	❑ Inadequate response	❑ Intolerable adverse event
❑ Orencia (SC)/Orencia Clickject):	❑ Inadequate response	❑ Intolerable adverse event
❑ Remicade:	❑ Inadequate response	❑ Intolerable adverse event
❑ Rinvoq:	❑ Inadequate response	❑ Intolerable adverse event
❑ Simponi Aria:	❑ Inadequate response	❑ Intolerable adverse event
❑ Xeljanz/Xeljanz XR:	❑ Inadequate response	❑ Intolerable adverse event

❑ No - none of the above

8. Does the patient have one of the following documented clinical reasons to avoid the preferred products that are TNF inhibitors (Enbrel, Humira, Cimzia syringe)? ***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 - Risk of lymphoma
   - ❑ Yes - Autoantibody formation/lupus-like syndrome (attributed to TNF inhibitor)
   - ❑ No - none of the above
   - ❑ Not applicable – requested medication is a TNF inhibitor
9. Will the requested drug be used in combination with any other biologic (e.g., Humira) or targeted synthetic disease-modifying antirheumatic drug (DMARD) (e.g., Olumiant, Otezla, Xeljanz) or potent immunosuppressant such as azathioprine or cyclosporine? ❑ Yes ❑ No
10. 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? *If Yes, skip to #12* ❑ Yes ❑ No
11. 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 #14* ❑ Yes ❑ No
12. 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 #17*
13. Has the patient been tested for tuberculosis (TB) within the previous 12 months? ❑ Yes ❑ No
14. What were the results of the tuberculosis (TB) test?
    ❑ Positive for TB ❑ Negative for TB, *skip to #17* ❑ Unknown
15. Does the patient have latent or active tuberculosis (TB)? ❑ Latent ❑ Active ❑ Unknown
16. Has treatment for latent tuberculosis (TB) infection been initiated or completed?
    ❑ Yes – treatment initiated ❑ Yes – treatment completed ❑ No
17. Is this request for continuation of therapy with the requested drug? ❑ Yes ❑ No *If No, skip to #21*
18. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program? *If Yes or Unknown, skip to #21* ❑ Yes ❑ No ❑ Unknown
19. 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.*** _____***%*** *No further questions*

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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?
ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried. *If Yes, no further questions.* ❑ Yes ❑ No

22. 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.*** *If Yes, skip to #26* ❑ Yes ❑ No

23. 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.***
If Yes, skip to #26 ❑ Yes ❑ No

24. Has the patient been tested for the rheumatoid factor (RF) biomarker OR 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
If Yes, indicate if the patient tested positive, negative or if the test was not completed for the C-reactive protein (CRP) biomarker or erythrocyte sedimentation rate (ESR). _____

26. Has the patient had an inadequate response to at least one tumor necrosis factor (TNF) inhibitor?
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)**

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