CVS caremark™ {{PANUMCODE}}

Orencia

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: {{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 quantity and frequency?
   a) Loading dose:
   - ❑ Orencia IV 250 mg Quantity and frequency: _____
   - ❑ Orencia SQ 125 mg Quantity and frequency: _____
   - ❑ Orencia SQ 87.5 mg Quantity and frequency: _____
   - ❑ Orencia SQ 50 mg Quantity and frequency: _____
   - ❑ Other _____

   b) Maintenance dose:
   - ❑ Orencia IV 250 mg Quantity and frequency: _____
   - ❑ Orencia SQ 125 mg Quantity and frequency: _____
   - ❑ Orencia SQ 87.5 mg Quantity and frequency: _____
   - ❑ Orencia SQ 50 mg Quantity and frequency: _____
   - ❑ Other _____

2. Has the patient been diagnosed with any of the following?
   - ❑ Moderately to severely active rheumatoid arthritis (RA)
   - ❑ Moderately to severely active **polyarticular** juvenile idiopathic arthritis (pJIA)
   - ❑ Moderately to severely active **oligoarticular** juvenile idiopathic arthritis
   - ❑ Active psoriatic arthritis (PsA)
   - ❑ Chronic graft versus host disease
   - ❑ Immune checkpoint inhibitor-related toxicity
   - ❑ Prophylaxis of acute graft versus host disease
   - ❑ Systemic juvenile idiopathic arthritis (sJIA)
   - ❑ Other _____

3. What is the ICD-10 code? _____

4. What is the patient's weight? _____ kg

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

Section A: Preferred Product

5. These are the preferred products for which coverage is provided for the treatment of the following indications:
   a) Rheumatoid arthritis: **Enbrel, Humira, Kevzara, Orencia (SC)/Orencia Clickject, Remicade, Rinvoq, Simponi Aria, Xeljanz/Xeljanz XR, Cimzia syringe (secondary)***, *skip to Section B: All Requests if Orencia (SC)/Orencia Clickject is being prescribed.*
   b) Psoriatic arthritis: **Cosentyx, Enbrel, Humira, Otezla, Remicade, Rinvoq, Simponi Aria, Skyrizi (SC), Stelara (SC), Tremfya, Cimzia syringe (secondary)***
   Can the patient's treatment be switched to a preferred product?
   Note: 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 Section B: All Requests*

6. Is this request for continuation of therapy with the requested product? ❑ Yes ❑ No *If No, skip to #8*

7. 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 Section B: All Requests*

8. Does the patient have a documented inadequate response or intolerable adverse event with any of the following preferred products? ***ACTION REQUIRED: If Yes, attach supporting chart note(s).*** *Indicate ALL that apply.*

❑ Cimzia syringe:	❑ Inadequate response	❑ Intolerable adverse event
❑ Cosentyx:	❑ Inadequate response	❑ Intolerable adverse event
❑ Enbrel:	❑ Inadequate response	❑ Intolerable adverse event
❑ Humira:	❑ Inadequate response	❑ Intolerable adverse event
❑ Otezla:	❑ Inadequate response	❑ Intolerable adverse event
❑ Rinvoq:	❑ Inadequate response	❑ Intolerable adverse event
❑ Skyrizi SC:	❑ Inadequate response	❑ Intolerable adverse event
❑ Stelara SC:	❑ Inadequate response	❑ Intolerable adverse event
❑ Tremfya:	❑ Inadequate response	❑ Intolerable adverse event
❑ Remicade:	❑ Inadequate response	❑ Intolerable adverse event
❑ Simponi Aria:	❑ Inadequate response	❑ Intolerable adverse event

   ❑ No - none of the above

9. Does the patient have any of the following?
   ❑ Documented clinical reason(s) to avoid TNF inhibitors
   ❑ Documented clinical reason(s) to avoid JAK inhibitors
   ❑ Documented clinical reason(s) to avoid TNF inhibitors and JAK inhibitors
   ❑ None of the above

10. Does the patient have one of the following documented clinical reasons to avoid the preferred products that are TNF inhibitors (Cimzia syringe, Enbrel, Humira, Remicade and Simponi Aria)? ***ACTION REQUIRED: If Yes, attach supporting chart note(s).***
    ❑ Yes - History of demyelinating disorder, *specify product(s):* _____
    ❑ Yes - History of hepatitis B virus infection, *specify product(s):* _____
    ❑ Yes - History of congestive heart failure, *specify product(s):* _____
    ❑ Yes - Autoantibody formation/lupus-like syndrome (attributed to TNF inhibitor), *specify product(s):* _____
    ❑ Yes - History or risk of lymphoma or other malignancy, *specify product(s):* _____
    ❑ Yes - History of being a primary non-responder to a TNF inhibitor (i.e., no clinical response with initial treatment), *specify product(s):* _____
    ❑ No - none of the above

11. Does the patient have one of the following documented clinical reasons to avoid the preferred product that is a JAK inhibitor (Rinvoq)? ***ACTION REQUIRED: If Yes, attach supporting chart note(s).***
    ❑ Yes - History or risk of lymphoma, lung cancer, non-melanoma skin cancer, or other malignancy
    ❑ Yes - History or risk of major adverse cardiovascular events (MI, stroke, etc.)
    ❑ Yes - History or risk of thrombotic events (PE, DVT, arterial thrombosis, etc.)
    ❑ Yes - History of hepatitis B or hepatitis C virus infection
    ❑ Yes - History of being a primary non-responder to a JAK inhibitor (i.e., no clinical response with initial treatment)
    ❑ No - none of the above

Section B: All Requests

12. 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

13. 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 #17* ❑ Yes ❑ No

14. 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

15. What were the results of the tuberculosis (TB) test?
    ❑ Positive for TB ❑ Negative for TB, *skip to #17* ❑ Unknown

16. 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

17. Is the requested drug being prescribed by or in consultation with a:
    ❑ Dermatologist ❑ Hematologist ❑ Oncologist ❑ Rheumatologist ❑ None of the above

18. Is the patient currently receiving Orencia? ❑ Yes ❑ No
    If diagnosis is chronic graft versus host disease, immune checkpoint inhibitor-related toxicity, or prophylaxis of acute graft versus host disease, skip to diagnosis section.

19. Is this request for continuation of therapy with the requested drug?
    ❑ Yes ❑ No *If No, skip to diagnosis section.*

20. 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.* ❑ Yes ❑ No ❑ Unknown

21. 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

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

Section C: Rheumatoid Arthritis

Continuation

22. 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

Initiation

23. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic drug (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

24. 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 #26.***
❑ Yes ❑ No

25. 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 *If No, no further questions.*

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 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

27. 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

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

Section D: Polyarticular Juvenile Idiopathic Arthritis and Oligoarticular Juvenile Idiopathic Arthritis
Continuation

29. 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

Initiation

30. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic drug (e.g., Xeljanz) that is 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

31. Has the patient had an inadequate response to methotrexate or another conventional synthetic drug (e.g., leflunomide, sulfasalazine, hydroxychloroquine) 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

32. Has the patient had an inadequate response to a trial of scheduled non-steroidal anti-inflammatory drugs (NSAIDs) and/or intra-articular glucocorticoids (e.g., triamcinolone hexacetonide)? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy.*** ❑ Yes ❑ No *If No, skip to #34*

33. Does the patient have one of the following risk factors for poor outcome: a) involvement of ankle, wrist, hip, sacroiliac joint, and/or temporomandibular joint (TMJ), b) presence of erosive disease or enthesitis, c) delay in diagnosis, d) elevated levels of inflammation markers, or e) symmetric disease?
If Yes, no further questions. ❑ Yes ❑ No

34. Does the patient have any of the following risk factors for disease severity and potentially a more refractory disease course: 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 E: Psoriatic Arthritis

Continuation

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 ❑ Enthesitis
❑ Skin and/or nail involvement ❑ Dactylitis ❑ Axial disease
❑ None of the above

Initiation

37. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic drug (e.g., Rinvoq, Otezla) that is indicated for active psoriatic 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

38. Does the patient have mild to moderate disease? ❑ Yes ❑ No *If No, skip to #44*

39. Does the patient have enthesitis or predominantly axial disease? *If Yes, no further questions.* ❑ Yes ❑ No

40. Has the patient had an inadequate response to methotrexate, leflunomide, or another conventional synthetic drug (e.g., sulfasalazine) 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

41. Has the patient had an intolerance to methotrexate, leflunomide, or another conventional synthetic drug (e.g., sulfasalazine)? ***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

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

43. Does the patient have a contraindication to another conventional synthetic drug (e.g., sulfasalazine)?
ACTION REQUIRED: If Yes, please attach documentation of clinical reason to avoid therapy.
❑ Yes ❑ No *No further questions.*
If Yes, indicate clinical reason: _____

44. Does the patient have severe disease? ❑ Yes ❑ No

Section F: Chronic Graft Versus Host Disease

45. 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

46. 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

47. Does the patient have an intolerance or contraindication to corticosteroids? ***ACTION REQUIRED: Please attach chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy. If therapy is not advisable, please attach documentation of clinical reason to avoid therapy.*** ❑ Yes ❑ No

Section G: Immune Checkpoint Inhibitor-Related Toxicity

48. 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

49. Does the patient have cardiac toxicity? ❑ Yes ❑ No

Section H: Prophylaxis of Acute Graft Versus Host Disease

50. Is the patient undergoing hematopoietic stem cell transplantation (HSCT) from a matched or 1 allele- mismatched unrelated-donor? ❑ Yes ❑ No

51. Will the requested medication be used in combination with a calcineurin inhibitor (e.g., cyclosporine, tacrolimus) and methotrexate? ❑ 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