Otezla

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 prescribed dose and frequency?
   a) Loading dose:
   ❑ Otezla 30 mg Quantity and Frequency: _____
   ❑ Otezla starter pack
   ❑ Other: _____
   b) Maintenance dose:
   ❑ Otezla 30 mg Quantity and Frequency: _____
   ❑ Other: _____
2. *Initial therapy*: Does the prescribed dose exceed 10 mg in the morning on day 1, 10 mg in the morning and evening on day 2, 10 mg in the morning and 20 mg in the evening on day 3, 20 mg in the morning and evening on day 4, 20 mg in the morning and 30 mg in the evening on day 5, and 30 mg in the morning and evening thereafter? ❑ Yes ❑ No
3. Has the patient been diagnosed with any of the following?
   ❑ Moderate to severe plaque psoriasis
   ❑ Active psoriatic arthritis (PsA) WITH co-existent plaque psoriasis
   ❑ Active psoriatic arthritis (PsA) WITHOUT co-existent plaque psoriasis
   ❑ Behcet's disease
   ❑ Other _____
4. What is the ICD-10 code? _____
5. Will the requested drug be used in combination with any other biologic (e.g., Humira) or targeted synthetic drug (e.g., Olumiant, Xeljanz)? ❑ Yes ❑ No
6. Is the requested drug being prescribed by or in consultation with a rheumatologist or dermatologist?
   ❑ Yes ❑ No
7. Is this request for continuation of therapy with the requested drug?
   ❑ Yes ❑ No *If No, skip to diagnosis section.*

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8. 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

9. Has the patient achieved or maintained 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

10. Has the patient experienced an improvement from baseline? ***ACTION REQUIRED: Please attach chart notes or medical record documentation supporting positive clinical response.*** ❑ Yes ❑ No
If Yes, indicate improvement: _____

Complete the following section based on the patient's <u>PRIMARY</u> diagnosis, if applicable.

<u>Section A: Plaque Psoriasis</u>

Initial Request

11. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic drug (e.g., Sotyktu) indicated for the treatment of plaque psoriasis? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried and no further questions.*** ❑ Yes ❑ No

12. Has the patient experienced an inadequate response to, or has an intolerance to phototherapy (e.g., UVB, PUVA) or topical therapies (e.g., medium or higher potency topical corticosteroids, calcineurin inhibitors, vitamin D analogs)? ***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

13. Does the patient have a contraindication or clinical reason to avoid phototherapy (e.g., UVB, PUVA)? ***ACTION REQUIRED: If Yes, please attach documentation of contraindication or clinical reason to avoid phototherapy.*** ❑ Yes ❑ No *If No, skip to #15*

14. Does the patient have a contraindication or clinical reason to avoid topical therapies (e.g., medium or higher potency topical corticosteroids, calcineurin inhibitors, vitamin D analogs)? ***ACTION REQUIRED: If Yes, please attach documentation of contraindication or clinical reason to avoid topical therapies and no further questions.*** ❑ Yes ❑ No

15. Has the patient experienced an inadequate response to or has an intolerance to pharmacologic treatment with ONE of the following medications: methotrexate, cyclosporine, or acitretin? ***ACTION REQUIRED: If Yes, please attach chart notes, medication record documentation, or claims history supporting previous medications tried, including response to therapy and no further questions.*** ❑ Yes ❑ No

16. Does the patient have a clinical reason to avoid pharmacologic treatment with ALL of the following medications: methotrexate, cyclosporine and acitretin? ***ACTION REQUIRED: If Yes, please attach documentation of clinical reason to avoid therapy.***
❑ Yes ❑ No ***If Yes, indicate clinical reason:*** _____

Continuation of Therapy

17. Has the patient experienced a reduction in body surface area (BSA) affected from baseline? ***ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation of decreased body surface area affected and no further questions.*** ❑ Yes ❑ No

18. Has the patient experienced an improvement in signs and symptoms of the condition from baseline (e.g., itching, redness, flaking, scaling, burning, cracking, pain)? ***ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation of improvement in signs and symptoms.*** ❑ Yes ❑ No

<u>Section B: Psoriatic Arthritis</u>

Initiation

19. 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 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

20. Does the patient have enthesitis? *If Yes, no further questions.* ❑ Yes ❑ No

21. 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

22. 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

23. 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 contraindication:*** _____

24. 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

Continuation

25. Has the patient experienced an improvement in any of the following from baseline? ***ACTION REQUIRED: Please attach chart notes or medical record documentation supporting positive clinical response.***
    - ❑ Number of swollen joints
    - ❑ Number of tender joints
    - ❑ Dactylitis
    - ❑ Enthesitis
    - ❑ Skin and/or nail involvement
    - ❑ Axial Disease
    - ❑ None of the above

Section C: Behcet's Disease

26. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) indicated for the treatment of Behcet's disease? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried and no further questions.*** ❑ Yes ❑ No

27. Is this request for the treatment of oral ulcers associated with Behcet's disease? ❑ Yes ❑ No

28. Has the patient had an inadequate response to at least one nonbiologic medication for Behcet's disease (e.g., colchicine, systemic glucocorticoids, azathioprine)? ***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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