Otrexup, Rasuvo

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 drug is being prescribed? ❑ Otrexup ❑ Rasuvo ❑ Other _____

2. What is the diagnosis?
   ❑ Rheumatoid arthritis (RA) ❑ Psoriasis
   ❑ Polyarticular juvenile idiopathic arthritis (pJIA) ❑ Other _____

3. What is the ICD-10 code? _____

4. Is the product being requested for the treatment of one of the following indications?
   ❑ Rheumatoid arthritis including Polyarticular Juvenile Idiopathic Arthritis, *skip to #8*
   ❑ Psoriasis, *skip to #8*
   ❑ None of the above

5. The preferred injectable methotrexate product for your patient's plan is Rasuvo. Can the patient's treatment be switched to Rasuvo? ***If Yes, fax a new prescription to the pharmacy and skip to #8.***
   ❑ Yes ❑ No ❑ Not applicable, Rasuvo is being prescribed, *skip to #8*

6. Has the patient had a documented intolerable adverse event with the preferred product (Rasuvo)?
   ACTION REQUIRED: If Yes, attach chart notes describing the intolerable adverse event(s) experienced from treatment with Rasuvo. ❑ Yes ❑ No

7. Was the documented intolerable adverse event an expected adverse event attributed to the active ingredient as described in the prescribing information? ***ACTION REQUIRED: If No, attach supporting chart note(s).***
   ❑ Yes ❑ No

8. Has the patient experienced an inadequate response OR intolerance to generic oral methotrexate?
   ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting inadequate response and/or intolerance to generic oral methotrexate.
   ❑ Yes - Inadequate response ❑ Yes - Intolerance ❑ No

9. Is the patient unable to prepare and administer generic injectable methotrexate? ***ACTION REQUIRED: If Yes, please attach supporting chart notes or medical record documentation of member's inability to prepare and administer generic injectable methotrexate.*** ❑ Yes ❑ No

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

10. Is the patient currently receiving requested drug? ❑ Yes ❑ No *If No, no further questions.*

11. How long has the patient received treatment with requested drug? _____ months
If less than 3 months, no further questions.

12. 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 requested drug? ❑ 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