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

CVS caremark™ {{PANUMCODE}}

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: {{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 diagnosis?
   - ❑ Rheumatoid arthritis (RA)
   - ❑ Polyarticular juvenile idiopathic arthritis (pJIA)
   - ❑ Psoriasis
   - ❑ Other _____
2. What is the ICD-10 code? _____
3. Has the patient experienced inadequate response to generic oral methotrexate? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting inadequate response to generic oral methotrexate and skip to #5.*** ❑ Yes ❑ No
4. Has the patient experienced an intolerance to generic oral methotrexate? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting inadequate response to generic oral methotrexate.*** ❑ Yes ❑ No *If No, complete this form in its entirety and State Step Therapy section.*
5. 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 *If No, complete this form in its entirety and State Step Therapy section.*
6. Is the patient currently receiving Rasuvo? ❑ Yes ❑ No *If No, no further questions.*
7. How long has the patient received treatment with Rasuvo? _____ months
   If less than 3 months, no further questions.
8. 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 Rasuvo? ❑ Yes ❑ No

State Step Therapy

1. Is the requested drug being used for an FDA-approved indication or an indication supported in the compendia of current literature (examples: AHFS, Micromedex, current accepted guidelines)? ❑ Yes ❑ No

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

2. Does the prescribed dose and quantity fall within the FDA-approved labeling or within dosing guidelines found in the compendia of current literature? ❑ Yes ❑ No

3. Does the patient reside in Maryland? ❑ Yes ❑ No *If No, skip to #7*

4. Is the alternate drug (generic oral methotrexate, generic injectable methotrexate) FDA-approved for the medical condition being treated?
   ❑ Yes ❑ No *If No, please specify:* _____

5. Has the prescriber provided proof, documented in the patient's chart notes, indicating that the requested drug was ordered for the patient in the past 180 days? ❑ Yes ❑ No *If No, skip to #7*

6. Has the prescriber provided proof, documented in the patient chart notes, that in their opinion the requested drug is effective for the patient's condition? ❑ Yes ❑ No *No further questions*.

7. Are any of the following conditions met for the alternate drug (generic oral methotrexate, generic injectable methotrexate)?
   ❑ The alternate drug is contraindicated
   ❑ The alternate drug is likely to cause an adverse reaction or physical or mental harm or decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities
   ❑ The alternate drug is expected to be ineffective
   ❑ The alternate drug or a drug in the same class or with the same action was previously tried and was stopped due to ineffectiveness or an adverse event
   ❑ Use of the alternate drug is not in the patient's best interest
   ❑ The alternate drug was tried while covered by the current or the previous health benefit plan
   ❑ None of the above
   If Yes, please specify: _____

8. Is the patient stable or currently receiving a positive therapeutic outcome with the requested drug and a change in the prescription drug is expected to be ineffective or cause harm to the patient?
   If Yes, then no further questions. ❑ Yes ❑ No

9. Is the requested prescription drug necessary to save the life of the patient? ❑ 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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