2211 Sanders Road, Northbrook, IL 60062 Phone (866) 814-5506

Fax Transmittal

Fax: {Auth.OfficeContactFaxNumber}
To: {Auth.ProviderBilling.Name.Legal}

From: CVS

Fax: (855) 330-1720

Re: Prior Authorization for {Auth.Member.MemberNameFirst} {Auth.Member.MemberNameLast}

Electronically (4-5 **minutes** process time)	Phone (10-15 **minutes** process time)	Fax (24-72 **hours** process time)
CVS/Caremark now accepts PA requests on-line 24/7. No fax machines, no phone hold times, faster approval. Most requests will not require a fax or phone call. To request a Prior Authorization online, navigate to https://provider.carefirst.com/providers/home.page and click on the orange tab in the upper right hand corner; or for more details about how to submit and review your prior authorization requests online, view the training video available at www.carefirst.com/learninglibrary > Pharmacy.	Calling us with your PA request during our business hours is another option The process over the phone can take between 10 and 15 minutes. OR online	You may also continue to fax us your PA request Faxes received are processed within 24 to 72 hours. OR online

The information contained in this message may be privileged and confidential and protected from disclosure. If the reader of this message is not the intended recipient, or an employee or agent responsible for delivering this message to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If you have received this communication in error, please notify us immediately by replying to the message and deleting it from your computer. Thank you, CVS/Caremark.

Spevigo

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 1-855-330-1720**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-888-877-0518.** 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: {Auth.Member.MemberNameFirst} {Auth.Member.MemberNameLast}
Date: {System.DateTime.Today}
Patient's ID: {Auth.Member.MemberID}
Patient's Date of Birth: {Auth.Member.MemberBirthDate}
Physician's Name: {Auth.ProviderBilling.Name.Legal}
Specialty: ______________________________________
NPI#: {Auth.ProviderBilling.NPI}

Referring Provider Info: ❑ **Same as Requesting Provider**
Name: ____ **NPI#:** _______________________________
Fax: _________________________ **Phone:** ______________________

Rendering Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: ____ **NPI#:** _______________________________
Fax: _________________________ **Phone:** ______________________

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: __________________________*kg*

Patient Height: __________________________*cm*

Please indicate the place of service for the requested drug:
❑ *Ambulatory Surgical* ❑ *Home* ❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital* ❑ *Office* ❑ *Pharmacy*

Clinical Criteria Questions:

1. 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

2. 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 #6* ❑ Yes ❑ No

3. 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

4. What were the results of the tuberculosis (TB) test?
   ❑ Positive for TB

❑ Negative for TB, skip to #6
❑ Unknown

5. 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
6. What is the diagnosis?
   ❑ Generalized pustular psoriasis (GPP) flare
   ❑ Other: ____
7. Is the requested drug being prescribed by or in consultation with a dermatologist? ❑ Yes ❑ No
8. Does the patient have a known documented history of generalized pustular psoriasis (either relapsing [greater than 1 episode] or persistent [greater than 3 months])? ***ACTION REQUIRED: Please attach chart note(s) or medical record documentation of history of generalized pustular psoriasis.*** ❑ Yes ❑ No
9. Is the patient presenting with primary, sterile, macroscopically visible pustules on non-acral skin (excluding cases where pustulation is restricted to psoriatic plaques)? ***ACTION REQUIRED: Please attach chart note(s) or medical record documentation of presentation of pustules.*** ❑ Yes ❑ No
10. Is the generalized pustular psoriasis (GPP) flare of moderate-to-severe intensity (e.g., at least 5% body surface area is covered with erythema and the presence of pustules; Generalized Pustular Psoriasis Physician Global Assessment [GPPPGA] total score greater or equal to 3)? ***ACTION REQUIRED: Please attach chart note(s) or medical record documentation supporting GPP flare of moderate-to-severe intensity.***
    If Yes, no further questions. ❑ Yes ❑ No
11. Does the patient have systemic symptoms or laboratory abnormalities commonly associated with generalized pustular psoriasis (GPP) flares (e.g., fever, asthenia, myalgia, elevated C-reactive protein [CRP], leukocytosis, neutrophilia [above ULN])? ***ACTION REQUIRED: Please attach chart note(s) or medical record documentation supporting systemic symptoms or laboratory abnormalities.***
    If Yes, no further questions. ❑ Yes ❑ No
12. Did the patient have a skin biopsy to confirm the presence of Kogoj's spongiform pustules?
    ACTION REQUIRED: Please attach chart note(s) or medical record documentation of skin biopsy.
    If Yes, no further questions. ❑ Yes ❑ No
13. Does the patient have a documented IL36RN, CARD14, or AP1S3 gene mutation? ***ACTION REQUIRED: Please attach chart note(s), medical record documentation or genetic test result(s) supporting gene mutation.***
    ❑ 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 Specialty Programs Fax: 1-855-330-1720

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Spevigo SGM 5580-A – 07/2023.