Stelara

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's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

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*

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

Criteria Questions:

1. What is the prescribed dose and frequency?
   - ❑ Stelara SQ 45mg Frequency: _____
   - ❑ Stelara SQ 90mg Frequency: _____
   - ❑ Stelara IV x 1 dose of ❑ 260mg, ❑ 390mg or ❑ 520mg then Stelara SQ 90mg Frequency: _____
   - ❑ Other _____

2. What is the diagnosis?
   - ❑ Plaque psoriasis (PsO)
   - ❑ Psoriatic arthritis with co-existent plaque psoriasis
   - ❑ Active psoriatic arthritis WITHOUT co-existent plaque psoriasis (PsA)
   - ❑ Moderately to severely active Crohn's disease (CD)
   - ❑ Moderately to severely active ulcerative colitis (UC)
   - ❑ Other _____

3. What is the ICD-10 code? _____ Patient's weight: _____ kg / lbs ***(circle one)***

4. Will the requested drug be used in combination with any other biologic (e.g., Humira) or targeted synthetic disease modifying antirheumatic drug (DMARD) (e.g., Olumiant, Otezla, Xeljanz)? ❑ Yes ❑ No

5. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic DMARD (e.g., Olumiant, Xeljanz) associated with an increased risk of tuberculosis? *If Yes, skip to #7* ❑ Yes ❑ No

6. 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? *If Yes, skip to #9* ❑ Yes ❑ No

7. Does the patient have risk factors for tuberculosis (TB) (e.g., persons with close contact to people with infectious TB disease; persons who have recently immigrated from areas of the world with high rates of TB [e.g., Africa, Asia, Eastern Europe, Latin America, Russia]; children less than 5 years of age who have a positive TB test; groups with high rates of TB transmission [homeless persons, injection drug users, persons with HIV infection], or persons who work or reside with people who are at an increased risk for active TB [e.g., hospitals, long-term care facilities, correctional facilities, homeless shelters])? ❑ Yes ❑ No *If No, skip to #12*

8. Has the patient been tested for tuberculosis (TB) within the previous 12 months? ❑ Yes ❑ No

9. What were the results of the TB test?
   ❑ Positive for TB ❑ Negative for TB, *skip to #12* ❑ Unknown

10. Does the patient have latent or active tuberculosis (TB)? ❑ Latent ❑ Active ❑ Unknown

11. Has treatment for latent tuberculosis (TB) infection been initiated or completed?
    ❑ Yes - treatment initiated ❑ Yes - treatment completed ❑ No

12. Is the patient currently receiving Stelara?

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

14. 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

15. Has the patient achieved or maintained positive clinical response to treatment as evidenced by low disease activity or improvement in signs and symptoms since starting treatment with the requested drug?
    ❑ Yes ❑ No *No further questions*

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

Section A: Plaque Psoriasis AND/OR Psoriatic Arthritis **with** Co-Existent Plaque Psoriasis

16. Has the patient been diagnosed with moderate to severe plaque psoriasis? ❑ Yes ❑ No

17. Has the patient ever received (including current utilizers) Otezla or a biologic (e.g.Humira) indicated for the treatment of moderate to severe plaque psoriasis? *If Yes, no further questions.* ❑ Yes ❑ No

18. Are crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) affected? *If Yes, no further questions.* ❑ Yes ❑ No

19. What is the percentage of body surface area (BSA) affected (prior to starting the requested medication)?
    ❑ Greater than or equal to 3% to less than 10% of BSA
    ❑ Greater than or equal to 10% of BSA *No further questions*
    ❑ Less than 3% of BSA

20. Has the patient experienced an inadequate response, or has an intolerance to phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine or acitretin?
    If Yes, no further questions ❑ Yes ❑ No

21. Does the patient have a clinical reason to avoid pharmacologic treatment with methotrexate, cyclosporine and acitretin? ❑ Yes ❑ No
    If Yes, indicate clinical reason: _____

Section B: Crohn's Disease

22. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) indicated for Crohn's disease?
    If Yes, no further questions. ❑ Yes ❑ No

23. Has the patient tried and had an inadequate response to at least one conventional therapy option?
    If Yes, indicate below and no further questions.
    ❑ Yes - Sulfasalazine (Azulfidine, Sulfazine)
    ❑ Yes - Metronidazole (Flagyl)
    ❑ Yes - Ciprofloxacin (Cipro)
    ❑ Yes - Prednisone
    ❑ Yes - Budesonide (Entocort EC)
    ❑ Yes - Azathioprine (Azasan, Imuran)
    ❑ Yes - Mercaptopurine (Purinethol)
    ❑ Yes - Methotrexate intramuscular (IM) or subcutaneous (SC)
    ❑ Yes - Methylprednisolone (Solu-Medrol)
    ❑ Yes - Rifaximin (Xifaxan)
    ❑ Yes - Tacrolimus
    ❑ No

24. Does the patient have a contraindication or intolerance to at least one conventional therapy option (e.g., azathioprine [Azasan, Imuran], budesonide [Entocort EC], ciprofloxacin [Cipro], mercaptopurine [Purinethol], methylprednisolone [Solu-Medrol], methotrexate, metronidazole [Flagyl], prednisone, sulfasalazine [Azulfidine, Sulfazine], rifaximin [Xifaxan], tacrolimus)? ❑ Yes ❑ No

Section C: Ulcerative Colitis

25. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic disease modifying drug (e.g., Xeljanz) indicated for moderately to severely active ulcerative colitis? *If Yes, no further questions.* ❑ Yes ❑ No

26. Has the patient tried and had an inadequate response to at least one conventional therapy option?
    If Yes, indicate below and no further questions.
    ❑ Yes - Azathioprine (Azasan, Imuran)
    ❑ Yes - Corticosteroid (e.g., budesonide [Entocort, Uceris], hydrocortisone [Cortifoam, Colocort, Solu-Cortef, Cortef], methylprednisolone [Medrol, Solu-Medrol], prednisone)
    ❑ Yes - Cyclosporine (Sandimmune)
    ❑ Yes - Mesalamine (e.g., Asacol, Lialda, Pentasa, Canasa, Rowasa), balsalazide, olsalazine
    ❑ Yes - Mercaptopurine (Purinethol)
    ❑ Yes - Sulfasalazine
    ❑ Yes - Tacrolimus (Prograf)
    ❑ Yes - Metronidazole (Flagyl) or Ciprofloxacin (Cipro) (for pouchitis only)
    ❑ No

27. Does the patient have a contraindication or intolerance to at least one conventional therapy option (e.g., azathioprine [Azasan, Imuran], corticosteroid [e.g., budesonide [Entocort, Uceris], hydrocortisone, methylprednisolone, prednisone, cyclosporine [Sandimmune], mesalamine [Asacol, Lialda, Pentasa, Canasa, Rowasa], balsalazide, olsalazine, mercaptopurine [Purinethol], sulfasalazine, tacrolimus [Prograf], metronidazole/ciprofloxacin [for pouchitis only]) ❑ 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