CareFirst Family of health care plans

CVS caremark™

Actemra

Prior Authorization Request

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

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 requested formulation?
   ❑ Prefilled syringes for subcutaneous injection ❑ Vials for intravenous infusion

2. Has the patient been diagnosed with any of the following?
   ❑ Moderately to severely active rheumatoid arthritis (RA)
   ❑ Active polyarticular juvenile idiopathic arthritis (pJIA)
   ❑ Active systemic juvenile idiopathic arthritis (sJIA)
   ❑ Other _____
   ❑ Giant cell arteritis
   ❑ Unicentric Castleman's disease
   ❑ Multicentric Castleman's disease

3. What is the ICD-10 code? _____ *If diagnosis is giant cell arteritis or Castleman's disease, skip to #14.*

Section A: Preferred Product

4. These are the preferred products for which coverage is provided for treatment of the following condition: Rheumatoid arthritis: **Enbrel, Humira, Kevzara, Orencia (subcutaneous/ClickJect)**
   Can the patient's treatment be switched to a preferred product?
   ❑ Yes - Please specify: _____ ***If Yes, please call 1-866-814-5506 to have the updated form faxed to your office OR you may complete the PA electronically (ePA). You may sign up online via CoverMyMeds at: www.covermymeds.com/epa/caremark/ or call 1-866-452-5017.***
   ❑ No ❑ Not applicable - Requested for condition not listed above, *skip to Section B: All Requests*

5. Is this request for continuation of therapy with the requested product? ❑ Yes ❑ No *If No, skip to #7*

6. Is the patient currently receiving the requested product through samples or a manufacturer's patient assistance program? If unknown, answer Yes. ❑ Yes ❑ No *If No, skip to Section B: All Requests*

7. Has the patient had a documented inadequate response or intolerable adverse event with any of the following preferred products? Please indicate ALL that apply. ***ACTION REQUIRED: If Yes, attach supporting chart note(s).***
   ❑ Enbrel: ❑ Inadequate response ❑ Intolerable adverse event
   ❑ Humira: ❑ Inadequate response ❑ Intolerable adverse event

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. Actemra PDPD SGM - 2/2018.

❑ Kevzara: ❑ Inadequate response ❑ Intolerable adverse event
❑ Orencia (SC/ClickJect): ❑ Inadequate response ❑ Intolerable adverse event
❑ No - none of the above

8. Does the patient have one of the following documented clinical reasons to avoid Enbrel and Humira?
ACTION REQUIRED: If Yes, attach supporting chart note(s).
❑ Yes - History of demyelinating disorder ❑ Yes - Autoantibody formation/lupus-like syndrome
❑ Yes - History of congestive heart failure ❑ Yes - Risk of lymphoma
❑ Yes - History of hepatitis B virus infection ❑ No - none of the above

Section B: All Requests

9. Is this request for continuation of therapy? ❑ Yes ❑ No *If No, skip to #13*

10. Is the patient currently receiving Actemra through samples or a manufacturer's patient assistance program? ❑ Yes ❑ No ❑ Unknown *If Yes or Unknown, skip to #13*

11. How long has the patient been receiving the requested medication? _____ months
If less than 3 months, no further questions.

12. Has the patient achieved or maintained positive clinical response to treatment as evidenced by low disease activity or improvement in signs and symptoms? *If Yes, no further questions* ❑ Yes ❑ No

13. Has the patient received any of the following medications?
If Yes, please indicate the most recent medication and skip to diagnosis section.
❑ Cimzia ❑ Cosentyx ❑ Enbrel ❑ Humira ❑ Inflectra ❑ Kevzara ❑ Kineret ❑ Orencia
❑ Remicade ❑ Renflexis ❑ Rituxan ❑ Siliq ❑ Simponi ❑ Simponi Aria ❑ Stelara ❑ Taltz ❑ Tremfya ❑ Xeljanz ❑ Xeljanz XR ❑ No

14. Has the patient undergone pretreatment screening for latent tuberculosis (TB) infection with either a TB skin test or an interferon gamma release assay (e.g., QFT-GIT, T-SPOT.TB)? ❑ Yes ❑ No

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

Section C: Rheumatoid Arthritis

15. Has the patient experienced an inadequate response after at least 3 months of treatment with the methotrexate dose greater than or equal to 20 mg per week? *If Yes, no further questions* ❑ Yes ❑ No

16. Has the patient experienced intolerance to methotrexate? *If Yes, no further questions* ❑ Yes ❑ No

17. Does the patient have a contraindication to methotrexate? ❑ Yes ❑ No
If Yes, indicate the contraindication: _____

Section D: Polyarticular Juvenile Idiopathic Arthritis

18. Has the patient experienced an inadequate response to a tumor necrosis factor (TNF) inhibitor (e.g., Enbrel, Humira, or Remicade) after at least 3 months of treatment?
If Yes, no further questions ❑ Yes ❑ No

19. Has the patient experienced an intolerable adverse event to a tumor necrosis factor (TNF) inhibitor (e.g., Enbrel, Humira, or Remicade)? *If Yes, no further questions* ❑ Yes ❑ No

20. Does the patient have contraindication to a tumor necrosis factor (TNF) inhibitors (e.g., Enbrel, Humira, or Remicade)? ❑ Yes ❑ No

Section E: Systemic Juvenile Idiopathic Arthritis

21. Has the patient experienced an inadequate response to ANY of the following?
❑ At least 2 weeks of treatment with corticosteroids (e.g. prednisone, methylprednisolone)
❑ At least 3 months of treatment with methotrexate
❑ At least 3 months of treatment with leflunomide
❑ No – No history of an inadequate response to any of the above

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)**