CareFirst
The CareFirst BlueCross BlueShield family of health care plans

CVS/caremark

Cosentyx (for Maryland only)

Prior Authorization Request

Send completed form to: Case Review Unit CVS Caremark Specialty Programs 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.

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

1. What is the diagnosis?
   - ❑ Moderate to severe plaque psoriasis
   - ❑ Active psoriatic arthritis
   - ❑ Active ankylosing spondylitis
   - ❑ Other _____

2. What is the ICD-10 code? _____

3. Would the prescriber like to request an override of the step therapy requirement? ❑ Yes ❑ No *If No, skip to #6*

4. Has the member received the medication through a pharmacy or medical benefit within the past 180 days? ❑ Yes ❑ No ACTION REQUIRED: ***Please provide documentation to substantiate the member had a prescription paid for within the past 180 days (i.e. PBM medication history, pharmacy receipt, EOB etc.)***

5. Is the medication effective in treating the member's condition? ❑ Yes ❑ No *Continue to #6 and complete this form in its entirety.*

6. The preferred products for your patient's health plan are Enbrel and Humira. Is the prescriber willing to switch to one of the preferred products? ***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.***

   - ❑ Yes - Enbrel
   - ❑ Yes - Humira
   - ❑ No - Continue request for Cosentyx

7. Has the patient received at least a 28-day supply of Cosentyx within the previous 120 days in a paid claim through a pharmacy or medical benefit? *If Yes, skip to #11* ❑ Yes ❑ No

8. Is this request to continue treatment with the prescribed product after an interruption in therapy of greater than 120 days was required due to a medical reason such as pregnancy, surgery, or intercurrent medical illness? *If Yes, skip to #11* ❑ Yes ❑ No

9. Does the patient have one of the following clinical reasons to avoid the use of Enbrel or Humira? ❑ Yes ❑ No ***If Yes, please document clinical reason and skip to #11.***
   - ❑ Contraindication to Enbrel or Humira
   - ❑ History of demyelinating disorder
   - ❑ History of congestive heart failure
   - ❑ History of hepatitis B virus infection
   - ❑ Autoantibody formation/lupus-like syndrome
   - ❑ Other _____

10. Has the patient had an inadequate response, intolerance or confirmed adverse event to either Enbrel **OR** Humira?
❑ Yes ❑ No

11. Has the patient received or will be receiving the initial five weekly doses (i.e., loading dose)?
❑ Yes, received ❑ Yes, will receive ❑ No

12. Has the patient received at least a 28-day supply of any of the following medications in a paid claim through a pharmacy or medical benefit in the previous 120 days? ***If Yes, please specify the most recent medication.***
No further questions if Enbrel, Humira or Remicade are marked below.
❑ Actemra ❑ Cimzia ❑ Cosentyx ❑ Enbrel ❑ Humira ❑ Orencia ❑ Remicade ❑ Simponi
❑ Simponi Aria ❑ Stelara ❑ Xeljanz ❑ No *If No, skip to #15*

13. How long has the patient been receiving the requested medication? _____ weeks/ months ***(circle one)***
If the patient has NOT received a 28-day supply of COSENTYX in a paid claim through a pharmacy or medical benefit in the previous 120 days, skip to diagnosis section.

14. *If continuation of therapy,* has the patient achieved or maintained positive clinical response to treatment as evidenced by one of the following? *No further questions.*
❑ Yes - Low disease activity ❑ Yes - Improvement in signs and symptoms
❑ Yes - Maintenance of improvement in signs and symptoms ❑ No

15. 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)? ***ACTION REQUIRED: If Negative, attach documentation (e.g., patient's chart, laboratory report, or medical record).***
❑ Yes - Positive result ❑ Yes- Negative result ❑ Unknown (No test completed)

16. Was active tuberculosis (TB) infection ruled out? ❑ Yes ❑ No

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

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

Section A: Moderate to Severe Plaque Psoriasis

18. What is the percentage of body surface area (BSA) affected? _____ % of BSA

19. *If less than 5% BSA,* are crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) affected? ❑ Yes ❑ No

20. Please specify previous/current therapies, duration and outcome of previously prescribed/considered therapies (e.g., phototherapy [e.g., UVB, PUVA], methotrexate, cyclosporine, and/or acitretin).

If patient has NOT received prior medication(s), please document "None."

A) Drug/therapy and dose: _____ Duration/number of sessions: _____
Currently receiving? ❑ Yes ❑ No
Outcome: ❑ Inadequate response ❑ Intolerance ❑ Contraindication ❑ Other _____
If intolerance, contraindication or other, please specify: _____

B) Drug/therapy and dose: _____ Duration/number of sessions: _____
Currently receiving? ❑ Yes ❑ No
Outcome: ❑ Inadequate response ❑ Intolerance ❑ Contraindication ❑ Other _____
If intolerance, contraindication or other, please specify: _____

21. *If patient has not experienced an inadequate response, intolerance, or adverse event,* does the patient have severe psoriasis that warrants a biologic DMARD as first-line therapy? ❑ Yes ❑ No

Section B: Active Ankylosing Spondylitis

22. Has the patient received treatment with at least TWO nonsteroidal anti-inflammatory drugs (NSAIDs)?
    ❑ Yes ❑ No *If No, skip to #25*

23. Did the patient receive NSAIDs for at least 4 weeks in total at the maximum recommended or tolerated anti-inflammatory dose?
    ❑ Yes – maximum recommended dose
    ❑ Yes – maximum tolerated anti-inflammatory dose
    ❑ No, *skip to #25*

24. Has the patient experienced an inadequate response to NSAIDs? *If Yes, no further questions.* ❑ Yes ❑ No

25. Does the patient have intolerance or contraindication to at least two NSAIDs?
    ❑ Yes ❑ No ***If Yes, please specify*** _____

Section C: Active Psoriatic Arthritis

26. Please specify previous/current treatment, duration and outcome of previously prescribed/considered treatment (e.g., methotrexate, sulfasalazine or leflunomide).

    Please specify and no further question. If patient has NOT received prior treatment(s), please document "None."

    Treatment: _____ Duration: _____ Currently receiving? ❑ Yes ❑ No

    Outcome: ❑ Inadequate response ❑ Intolerance ❑ Contraindication ❑ Other _____

    If intolerance, contraindication or other, please specify: _____

27. Does the patient have any of the following conditions?
    If Yes, indicate below and no further questions. If No, mark "NO" and continue to #28.
    ❑ Active enthesitis ❑ Active dactylitis (i.e., sausage digit)
    ❑ Predominant axial disease (i.e., extensive spinal involvement) ❑ No

28. Does the patient have severely active disease as evidenced by any of the following?
    ❑ Multiple swollen joints
    ❑ Structural damage in the presence of inflammation
    ❑ Clinically relevant extra-articular manifestations, ***please specify:*** _____
    ❑ 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)**