Enbrel

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. Has the patient been diagnosed with any of the following?
   - ❑ Moderately to severely active rheumatoid arthritis (RA)
   - ❑ Moderate to severe chronic plaque psoriasis
   - ❑ Active psoriatic arthritis (PsA)
   - ❑ Active ankylosing spondylitis (AS)
   - ❑ Active axial spondyloarthritis
   - ❑ Moderately to severely active polyarticular juvenile idiopathic arthritis (pJIA)
   - ❑ Reactive arthritis
   - ❑ Active systemic juvenile idiopathic arthritis
   - ❑ Other _____

2. What is the ICD-10 code? _____

Section A: Preferred Product - For Plaque Psoriasis

3. The primary preferred product for which coverage is provided for the treatment of plaque psoriasis is **Humira**. Can the patient's treatment be switched to the primary preferred product (Humira)?
   - ❑ Yes ***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 other than plaque psoriasis, *skip to Section B: All Requests*

4. Is this request for continuation of therapy with the requested product? ❑ Yes ❑ No *If No, skip to #8*

5. Is the patient currently receiving the requested product through samples or a manufacturer's patient assistance program? If unknown, answer Yes. *If Yes, skip to #8* ❑ Yes ❑ No

6. Has the patient had a documented inadequate response or intolerable adverse event with the primary preferred product **Humira**? ***ACTION REQUIRED: If Yes, attach supporting chart note(s).***
   - ❑ Yes - Inadequate response ❑ Yes - Intolerable adverse event

❑ No - none of the above

7. The secondary preferred products for which coverage is provided for the treatment of plaque psoriasis are **Stelara or Taltz*.**
Note: Secondary preferred products for plaque psoriasis are Stelara and Taltz. These preferred product options only apply to members who have had a documented inadequate response or intolerable adverse event with Humira, or who have a documented clinical reason to avoid TNF inhibitors.

   Can the patient's treatment be switched to either of these preferred products? *Indicate below and skip to Section B: All Requests*
   ❑ 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

8. 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).***
   ❑ Humira: ❑ Inadequate response ❑ Intolerable adverse event
   ❑ Stelara: ❑ Inadequate response ❑ Intolerable adverse event
   ❑ Taltz: ❑ Inadequate response ❑ Intolerable adverse event
   ❑ 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 Enbrel 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.
    ❑ Actemra ❑ Cimzia ❑ Cosentyx ❑ 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 or Polyarticular Juvenile Idiopathic Arthritis

5. *If diagnosis is RA,* 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. *If diagnosis is pJIA,* has the patient experienced an inadequate response after at least 3 months of treatment with methotrexate? *If Yes, no further questions* ❑ Yes ❑ No

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

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

Section D: Ankylosing Spondylitis or Axial Spondyloarthritis

19. Has the patient experienced an inadequate response with at least TWO nonsteroidal anti-inflammatory drugs (NSAIDs), or has an intolerance or contraindication to at least two NSAIDs? ❑ Yes ❑ No

Section E: Plaque Psoriasis

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

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

22. 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

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

24. Does the patient have severe psoriasis that warrants a biologic DMARD as first-line therapy? ❑ 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)**