

**Otezla (for Maryland only)  
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.

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**Patient's Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**Patient's ID:** \_\_\_\_\_ **Patient's Date of Birth:** \_\_\_\_\_  
**Physician's Name:** \_\_\_\_\_ **NPI#:** \_\_\_\_\_  
**Specialty:** \_\_\_\_\_ **Physician Office Fax:** \_\_\_\_\_  
**Physician Office Telephone:** \_\_\_\_\_  
**Request Initiated For:** \_\_\_\_\_

- Has the patient been diagnosed with any of the following?  
 Moderate to severe plaque psoriasis  
 Active psoriatic arthritis (PsA)  
 Other \_\_\_\_\_
- What is the ICD-10 code? \_\_\_\_\_

**Section A: Preferred Product - For Plaque Psoriasis**

- These are the primary preferred products for which coverage is provided for treatment of the following condition:

Plaque psoriasis: **Humira (primary); Stelara/Taltz (secondary)\***

*\*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.*

Can the patient's treatment be switched to a preferred drug?

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/](http://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

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

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6. 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).**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Humira:                | <input type="checkbox"/> Inadequate response | <input type="checkbox"/> Intolerable adverse event |
| <input type="checkbox"/> Stelara:               | <input type="checkbox"/> Inadequate response | <input type="checkbox"/> Intolerable adverse event |
| <input type="checkbox"/> Taltz:                 | <input type="checkbox"/> Inadequate response | <input type="checkbox"/> Intolerable adverse event |
| <input type="checkbox"/> No - none of the above |  |  |

*If No - none of the above, complete this form in its entirety and Maryland State Step Therapy.*

7. Does the patient have one of the following documented clinical reasons to avoid Humira?  
**ACTION REQUIRED: If Yes, attach supporting chart note(s).**

- Yes - History of demyelinating disorder
- Yes - History of congestive heart failure
- Yes - History of hepatitis B virus infection
- Yes - Autoantibody formation/lupus-like syndrome
- Yes - Risk of lymphoma
- No - none of the above

8. Does the patient have one of the following documented exclusions to therapy with the preferred products?  
**ACTION REQUIRED: If Yes, attach supporting chart note(s).**

- Yes - Prior or active malignancy
- Yes - Routine travel to tuberculosis (TB)-endemic areas
- No *If No, complete this form in its entirety and Maryland State Step Therapy.*

**Section B: All Requests**

9. Is this request for continuation of therapy?  Yes  No

**For plaque psoriasis requests: If No, skip to #13**

**For psoriatic arthritis requests: If No, no further questions.**

10. Is the patient currently receiving Otezla through samples or a manufacturer's patient assistance program?

- Yes  No  Unknown **For plaque psoriasis requests: If Yes or Unknown, skip to #13.**

11. How long has the patient been receiving the requested medication? \_\_\_\_\_ months

*If less than 4 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.*

- Cosentyx  Enbrel  Humira  Inflectra  Remicade  Renflexis  Siliq  Stelara  Taltz  
 Tremfya  No

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

**Section C: Plaque Psoriasis**

14. What is the percentage of body surface area (BSA) affected? \_\_\_\_\_ %

15. *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

16. 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

17. Does the patient have a clinical reason to avoid pharmacologic treatment with methotrexate, cyclosporine or acitretin?  Yes  No

***If Yes, indicate the clinical reason:*** \_\_\_\_\_

Maryland Step Therapy

1. Is the requested drug being used to treat stage four advanced metastatic cancer?  
 Yes  No *If No, skip to #3*
2. Is the requested drug's use consistent with the FDA-approved indication or the National Comprehensive Cancer Network Drugs & Biologics Compendium indication for the treatment of stage four advanced metastatic cancer and is supported by peer-reviewed medical literature? *If Yes, no further questions*  Yes  No
3. Is the requested drug being used for an FDA-approved indication OR an indication supported in the compendia of current literature (examples: AHFS, Lexicomp, Clinical Pharmacology, Micromedex, current accepted guidelines)?  Yes  No
4. Does the prescribed quantity fall within the manufacturer's published dosing guidelines or within dosing guidelines found in the compendia of current literature (examples: package insert, AHFS, Lexicomp, Clinical Pharmacology, Micromedex, current accepted guidelines)?  Yes  No
5. Do patient chart notes document the requested drug was ordered with a paid claim at the pharmacy, the pharmacy filled the prescription and delivered to the patient or other documentation that the requested drug was prescribed for the patient in the last 180 days?  Yes  No
6. Has the prescriber provided proof documented in the patient chart notes that in their opinion the requested drug is effective for the patient's condition?  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)**