Otrexup, Rasuvo
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.

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 drug is being prescribed? ❑ Otrexup ❑ Rasuvo ❑ Other _____
2. What is the diagnosis?
   ❑ Rheumatoid arthritis (RA) ❑ Polyarticular juvenile idiopathic arthritis (pJIA)
   ❑ Psoriasis (PsO) ❑ Other _____
3. What is the ICD-10 code? _____
4. *If diagnosis is RA or pJIA,* has the patient had an inadequate response or intolerance to generic methotrexate? *If Yes, skip to #7* ❑ Yes - Inadequate response ❑ Yes - Intolerance ❑ No
5. *If diagnosis is PsO,* has the patient had an inadequate response or intolerance to generic oral methotrexate? ❑ Yes - Inadequate response ❑ Yes - Intolerance ❑ No
6. Is the patient unable to prepare and administer generic injectable methotrexate? ❑ Yes ❑ No
7. Has the patient received the prescribed medication in a paid claim through a pharmacy or medical benefit in the previous 120 days? ❑ Yes ❑ No *If No, no further questions*
8. How long has the patient received treatment with the requested medication? _____ months
9. Has the patient achieved or maintained positive clinical response to treatment as evidenced by low disease activity or improvement in signs and symptoms? ❑ 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)**