

Member Name: {{MEMFIRST}} {{MEMLAST}} DOB: {{MEMBERDOB}} PA Number: {{PANUMBER}}



[[PANUMCODE]]

Rasuvo

Prior Authorization Request

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: {{MEMFIRST}} {{MEMLAST}} **Date:** {{TODAY}}
Patient's ID: {{MEMBERID}} **Patient's Date of Birth:** {{MEMBERDOB}}
Physician's Name: {{PHYFIRST}} {{PHYLAST}}
Specialty: _____, **NPI#:** _____
Physician Office Telephone: {{PHYSICIANPHONE}} **Physician Office Fax:** {{PHYSICIANFAX}}
Request Initiated For: {{DRUGNAME}}

- What is the diagnosis?
 Rheumatoid arthritis (RA)
 Polyarticular juvenile idiopathic arthritis (pJIA)
 Psoriasis
 Other _____
- What is the ICD-10 code? _____
- Has the patient experienced any of the following?
 Intolerance to generic oral methotrexate
 Inadequate response to generic oral methotrexate
 No *If No, complete this form in its entirety and State Step Therapy section.*
- Is the patient unable to prepare and administer generic injectable methotrexate?
 Yes No *If No, complete this form in its entirety and State Step Therapy section.*
- Is the patient currently receiving the requested medication? Yes No *If No, no further questions.*
- How long has the patient been receiving the requested medication? _____ months
If less than 3 months, no further questions.
- Has the patient achieved or maintained positive clinical response to treatment as evidenced by low disease activity or improvement in signs and symptoms with the requested medication? Yes No

State Step Therapy

- 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
- 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
- Does the patient reside in Maryland? Yes No *If No, skip to #7*

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

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. Rasuvo State Step SGM - 12/2020.

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4. Is the alternate drug (generic oral methotrexate, generic injectable methotrexate) FDA-approved for the medical condition being treated?
 Yes No *If No, please specify:* _____
5. Has the prescriber provided proof, documented in the patient's chart notes, indicating that the requested drug was ordered for the patient in the past 180 days? Yes No *If No, skip to #7*
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 *No further questions*
7. Are any of the following conditions met for the alternate drug (generic oral methotrexate, generic injectable methotrexate)?
 - The alternate drug is contraindicated
 - The alternate drug is likely to cause an adverse reaction, physical or mental harm
 - The alternate drug is expected to be ineffective
 - The alternate drug was previously tried or a drug in the same class or with the same action was previously tried and was stopped due to ineffectiveness or an adverse event
 - The alternate drug is not in the patient's best interest
 - The alternate drug was tried while covered by the current or the previous health benefit plan
 - None of the above*If Yes, please specify:* _____
8. Is the patient stable or currently receiving a positive therapeutic outcome with the requested drug and a change in the prescription drug is expected to be ineffective or cause harm to the patient? 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)

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