Remicade (for Maryland only)

Prior Authorization Request

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

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 1-855-330-1720**. 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:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Additional Demographic Information:

Patient Weight: _____*kg*

*Patient Height:*_____*ft* _____*inches*

Site of Service Questions (SOS):

A. Indicate the site of service requested:
- ❑ Outpatient hospital
- ❑ Home infusion, *skip to Clinical Questions*
- ❑ Ambulatory surgical, *skip to Clinical Questions*
- ❑ Physician office, *skip to Clinical Questions*
- ❑ Pharmacy, *skip to Clinical Questions*
- ❑ Inpatient hospital, *skip to Clinical Questions*

B. Is the patient less than 21 years old or 65 years of age or older?
- ❑ Yes – less than 21 years old
- ❑ Yes – age 65 years or older, *skip to Clinical Criteria Questions*
- ❑ No, *Skip to Question D.*

C. After tolerance of Remicade, Inflectra or Renflexis has been established, would this patient be a candidate to receive the medication at a site of service other than the outpatient hospital setting?
Indicate and skip to Clinical Criteria Questions ❑ Yes ❑ No

D. Is this a new request for Remicade, Inflectra or Renflexis? ❑ Yes, *skip to Clinical Criteria Questions* ❑ No

E. Has the patient received at least 3 infusions of Remicade, Inflectra or Renflexis?
❑ Yes ❑ No, *skip to Clinical Criteria Questions*

F. Has the patient experienced a gap in therapy exceeding 2 infusions or more and the current request is a re-initiation of therapy? ❑ Yes, *skip to Clinical Criteria Questions* ❑ No

G. Does the patient have laboratory confirmed anti- Remicade, anti- Inflectra or anti-Renflexis antibodies? ***ACTION REQUIRED: Attach supporting clinical documentation.*** ❑ Yes, *skip to Clinical Criteria Questions* ❑ No

H. Has the patient experienced moderate to severe adverse reactions which may include hypertension or hypotension, tachycardia or syncope that have not responded to conventional interventions? ***ACTION REQUIRED: Attach supporting clinical documentation.*** ❑ Yes, *skip to Clinical Criteria Questions* ❑ No

I. Has the patient previously experienced a severe adverse event during or immediately after an infusion including but not limited to: anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures? ***ACTION REQUIRED: Attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

J. Is the patient medically unstable which may include respiratory, cardiovascular, or renal conditions that may predispose the member to a severe adverse event that cannot be managed in an alternate setting without appropriate medical personnel and equipment? ***ACTION REQUIRED: Attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

K. Does the patient have severe venous access issues that require the use of a special intervention? ***ACTION REQUIRED: Attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

L. Has the patient's home been previously determined to be inappropriate for home infusion by a social worker, case manager, or previous home care nurse assessment AND other non-hospital sites of service (physician office, pharmacy, ambulatory surgical, and inpatient hospital) are not within a reasonable distance from the patient's home? ***ACTION REQUIRED: Attach supporting clinical documentation.*** ❑ Yes ❑ No

Criteria Questions:

1. What drug is being prescribed? ❑ Remicade ❑ Inflectra ❑ Renflexis

2. Has the patient been diagnosed with any of the following?
❑ Moderately to severely active Crohn's disease (CD)
❑ Moderately to severely active ulcerative colitis (UC)
❑ Moderately to severely active rheumatoid arthritis (RA)
❑ Active ankylosing spondylitis
❑ Active axial spondyloarthritis
❑ Active psoriatic arthritis (PsA)
❑ Chronic **and** severe plaque psoriasis
❑ Granulomatosis with polyangiitis (Wegener's granulomatosis)
❑ Other _____
❑ Juvenile idiopathic arthritis (JIA)
❑ Behçet's syndrome
❑ Severe, refractory hidradenitis suppurativa
❑ Pyoderma gangrenosum
❑ Sarcoidosis
❑ Takayasu's arteritis
❑ Uveitis

3. What is the ICD-10 code? _____

4. Would the prescriber like to request an override of the step therapy requirement? ❑ Yes ❑ No *If No, skip to #7*

5. Has the member received the medication through a pharmacy or medical benefit within the past 180 days?
❑ Yes ❑ No ***Action Required: If Yes, 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.)***

6. Is the medication effective in treating the member's condition?
❑ Yes ❑ No *Continue to #7 and complete this form in its entirety.*

7. Has the patient received 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.***
❑ Actemra ❑ Cimzia ❑ Cosentyx ❑ Enbrel ❑ Entyvio ❑ Humira ❑ Inflectra ❑ Kineret ❑ Orencia ❑ Otezla ❑ Remicade ❑ Renflexis ❑ Rituxan ❑ Simponi ❑ Simponi Aria ❑ Stelara ❑ Taltz ❑ Tysabri ❑ Xeljanz ❑ Xeljanz XR ❑ No *If No, skip to #10*

8. *If patient is continuing therapy*, how long has the patient been receiving the requested medication?
_____ weeks / months ***(circle one) If the patient has NOT received the requested medication in a paid claim through a pharmacy or medical benefit in the previous 120 day, skip to #10.***

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 *If diagnosis is RA, skip to diagnosis section. For all other indications, no further questions.*

10. 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.

Section A: Crohn's Disease or Ulcerative Colitis

11. *If the diagnosis is Crohn's disease,* does the patient have fistulizing disease? ❑ Yes ❑ No

12. *If the diagnosis is ulcerative colitis,* does the patient have pouchitis? ❑ Yes ❑ No

13. Has the patient tried and had an inadequate response to at least ONE conventional therapy option?
For CD: e.g., azathioprine [Azasan, Imuran], budesonide [Entocort EC], ciprofloxacin [Cipro], mesalamine [Asacol, Delzicol, Pentasa, Lialda], mercaptopurine [Purinethol], methylprednisolone [Solu-Medrol], methotrexate, metronidazole [Flagyl], prednisone, sulfasalazine [Azulfidine, Sulfazine], rifaximin [Xifaxan])
❑ Yes ❑ No

For UC: e.g., azathioprine [Azasan, Imuran], corticosteroid [e.g., budesonide, hydrocortisone, methylprednisolone, prednisone], cyclosporine [Sandimmune], mesalamine [Asacol, Lialda, Pentasa, Canasa, Rowasa], mercaptopurine [Purinethol], sulfasalazine, tacrolimus, metronidazole/ciprofloxacin [for pouchitis only] ❑ Yes ❑ No

If Yes, please indicate the previous treatment regimen:
_____

14. Does the patient have a contraindication or intolerance to at least ONE conventional therapy option?
❑ Yes ❑ No
If Yes, please indicate the contraindication/intolerance:
_____

Section B: Rheumatoid Arthritis

15. Is the requested medication being prescribed in combination with methotrexate or leflunomide? ❑ Yes ❑ No
If No, indicate clinical reason for not using methotrexate or leflunomide:
_____

16. Has the patient experienced an inadequate response after at least 3 months of treatment with methotrexate?
❑ Yes ❑ No *If No, skip to #18*

17. What was the maximum titrated methotrexate dose? _____ mg per week

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

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

Section C: Ankylosing Spondylitis or Axial Spondyloarthritis

20. Has the patient experienced an inadequate response with at least TWO nonsteroidal anti-inflammatory drugs (NSAIDs) over a 4-week period in total at the maximum recommended or tolerated anti-inflammatory dose?
If Yes, no further questions ❑ Yes ❑ No

21. Does the patient have intolerance or contraindication to at least two NSAIDs? ❑ Yes ❑ No
If Yes, indicate the intolerance/contraindication: _____

Section D: Plaque Psoriasis

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

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

24. Has the patient experienced an inadequate response to phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine or acitretin? *If Yes, no further questions* ❑ Yes ❑ No

25. Has the patient had an intolerance or adverse event to a trial of phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine or acitretin? *If Yes, no further questions* ❑ Yes ❑ No

26. Does the patient have a clinical reason to avoid pharmacologic treatment with methotrexate, cyclosporine or acitretin? ❑ Yes ❑ No ***If Yes, indicate the clinical reason:*** _____

27. Does the patient have severe psoriasis that warrants a biologic DMARD as first-line therapy? ❑ Yes ❑ No

Section E: Juvenile Idiopathic Arthritis

28. Has the patient received treatment with a self-injectable TNF inhibitor indicated for idiopathic arthritis (JIA) (e.g., Enbrel or Humira)?
    ❑ Yes – Enbrel ❑ Yes – Humira ❑ Yes – Both Enbrel and Humira ❑ Other _____

29. Has the patient experienced any of the following during treatment with Enbrel or Humira?
    ❑ Yes – Inadequate response to at least a 3-month trial
    ❑ Yes – Development of antibodies
    ❑ Yes – Intolerable adverse event (e.g., hypersensitivity reaction)
    ❑ No

Section F: Uveitis

30. Has the patient had an inadequate response or intolerance, or has a contraindication to a trial of immunosuppressive therapy for uveitis (e.g., methotrexate, azathioprine, or mycophenolate mofetil)?
    ❑ Yes – methotrexate
    ❑ Yes – azathioprine
    ❑ Yes – mycophenolate mofetil
    ❑ Yes – other _____
    ❑ 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)**