Taltz

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.

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. What is the diagnosis?
   - ❑ Moderate to severe plaque psoriasis
   - ❑ Active psoriatic arthritis (PsA)
   - ❑ Active ankylosing spondylitis (AS)
   - ❑ Active axial spondyloarthritis
   - ❑ Other _____

2. What is the ICD-10 code? _____

Section A: Preferred Product

3. These are the preferred products for which coverage is provided for the treatment of the following indications:
   a) Ankylosing spondylitis: **Cosentyx, Enbrel, Humira**
   b) Psoriatic arthritis: **Cosentyx, Enbrel, Humira, Otezla**
   Can the patient's treatment be switched to a preferred product?

   ❑ Yes - Please indicate: _____ ***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 not listed above, *skip to Section B: All Requests*

4. Is this request for continuation of therapy with the requested product? ❑ Yes ❑ No *If No, skip to #6*

5. 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*

6. Does the patient have a documented inadequate response or intolerable adverse event with any of the following preferred products? ***ACTION REQUIRED: If Yes, attach supporting chart note(s).*** *Indicate ALL that apply.*

❑ Cosentyx:	❑ Inadequate response	❑ Intolerable adverse event
❑ Enbrel:	❑ Inadequate response	❑ Intolerable adverse event
❑ Humira:	❑ Inadequate response	❑ Intolerable adverse event
❑ Otezla:	❑ Inadequate response	❑ Intolerable adverse event

❑ No - None of the above, *complete this form in its entirety and State Step Therapy section.*

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

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7. Does the patient have one of the following documented clinical reasons to avoid the preferred products that are TNF inhibitors (Enbrel and 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 (attributed to TNF inhibitor)
   ❑ Yes - Risk of lymphoma
   ❑ No - none of the above
   ❑ Not applicable - requested medication is a TNF inhibitor
   If No - none of the above OR Not applicable - requested medication is a TNF inhibitor complete this form in its entirety and State Step Therapy section.

Section B: All Requests

8. Will the requested drug be used in combination with any other biologic (e.g., Humira) or targeted synthetic disease-modifying anti-rheumatic drug (DMARD) (e.g., Olumiant, Otezla, Xeljanz)? ❑ Yes ❑ No

9. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic DMARD (e.g., Olumiant, Xeljanz)? *If Yes, skip to #11* ❑ Yes ❑ No

10. Has the patient had a tuberculosis (TB) test (e.g., tuberculosis skin test [PPD], an interferon-release assay [IGRA], or a chest x-ray) within 6 months of initiating therapy? *If Yes, skip to #13* ❑ Yes ❑ No

11. Does the patient have risk factors for tuberculosis (TB) (e.g., persons with close contact to people with infectious TB disease; persons who have recently immigrated from areas of the world with high rates of TB [e.g., Africa, Asia, Eastern Europe, Latin America, Russia]; children less than 5 years of age who have a positive TB test; groups with high rates of TB transmission [e.g., homeless persons, injection drug users, persons with HIV infection], or persons who work or reside with people who are at an increased risk for active TB [e.g., hospitals, long-term care facilities, correctional facilities, homeless shelters])? ❑ Yes ❑ No *If No, skip to #16*

12. Has the patient been tested for tuberculosis (TB) within the previous 12 months? ❑ Yes ❑ No

13. What were the results of the tuberculosis (TB) test?
    ❑ Negative for TB, *skip to #16* ❑ Positive for TB ❑ Unknown

14. Does the patient have latent or active tuberculosis (TB)? ❑ Latent ❑ Active ❑ Unknown

15. Has treatment for latent tuberculosis (TB) infection been initiated or completed?
    ❑ Yes - treatment initiated ❑ Yes - treatment completed ❑ No

16. Is this request for continuation of therapy with the requested drug?
    ❑ Yes ❑ No *If No, skip to diagnosis section*

17. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program? *If Yes or Unknown, skip to diagnosis section* ❑ Yes ❑ No ❑ Unknown

18. Has the patient achieved or maintained positive clinical response as evidenced by low disease activity or improvement in signs and symptoms since starting treatment with the requested drug?
    ❑ Yes ❑ No *No further questions*

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

Section C: Plaque Psoriasis

19. Has the patient ever received (including current utilizers) Otezla or a biologic (e.g., Humira) indicated for the treatment of moderate to severe plaque psoriasis? *If Yes, no further questions.* ❑ Yes ❑ No

20. Are crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) affected? *If Yes, no further questions.* ❑ Yes ❑ No

21. What is the percentage of body surface area (BSA) affected (prior to starting the requested medication)?
    _____ % of BSA *If greater than or equal to 10%, no further questions*

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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 the clinical reason:*** _____

Section D: Ankylosing Spondylitis and Axial Spondyloarthritis

24. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) indicated for the treatment of active ankylosing spondylitis or active axial spondyloarthritis? *If Yes, no further questions.* ❑ Yes ❑ No

25. 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

State Step Therapy

1. 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

2. 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

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

4. Is the alternate drug (see below) 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 (see below)?
❑ 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
❑ 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

Preferred drug(s) based on diagnosis:
a) Ankylosing spondylitis: **Cosentyx, Enbrel, Humira**
b) Psoriatic arthritis: **Cosentyx, Enbrel, Humira, Otezla**

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)**

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

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