

**Actemra (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: _____

1. What is the requested formulation?
 Prefilled syringes for subcutaneous injection Vials for intravenous infusion
2. Has the patient been diagnosed with any of the following?
 Moderately to severely active rheumatoid arthritis (RA) Giant cell arteritis
 Active polyarticular juvenile idiopathic arthritis (pJIA) Unicentric Castleman's disease
 Active systemic juvenile idiopathic arthritis (sJIA) Multicentric Castleman's disease
 Other _____
3. What is the ICD-10 code? _____ *If diagnosis is giant cell arteritis or Castleman's disease, skip to #14.*

Section A: Preferred Product

4. These are the preferred products for which coverage is provided for treatment of the following condition:
Rheumatoid arthritis: **Enbrel, Humira, Kevzara, Orencia (subcutaneous/ClickJect)**
Can the patient's treatment be switched to a preferred product?
 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/ or call 1-866-452-5017.*
 No
 Not applicable - Requested for condition not listed above, *skip to Section B: All Requests*
5. Is this request for continuation of therapy with the requested product? Yes No *If No, skip to #7*
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*
7. 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).**
 Enbrel: Inadequate response Intolerable adverse event

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- Humira: Inadequate response Intolerable adverse event
- Kevzara: Inadequate response Intolerable adverse event
- Orencia (SC/ClickJect): Inadequate response Intolerable adverse event
- No - none of the above, *complete this form in its entirety and also complete Maryland State Step Therapy Section*

8. Does the patient have one of the following documented clinical reasons to avoid Enbrel and Humira?
ACTION REQUIRED: If Yes, attach supporting chart note(s).
- Yes - History of demyelinating disorder Yes - Autoantibody formation/lupus-like syndrome
 - Yes - History of congestive heart failure Yes - Risk of lymphoma
 - Yes - History of hepatitis B virus infection No - none of the above

Section B: All Requests

9. Is this request for continuation of therapy? Yes No *If No, skip to #13*
10. Is the patient currently receiving Actemra through samples or a manufacturer's patient assistance program?
 Yes No Unknown *If Yes or Unknown, skip to #13*
11. How long has the patient been receiving the requested medication? _____ months
If less than 3 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.
- Cimzia Cosentyx Enbrel Humira Inflectra Kevzara Kineret Orencia
 - Remicade Renflexis Rituxan Siliq Simponi Simponi Aria Stelara Taltz
 - Tremfya Xeljanz Xeljanz XR No
14. 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, if applicable.

Section C: Rheumatoid Arthritis

15. Has the patient experienced an inadequate response after at least 3 months of treatment with the methotrexate dose greater than or equal to 20 mg per week? *If Yes, no further questions* Yes No
16. Has the patient experienced intolerance to methotrexate? *If Yes, no further questions* Yes No
17. Does the patient have a contraindication to methotrexate? Yes No
If Yes, indicate the contraindication: _____

Section D: Polyarticular Juvenile Idiopathic Arthritis

18. Has the patient experienced an inadequate response to a tumor necrosis factor (TNF) inhibitor (e.g., Enbrel, Humira, or Remicade) after at least 3 months of treatment? *If Yes, no further questions* Yes No
19. Has the patient experienced an intolerable adverse event to a tumor necrosis factor (TNF) inhibitor (e.g., Enbrel, Humira, or Remicade)? *If Yes, no further questions* Yes No
20. Does the patient have contraindication to a tumor necrosis factor (TNF) inhibitors (e.g., Enbrel, Humira, or Remicade)? Yes No

Section E: Systemic Juvenile Idiopathic Arthritis

21. Has the patient experienced an inadequate response to ANY of the following?
- At least 2 weeks of treatment with corticosteroids (e.g. prednisone, methylprednisolone)
 - At least 3 months of treatment with methotrexate
 - At least 3 months of treatment with leflunomide
 - No – No history of an inadequate response to any of the above

Maryland State 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? 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)