CVS caremark™ {{PANUMCODE}}

Actemra

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: {{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}}

1. What is the prescribed dose and frequency?
   - ❑ Actemra IV 80 mg Quantity and Frequency: _____
   - ❑ Actemra SQ 162 mg syringe Quantity and Frequency: _____
   - ❑ Actemra SQ 162 mg autoinjector Quantity and Frequency: _____
   - ❑ Actemra IV 200 mg Quantity and Frequency: _____
   - ❑ Actemra IV 400 mg Quantity and Frequency: _____
   - ❑ Other _____

2. Has the patient been diagnosed with any of the following?
   - ❑ Moderately to severely active rheumatoid arthritis (RA)
   - ❑ Active systemic juvenile idiopathic arthritis (sJIA)
   - ❑ Active articular juvenile idiopathic arthritis
     - ❑ Polyarticular juvenile idiopathic arthritis (pJIA)
     - ❑ Oligoarticular juvenile idiopathic arthritis
   - ❑ Multicentric Castleman's disease
   - ❑ Giant cell arteritis
   - ❑ Immunotherapy-related inflammatory arthritis
   - ❑ Unicentric Castleman's disease
   - ❑ Cytokine release syndrome
   - ❑ Acute graft versus host disease
   - ❑ Other _____

3. What is the ICD-10 code? _____
   If diagnosis is giant cell arteritis or cytokine release syndrome skip to Section B: All Requests.

4. What is the patient's weight? _____ kg

Section A: Preferred Product

5. These are the preferred products for which coverage is provided for the treatment of rheumatoid arthritis: **Enbrel, Humira, Kevzara, Orencia (SC)/Orencia Clickject, Remicade, Rinvoq, Simponi Aria, Xeljanz/Xeljanz XR.** 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 - Continue request for Actemra
   - ❑ Not applicable - Requested for condition not listed above, *skip to Section B: All Requests.*

6. Is this request for continuation of therapy with the requested product? ❑ Yes ❑ No *If No, skip to #8*

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

7. 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.*

8. 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.

❑ Enbrel:	❑ Inadequate response	❑ Intolerable adverse event
❑ Humira:	❑ Inadequate response	❑ Intolerable adverse event
❑ Kevzara:	❑ Inadequate response	❑ Intolerable adverse event
❑ Orencia (SC/Clickject):	❑ Inadequate response	❑ Intolerable adverse event
❑ Remicade:	❑ Inadequate response	❑ Intolerable adverse event
❑ Rinvoq:	❑ Inadequate response	❑ Intolerable adverse event
❑ Simponi Aria:	❑ Inadequate response	❑ Intolerable adverse event
❑ Xeljanz/Xeljanz XR:	❑ Inadequate response	❑ Intolerable adverse event

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

9. Does the patient have one of the following documented clinical reasons to avoid the preferred products that are TNF inhibitors (Enbrel, Humira, Remicade, Simponi Aria)?
ACTION REQUIRED: If Yes, attach supporting chart note(s).
❑ Yes – History of demyelinating disorder, *please specify product(s):* _____
❑ Yes – History of congestive heart failure, *please specify product(s):* _____
❑ Yes – History of hepatitis B virus infection, *please specify product(s):* _____
❑ Yes – Autoantibody formation/lupus-like syndrome (attributed to TNF inhibitor), *please specify product(s):* _____
❑ Yes – Risk of lymphoma, *please specify product(s):* _____
❑ 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

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

11. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic DMARD (e.g., Olumiant, Xeljanz) associated with an increased risk of tuberculosis (TB)?
If Yes, skip to #13 ❑ Yes ❑ No

12. Has the patient had a tuberculosis (TB) test (e.g., tuberculosis skin test [PPD], interferon-release assay [IGRA], chest x-ray) within 6 months of initiating therapy? *If Yes, skip to #15* ❑ Yes ❑ No

13. 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 Section C.*

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

15. What were the results of the tuberculosis (TB) test?
❑ Positive for TB ❑ Negative for TB, *skip to Section C* ❑ Unknown

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

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

Section C: All Requests (Excludes Immunotherapy-Related Inflammatory Arthritis and Cytokine Release Syndrome)

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

19. 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

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

21. Please select the situation that applies to the patient
    a) Patient is continuing therapy at current
    ❑ Dose AND frequency ❑ Dose only ❑ Frequency only
    b) Prescriber is increasing
    ❑ Dose AND frequency ❑ Dose only ❑ Frequency only
    c) Prescriber is decreasing
    ❑ Dose AND frequency ❑ Dose only ❑ Frequency only

22. Does the patient require an increased dosing frequency due to lack of clinical response? ❑ Yes ❑ No

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

Section D: Rheumatoid Arthritis

23. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic DMARD (e.g., Xeljanz) that is indicated for moderately to severely active rheumatoid arthritis?
    If Yes, no further questions. ❑ Yes ❑ No

24. Has the patient experienced an inadequate response after at least 3 months of treatment with methotrexate at a dose greater than or equal to 20 mg per week? *If Yes, no further questions.* ❑ Yes ❑ No

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

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

Section E: Polyarticular and Oligoarticular Juvenile Idiopathic Arthritis

27. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic disease-modifying antirheumatic drug (DMARD) indicated for active articular juvenile idiopathic arthritis?
    If Yes, no further questions ❑ Yes ❑ No

28. Has the patient had an inadequate response to methotrexate or another non-biologic DMARD administered at an adequate dose and duration? *If Yes, no further questions* ❑ Yes ❑ No

29. Does the patient have any of the following risk factors?
    ❑ Positive rheumatoid factor ❑ Positive anti-cyclic citrullinated peptide antibodies
    ❑ Pre-existing joint damage ❑ None of the above

30. Does the patient meet any of the following?
    ❑ High-risk joints are involved (e.g., cervical spine, wrist, or hip) ❑ High disease activity
    ❑ High risk for disabling joint disease ❑ None of the above

Section F: Systemic Juvenile Idiopathic Arthritis (sJIA)

31. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) indicated for active systemic juvenile idiopathic arthritis? *If Yes, no further questions* ❑ Yes ❑ No

32. Has the patient experienced an inadequate response to ANY of the following? If Yes, please indicate.
    - ❑ At least 1 month trial of NSAIDs
    - ❑ 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

Section G: Unicentric Castleman's Disease

33. Has the patient been tested for HIV (human immunodeficiency virus)? ❑ Yes ❑ No

34. What were the results of the HIV test? ❑ Positive ❑ Negative ❑ Unknown

35. Has the patient been tested for herpesvirus-8? ❑ Yes ❑ No

36. What were the results of the herpesvirus-8 test? ❑ Positive ❑ Negative ❑ Unknown

37. Is the disease relapsed or refractory? ❑ Yes ❑ No

38. Will the requested drug be used as second-line therapy? ❑ Yes ❑ No

39. Will the requested drug be used as monotherapy? ❑ Yes ❑ No

Section H: Multicentric Castleman's Disease

40. Is the disease relapsed/refractory or progressive? ❑ Yes ❑ No

41. Will the requested drug be used as second-line therapy? ❑ Yes ❑ No

42. Will the requested drug be used as monotherapy? ❑ Yes ❑ No

Section I: Immunotherapy-Related Inflammatory Arthritis

43. Is the disease severe or refractory? ❑ Yes ❑ No

44. Has the patient tried and not responded to corticosteroids and anti-inflammatory agents? ❑ Yes ❑ No

Section J: Giant Cell Arteritis

45. Has the diagnosis been confirmed by temporal artery biopsy or cross-sectional imaging?
    If Yes, no further questions ❑ Yes ❑ No

46. Has the diagnosis been confirmed by acute-phase reactant elevation (i.e., high erythrocyte sedimentation rate [ESR] and/or high serum C-reactive protein [CRP])? ❑ Yes ❑ No

Section K: Cytokine Release Syndrome

47. Has the patient been diagnosed with chimeric antigen receptor (CAR) T cell-induced cytokine release syndrome (CRS)? *If Yes, no further questions* ❑ Yes ❑ No

48. Does the patient have refractory cytokine release syndrome (CRS) related to blinatumomab therapy?
    ❑ Yes ❑ No

Section L: Acute Graft Versus Host Disease

49. Has the patient experienced an inadequate response to systemic corticosteroids?
    If Yes, no further questions ❑ Yes ❑ No

50. Does the patient have an intolerance or contraindication to corticosteroids? ❑ 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 (Enbrel, Humira, Kevzara, Orencia (SC)/Orencia Clickject, Remicade, Rinvoq, Simponi Aria, Xeljanz/Xeljanz XR) 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 (Enbrel, Humira, Kevzara, Orencia (SC)/Orencia Clickject, Remicade, Rinvoq, Simponi Aria, Xeljanz/Xeljanz XR)?
   ❑ 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)**

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