



Cimzia

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 1-855-330-1720.** If you have questions regarding the prior authorization, please contact CVS Caremark at **1-888-877-0518**. 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:** _____

Referring Provider Info: Same as Requesting Provider

Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: Same as Referring Provider Same as Requesting Provider

Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

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

Required Demographic Information:

Patient Weight: _____ kg

Patient Height: _____ cm

Please indicate the place of service for the requested drug:

- Ambulatory Surgical Home Off Campus Outpatient Hospital
 On Campus Outpatient Hospital Office Pharmacy

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

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. MR Cimzia SGM -06/2021.

CVS Caremark Specialty Pharmacy • 2211 Sanders Road NBT-6 • Northbrook, IL 60062

Phone: 1-888-877-0518 • Fax: 1-855-330-1720 • www.caremark.com

Exception Criteria Questions:

- A. Is the product being requested for the treatment of an ADULT patient (18 years of age or older) with one of the following indications?
- Ankylosing spondylitis
 - Crohn’s disease
 - Plaque psoriasis
 - Psoriatic arthritis
 - Rheumatoid arthritis
 - Ulcerative colitis
- Yes No *If No, skip to Clinical Criteria Questions*
- B. These are the preferred products for which coverage is provided for treatment of the following indications:
- Ankylosing spondylitis, psoriatic arthritis, rheumatoid arthritis: **Remicade and Simponi Aria**
 - Plaque psoriasis: **Ilumya and Remicade**
 - Crohn’s disease, ulcerative colitis: **Entyvio and Remicade**
 - **Stelara IV** is indicated for a one time induction dose for Crohn’s disease and ulcerative colitis.
- Can the patient’s treatment be switched to a preferred product?
- Yes, *Please obtain Form for preferred product and submit for corresponding PA.*
- No
- If diagnosis is Plaque psoriasis, skip to Question M*
- C. Is this request for continuation of therapy with the requested product? Yes No, *If No, skip to Question E*
- D. Is the patient currently receiving the requested product through samples or a manufacturer’s patient assistance program? If unknown, answer Yes. Yes No, *skip to Clinical Criteria Questions*
- E. What is the diagnosis?
- | | |
|--|--|
| <input type="checkbox"/> Ankylosing spondylitis | <input type="checkbox"/> Crohn’s disease, <i>skip to Question I</i> |
| <input type="checkbox"/> Psoriatic arthritis | <input type="checkbox"/> Rheumatoid arthritis |
| <input type="checkbox"/> Ulcerative colitis, <i>skip to Question J</i> | <input type="checkbox"/> Other, <i>skip to Clinical Criteria Questions</i> |
- F. Is the patient currently pregnant or breastfeeding? Yes, *skip to Clinical Criteria Questions* No
- G. Does the patient have a documented inadequate response or intolerable adverse event to both of the preferred products (Remicade, Simponi Aria)? **Action Required: If ‘Yes’, attach supporting chart note(s).**
- Yes, *skip to Clinical Criteria Questions* No
- H. Does the patient have one of the following documented clinical reasons to avoid the preferred products that are TNF inhibitors (Remicade, Simponi Aria)? **Action Required: If ‘Yes’, attach supporting chart note(s).**
- Not applicable – Requested medical is a TNF inhibitor *skip to Clinical Criteria Questions*
 - Yes – History of demyelinating disorder, *skip to Clinical Criteria Questions*
 - Yes – History of congestive heart failure *skip to Clinical Criteria Questions*
 - Yes – History of hepatitis B virus infection *skip to Clinical Criteria Questions*
 - Yes – Autoantibody formation/lupus-like syndrome (attributed to TNF inhibitor) *skip to Clinical Criteria Questions*
 - Yes – Risk of lymphoma *skip to Clinical Criteria Questions*
 - No – None of the above *skip to Clinical Criteria Questions*
- I. Is the patient currently pregnant or breastfeeding? Yes, *skip to Clinical Criteria Questions* No
- J. Does the patient have a documented inadequate response or intolerable adverse event to both of the preferred products (Entyvio, Remicade)? **Action Required: If ‘Yes’, attach supporting chart note(s).** *If Yes, skip to Clinical Criteria Questions* Yes No

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

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. MR Cimzia SGM –06/2021.

CVS Caremark Specialty Pharmacy • 2211 Sanders Road NBT-6 • Northbrook, IL 60062

Phone: 1-888-877-0518 • Fax: 1-855-330-1720 • www.caremark.com

- K. Does the patient have one of the following documented clinical reasons to avoid the preferred product that is a TNF inhibitor (Remicade)? **Action Required: If 'Yes', attach supporting chart note(s).**
- Not applicable – requested medication is a TNF inhibitor
 - 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
- L. Does the patient have a documented inadequate response or intolerable adverse event to the preferred product that is not a TNF inhibitor (Entyvio)? **Action Required: If 'Yes', attach supporting chart note(s).**
- Yes No For yes or no, skip to Clinical Criteria Questions
- M. Is the patient currently pregnant or breastfeeding? Yes No
- N. Does the patient have a documented inadequate response or intolerable adverse event to the preferred products indicated for plaque psoriasis (Ilumya, Remicade)? **Action Required: If 'Yes', attach supporting chart note(s).**
If Yes, skip to Clinical Criteria Questions Yes No
- O. Does the patient have one of the following documented clinical reasons to avoid the preferred product that is a TNF inhibitor (Remicade)? **Action Required: If 'Yes', attach supporting chart note(s).**
- Not applicable – requested medication is a TNF inhibitor
 - 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
- P. Does the patient have a documented inadequate response or intolerable adverse event to the preferred product that is not a TNF inhibitor (Ilumya)? **Action Required: If 'Yes', attach supporting chart note(s).** Yes No

Clinical Criteria Questions:

1. What is the prescribed dose and frequency?

a) **Loading dose:**

- Cimzia Starter Kit Quantity and Frequency: _____
- Cimzia 200 mg PFS (prefilled syringe) Quantity and Frequency: _____
- Cimzia Kit (lyophilized powder - vial) Quantity and Frequency: _____
- Other _____

b) **Maintenance dose:**

- Cimzia 200 mg PFS (prefilled syringe) Quantity and Frequency: _____
- Cimzia Kit (lyophilized powder - vial) Quantity and Frequency: _____
- Other _____

2. Has the patient been diagnosed with any of the following?

- Moderately to severely active rheumatoid arthritis (RA)
- Active psoriatic arthritis WITH co-existent plaque psoriasis (PsA)
- Active psoriatic arthritis WITHOUT co-existent plaque psoriasis (PsA)
- Moderately to severely active Crohn's disease (CD)
- Active ankylosing spondylitis (AS)
- Active axial spondyloarthritis
- Moderate to severe plaque psoriasis
- Other ____

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

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. MR Cimzia SGM -06/2021.

CVS Caremark Specialty Pharmacy • 2211 Sanders Road NBT-6 • Northbrook, IL 60062

Phone: 1-888-877-0518 • Fax: 1-855-330-1720 • www.caremark.com

3. What is the ICD-10 code? _____
4. What is the patient's weight? ___kg/lbs (*circle one*)

Section A: All Requests

5. 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
6. 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? *If Yes, skip to #8*
 Yes No
7. 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 #10* Yes No
8. 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 #13*
9. Has the patient been tested for tuberculosis (TB) within the previous 12 months? Yes No
10. What were the results of the tuberculosis (TB) test?
 Positive for TB Negative for TB, *skip to #13* Unknown
11. Does the patient have latent or active tuberculosis (TB)? Latent Active Unknown
12. Has treatment for latent tuberculosis (TB) infection been initiated or completed?
 Yes—treatment initiated Yes—treatment completed No
13. Is this request for continuation of therapy with the requested drug? Yes No *If No, skip to diagnosis section.*
14. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program? Yes No Unknown *If Yes, or unknown, skip to diagnosis section*
15. 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

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

Section B: Rheumatoid Arthritis

Continuation

16. Has the patient achieved or maintained positive clinical response since starting treatment with the requested drug?
 Yes No
17. What is the percent of disease activity improvement from baseline in tender joint count, swollen joint count, pain, or disability? ***ACTION REQUIRED: Please attach chart notes or medical record documentation supporting positive clinical response and no further questions.*** _____%

Initiation

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

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

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. MR Cimzia SGM -06/2021.

CVS Caremark Specialty Pharmacy • 2211 Sanders Road NBT-6 • Northbrook, IL 60062

Phone: 1-888-877-0518 • Fax: 1-855-330-1720 • www.caremark.com

19. Does the patient meet BOTH of the following: a) the patient was tested for the rheumatoid factor (RF) biomarker AND b) the RF biomarker test was positive? **ACTION REQUIRED: If Yes, please attach laboratory results, chart notes, or medical record documentation of biomarker testing and skip to #26.**
 Yes No
20. Does the patient meet BOTH of the following: a) the patient was tested for the anti-cyclic citrullinated peptide (anti-CCP) biomarker AND b) the anti-CCP biomarker test was positive? **ACTION REQUIRED: If Yes, please attach laboratory results, chart notes, or medical record documentation of biomarker testing and skip to #26.**
 Yes No
21. Has the patient been tested for the rheumatoid factor (RF) biomarker? **ACTION REQUIRED: If Yes, please attach laboratory results, chart notes, or medical record documentation of biomarker testing.** Yes No
22. Has the patient been tested for the anti-cyclic citrullinated peptide (anti-CCP) biomarker? **ACTION REQUIRED: If Yes, please attach laboratory results, chart notes, or medical record documentation of biomarker testing** Yes No
23. Has the patient been tested for the C-reactive protein (CRP) and/or erythrocyte sedimentation rate (ESR) biomarker(s)? **ACTION REQUIRED: If Yes, please attach laboratory results, chart notes, or medical record documentation of biomarker testing** Yes No
24. Please indicate if the patient tested positive or negative for the C-reactive protein (CRP) biomarker, or if the test was not completed.
 Positive for CRP Negative for CRP Test for CRP was not completed
25. Please indicate if the patient tested positive or negative for the erythrocyte sedimentation rate (ESR) biomarker, or if the test was not completed.
 Positive for ESR Negative for ESR Test for ESR was not completed
26. 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? **ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy and no further questions.** Yes No
27. Has the patient experienced an intolerance to methotrexate? **ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy and no further questions.** Yes No
28. Does the patient have a contraindication to methotrexate? Yes No
ACTION REQUIRED: If Yes, please attach documentation of clinical reason to avoid therapy and indicate the contraindication: _____

Section C: Ankylosing Spondylitis or Axial Spondyloarthritis

Continuation

29. Which of the following has the patient experienced an improvement in from baseline? **ACTION REQUIRED: Please attach chart notes or medical record documentation supporting positive clinical response and no further questions.**
 Functional status Total spinal pain
 Inflammation (e.g., morning stiffness) None of the above

Initiation

30. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) indicated for active ankylosing spondylitis? **ACTION REQUIRED: If 'Yes', please attach chart notes, medical record documentation, or claims history supporting previous medications tried and no further questions.** Yes No

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

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. MR Cimzia SGM -06/2021.

CVS Caremark Specialty Pharmacy • 2211 Sanders Road NBT-6 • Northbrook, IL 60062

Phone: 1-888-877-0518 • Fax: 1-855-330-1720 • www.caremark.com

31. 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? **ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy. If therapy is if not advisable, please attach documentation of clinical reason to avoid therapy.** Yes No

Section D: Crohn's Disease

32. Has the patient achieved or maintained remission? **ACTION REQUIRED: If 'Yes', please attach chart notes or medical record documentation of remission and no further questions.** Yes No

Continuation

33. Which of the following has the patient experienced an improvement in from baseline? **ACTION REQUIRED: Please attach chart notes or medical record documentation supporting positive clinical response to therapy and no further questions.**
- Abdominal pain or tenderness
 - Diarrhea
 - Body weight
 - Abdominal mass
 - Hematocrit
 - Endoscopic appearance of the mucosa
 - Improvement on a disease activity scoring tool (e.g., Crohn's Disease Activity Index [CDAI] score)
 - None of the above

Initiation

34. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) indicated for moderately to severely active Crohn's disease? **ACTION REQUIRED: If 'Yes', attach chart notes, medical record documentation, or claims history supporting previous medications tried and no further questions.** Yes No
35. Does the patient have fistulizing disease? **ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation supporting diagnosis and no further questions.** Yes No
36. Has the patient tried and had an inadequate response to at least one conventional therapy option? **ACTION REQUIRED: If 'Yes', please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy and no further questions.**
- Yes - Sulfasalazine (Azulfidine, Sulfazine) Yes - Budesonide (Entocort EC)
 - Yes - Mercaptopurine (Purinethol) Yes - Azathioprine (Azasan, Imuran)
 - Yes - Metronidazole (Flagyl) Yes - Methotrexate IM or SC
 - Yes - Ciprofloxacin (Cipro) Yes - Methylprednisolone (Solu-Medrol)
 - Yes - Prednisone Yes - Rifaximin (Xifaxan)
 - Yes - Tacrolimus No
37. Does the patient have a contraindication or intolerance to at least one conventional therapy option (e.g., azathioprine [Azasan, Imuran], budesonide [Entocort EC], ciprofloxacin [Cipro], mercaptopurine [Purinethol], methylprednisolone [Solu-Medrol], methotrexate IM or SC, metronidazole [Flagyl], prednisone, sulfasalazine [Azulfidine, Sulfazine], rifaximin [Xifaxan], tacrolimus)? **ACTION REQUIRED: If 'Yes', please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy. If therapy is not advisable, please attach documentation of clinical reason to avoid therapy.** Yes No

Section E: Psoriatic Arthritis

Continuation

38. Which of the following has the patient experienced an improvement in from baseline? **ACTION REQUIRED: Please attach chart notes or medical record documentation supporting positive clinical response. Please select all that apply**
- Number of swollen joints

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

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. MR Cimzia SGM -06/2021.

CVS Caremark Specialty Pharmacy • 2211 Sanders Road NBT-6 • Northbrook, IL 60062

Phone: 1-888-877-0518 • Fax: 1-855-330-1720 • www.caremark.com

- Number of tender joints
- Dactylitis
- Enthesitis
- Skin and/or nail involvement
- None of the above

Section F: Plaque Psoriasis

Continuation

39. Has the patient experienced a reduction in body surface area (BSA) affected from baseline? **ACTION REQUIRED: If 'Yes', please attach chart notes or medical record documentation of decreased body surface area affected and no further questions.** Yes No
40. Has the patient experienced an improvement in signs and symptoms of the condition from baseline (e.g., itching, redness, flaking, scaling, burning, cracking, pain)? **ACTION REQUIRED: If 'Yes', please attach chart notes or medical record documentation of improvement in signs and symptoms.** Yes No

Initiation

41. 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? **ACTION REQUIRED: If 'Yes', attach chart notes, medical record documentation, or claims history supporting previous medications tried and no further questions...**
 Yes No
42. Are crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) affected? **ACTION REQUIRED: If 'Yes', please attach chart notes or medical record documentation of affected areas and body surface area affected and no further questions.** Yes No
43. What is the percentage of body surface area (BSA) affected (prior to starting the requested medication)?
ACTION REQUIRED: Please attach chart notes or medical record documentation of affected areas and body surface area affected. _____% *If greater than or equal to 10% of BSA, no further questions.*
44. 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? **ACTION REQUIRED: If 'Yes', please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy. If therapy is not advisable, please attach documentation of clinical reason to avoid therapy.** Yes No
45. Does the patient have a clinical reason to avoid pharmacologic treatment with methotrexate, cyclosporine and acitretin? **ACTION REQUIRED: If 'Yes', please attach documentation of clinical reason to avoid therapy** Yes No
If Yes, indicate the clinical reason: _____

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

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. MR Cimzia SGM -06/2021.

**CVS Caremark Specialty Pharmacy • 2211 Sanders Road NBT-6 • Northbrook, IL 60062
 Phone: 1-888-877-0518 • Fax: 1-855-330-1720 • www.caremark.com**

Step Therapy Override: Complete if Applicable for the state of Maryland.	Please Circle	
Is the requested drug being used to treat stage four advanced metastatic cancer?	Yes	No
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
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
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
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

Step Therapy Override: Complete if Applicable for the state of Virginia.	Please Circle	
Is the requested drug being used for an FDA-approved indication or an indication supported in the compendia of current literature (examples: AHFS, Micromedex, current accepted guidelines)?	Yes	No
Does the prescribed dose and quantity fall within the FDA-approved labeling or within dosing guidelines found in the compendia of current literature?	Yes	No
Is the request for a brand drug that has an AB-rated generic equivalent or interchangeable biological product available?	Yes	No
Has the patient had a trial and failure of the AB-rated generic equivalent or interchangeable biological product due to an adverse event (examples: rash, nausea, vomiting, anaphylaxis) that is thought to be due to an inactive ingredient?	Yes	No
Is the preferred drug contraindicated?	Yes	No
Is the preferred drug expected to be ineffective based on the known clinical characteristics of the patient and the prescription drug regimen?	Yes	No
Has the patient tried the preferred drug while on their current or previous health benefit plan and it was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event?	Yes	No
Is the patient currently receiving a positive therapeutic outcome with the requested drug for their medical 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)

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

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. MR Cimzia SGM -06/2021.

CVS Caremark Specialty Pharmacy • 2211 Sanders Road NBT-6 • Northbrook, IL 60062

Phone: 1-888-877-0518 • Fax: 1-855-330-1720 • www.caremark.com