CVS caremark™ {{PANUMCODE}}

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 1-866-249-6155**. 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: {{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?
   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 (PsA) WITH co-existent plaque psoriasis
   - ❑ Active psoriatic arthritis (PsA) WITHOUT co-existent plaque psoriasis
   - ❑ Active ankylosing spondylitis (AS)
   - ❑ Active non-radiographic axial spondyloarthritis
   - ❑ Moderately to severely active Crohn's disease (CD)
   - ❑ Moderate to severe plaque psoriasis
   - ❑ Other _____

3. What is the ICD-10 code? _____

4. What is the patient's weight? _____ kg/lbs ***(circle one)***

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

Section A: Preferred Product

5. These are the preferred products for which coverage is provided for treatment of the following indications:
   a) Ankylosing spondylitis: **Cosentyx, Enbrel, Humira, Remicade, Simponi Aria**
   b) Crohn's disease: **Humira, Remicade, Stelara (IV) (secondary)***
   c) Non-radiographic axial spondyloarthritis: **Cimzia syringe, Cosentyx**
   d) Plaque psoriasis: **Humira, Otezla, Remicade, Skyrizi, Stelara (SC), Taltz, Tremfya**
   e) Psoriatic arthritis: **Cosentyx, Enbrel, Humira, Otezla, Remicade, Simponi Aria, Stelara (SC), Tremfya**
   f) Rheumatoid arthritis: **Enbrel, Humira, Kevzara, Orencia /Orencia Clickject, Remicade, Rinvoq, Simponi Aria, Xeljanz/Xeljanz XR, Cimzia syringe (secondary)***
   Note: Secondary preferred product for CD is Stelara, and for RA is Cimzia syringe. This preferred product option only applies to members who have had a documented inadequate response or intolerable adverse event with primary preferred products.
   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*

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

7. Is the patient currently receiving the requested product through samples or a manufacturer's patient assistance program? If unknown, answer Yes. ❑ Yes ❑ No

8. Is the patient currently pregnant or breastfeeding? *If Yes, skip to Section B: All Requests* ❑ Yes ❑ No

9. 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.*

❑ Cimzia syringe:	❑ Inadequate response	❑ Intolerable adverse event
❑ Cosentyx:	❑ Inadequate response	❑ Intolerable adverse event
❑ Enbrel:	❑ Inadequate response	❑ Intolerable adverse event
❑ Humira:	❑ Inadequate response	❑ Intolerable adverse event
❑ Kevzara:	❑ Inadequate response	❑ Intolerable adverse event
❑ Orencia (Clickject):	❑ Inadequate response	❑ Intolerable adverse event
❑ Otezla:	❑ Inadequate response	❑ Intolerable adverse event
❑ Remicade:	❑ Inadequate response	❑ Intolerable adverse event
❑ Rinvoq:	❑ Inadequate response	❑ Intolerable adverse event
❑ Simponi Aria:	❑ Inadequate response	❑ Intolerable adverse event
❑ Skyrizi:	❑ Inadequate response	❑ Intolerable adverse event
❑ Stelara (SC):	❑ Inadequate response	❑ Intolerable adverse event
❑ Stelara (IV):	❑ Inadequate response	❑ Intolerable adverse event
❑ Taltz:	❑ Inadequate response	❑ Intolerable adverse event
❑ Tremfya:	❑ Inadequate response	❑ Intolerable adverse event
❑ Xeljanz/Xeljanz XR:	❑ Inadequate response	❑ Intolerable adverse event
❑ No- None of the above		

10. Does the patient have one of the following documented clinical reasons to avoid the preferred products that are TNF inhibitors (Remicade and/or 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

Section B: All Requests

11. 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

12. 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 #14* ❑ Yes ❑ No

13. 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 #16* ❑ Yes ❑ No

14. 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 #19*

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

16. What were the results of the tuberculosis (TB) test?
❑ Positive for TB ❑ Negative for TB, *skip to #19* ❑ Unknown

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

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

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

20. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program? ❑ Yes ❑ No ❑ Unknown

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

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

Section C: Rheumatoid Arthritis

Continuation

22. Has the patient achieved or maintained positive clinical response since starting treatment with the requested drug?
❑ Yes ❑ No

23. 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***. _____ *%*

Initiation

24. 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?
ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medication tried and no further questions. ❑ Yes ❑ No

25. 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 #32.*** ❑ Yes ❑ No

26. 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 #32.*** ❑ Yes ❑ No

27. 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

28. 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

29. 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

30. 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

31. 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

32. 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

33. 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

34. Does the patient have a contraindication to methotrexate? ***ACTION REQUIRED: If Yes, please attach documentation of clinical reason to avoid therapy.*** ❑ Yes ❑ No
If Yes, indicate the contraindication: _____

Section D: Ankylosing Spondylitis or Axial Spondyloarthritis

Continuation

35. Which of the following has the patient experienced an improvement in from baseline?
ACTION REQUIRED: Please attach chart notes or medical records supporting positive clinical response.
❑ Functional status ❑ Total spinal pain ❑ Inflammation (e.g., morning stiffness) ❑ None of the above

Initiation

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

37. Has the patient experienced an inadequate response with at least TWO nonsteroidal anti-inflammatory drugs (NSAIDs), or does the patient have 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 not advisable, please attach documentation of clinical reason to avoid therapy. ❑ Yes ❑ No

Section E: Crohn's Disease

Continuation

38. 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

39. Which of the following has the patient experienced an improvement in from baseline? ***ACTION REQUIRED: Please attach chart notes or medical records supporting positive clinical response.***
    - ❑ Abdominal pain or tenderness
    - ❑ Body weight
    - ❑ Hematocrit
    - ❑ Diarrhea
    - ❑ Abdominal mass
    - ❑ 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

40. 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

41. Does the patient have fistulizing Crohn's disease? ***ACTION REQUIRED: If Yes, please attach supporting chart notes or medical record documentation supporting diagnosis and no further questions.*** ❑ Yes ❑ No

42. Has the patient tried and had an inadequate response to at least one conventional therapy option? ***ACTION REQUIRED: If Yes, please attach patient's chart notes, medical record documentation, or claims history of previous medications tried, including response to therapy and no further questions.***
    - ❑ Yes - Sulfasalazine (Azulfidine, Sulfazine)
    - ❑ Yes - Metronidazole (Flagyl)
    - ❑ Yes - Ciprofloxacin (Cipro)
    - ❑ Yes - Prednisone
    - ❑ Yes - Budesonide (Entocort EC)
    - ❑ Yes - Azathioprine (Azasan, Imuran)
    - ❑ Yes - Mercaptopurine (Purinethol)
    - ❑ Yes - Methotrexate
    - ❑ Yes - Methylprednisolone (Solu-Medrol)
    - ❑ Yes - Rifaximin (Xifaxan)
    - ❑ Yes - Tacrolimus
    - ❑ No

43. 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 if not advisable, please attach documentation of clinical reason to avoid therapy.*** ❑ Yes ❑ No

Section F: Plaque Psoriasis

Continuation

44. 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

45. 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

Initial Request

46. 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

47. 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

48. 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, and no further questions*

49. 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, and no further questions.*** ❑ Yes ❑ No

50. 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 clinical reason: _____

Section G: Psoriatic Arthritis

51. *If continuation of therapy,* 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.***
❑ Number of swollen joints ❑ Number of tender joints ❑ Dactylitis ❑ Enthesitis
❑ Skin and/or nail involvement ❑ None of the above

52. Does the patient have psoriatic arthritis with co-existent plaque psoriasis? ❑ 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