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.

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 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
     Please indicate primary diagnosis being treated:
     - ❑ Active psoriatic arthritis ❑ Moderate to severe plaque psoriasis
   - ❑ Active non-radiographic axial spondyloarthritis
   - ❑ Moderately to severely active Crohn's disease (CD)
   - ❑ Active psoriatic arthritis (PsA)
   - ❑ Active ankylosing spondylitis (AS)
   - ❑ Moderate to severe plaque psoriasis
   - ❑ Other _____

3. What is the ICD-10 code? _____

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

Section A: Preferred Product

5. These are the preferred products for which coverage is provided for treatment of the following indications:
   Question continues on next page.
   a) Ankylosing spondylitis: **Cosentyx, Enbrel, Humira, Remicade, Rinvoq, Simponi Aria**
   b) Crohn's disease: **Humira, Remicade, Rinvoq, Skyrizi (IV), Skyrizi (SC), Stelara (IV), Stelara (SC)**
   c) Plaque psoriasis: **Humira, Ilumya, Otezla, Remicade, Skyrizi, Sotyktu, Stelara (SC), Taltz, Tremfya**
   d) Psoriatic arthritis: **Cosentyx, Enbrel, Humira, Otezla, Remicade, Rinvoq, Simponi Aria, Skyrizi, Stelara (SC), Tremfya**

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

e) Rheumatoid arthritis: **Enbrel, Humira, Kevzara, Orencia /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 non-preferred product, Cimzia
❑ Not applicable - Requested for condition not listed above, *skip to Section B: All Requests.*

6. *If request is for Cimzia syringe*, is this request for continuation of therapy with the requested product?
❑ Yes ❑ No ❑ N/A, request is for Cimzia vial *If No or N/A, 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 breastfeeding, pregnant, or planning pregnancy?
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
❑ Ilumya:	❑ 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 (IV):	❑ Inadequate response	❑ Intolerable adverse event
❑ Skyrizi (SC):	❑ Inadequate response	❑ Intolerable adverse event
❑ Sotyktu:	❑ Inadequate response	❑ Intolerable adverse event
❑ Stelara (IV):	❑ Inadequate response	❑ Intolerable adverse event
❑ Stelara (SC):	❑ 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

Section B: All Requests

10. Is the requested drug being prescribed by or in consultation with any of the following?
❑ Yes - Dermatologist ❑ Yes - Gastroenterologist ❑ Yes - Rheumatologist ❑ No - None of the above

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

12. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic drug (e.g., Olumiant, Xeljanz) associated with an increased risk of tuberculosis? *If Yes, skip to #16* ❑ 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? ❑ Yes ❑ No

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

15. Does the patient have latent or active tuberculosis (TB)?
    - ❑ Patient has latent TB and treatment for latent TB has been initiated
    - ❑ Patient has latent TB and treatment for latent TB has been completed
    - ❑ Patient has latent TB and treatment for latent TB has not been initiated
    - ❑ Patient has active TB

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? ❑ Yes ❑ No ❑ Unknown

18. Has the patient achieved or maintained a 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

19. Has the patient experienced substantial disease activity improvement (e.g., at least 20% from baseline) in tender joint count, swollen joint count, pain, or disability? ***ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation supporting positive clinical response and substantial disease activity improvement.***
    ❑ Yes ❑ No

Initiation

20. Has the patient ever received or is currently receiving a biologic (e.g., Humira) or targeted synthetic drug (e.g., Rinvoq, Xeljanz) indicated for moderately to severely active rheumatoid arthritis (excluding receiving the drug via samples or a manufacturer's patient assistance program)? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried and no further questions.*** ❑ Yes ❑ No

21. Does the patient meet either of the following: a) the patient was tested for the rheumatoid factor (RF) biomarker and the RF biomarker test was positive, or b) the patient was tested for the anti-cyclic citrullinated peptide (anti-CCP) biomarker and 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 #23.***
    ❑ Yes ❑ No

22. Has the patient been tested for all of the following biomarkers: a) rheumatoid factor (RF), b) anti-cyclic citrullinated peptide (anti-CCP), and c) C-reactive protein (CRP) and/or erythrocyte sedimentation rate (ESR)? ***ACTION REQUIRED: If Yes, please attach laboratory results, chart notes, or medical record documentation of biomarker testing.*** ❑ Yes ❑ No

23. Has the patient experienced an inadequate response after at least 3 months of treatment with methotrexate at a dose greater than or equal to 15 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

24. 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

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

26. Please indicate the contraindication to methotrexate. *List continues on next page.*
    - ❑ Clinical diagnosis of alcohol use disorder, alcoholic liver disease, or other chronic liver disease
    - ❑ Drug interaction
    - ❑ Risk of treatment-related toxicity
    - ❑ Pregnancy or currently planning pregnancy

❑ Breastfeeding
❑ Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension)
❑ Hypersensitivity
❑ History of intolerance or adverse event
❑ Other: _____

Section D: Psoriatic Arthritis

Continuation

27. 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 ❑ Dactylitis ❑ Number of tender joints
❑ Skin and/or nail involvement ❑ Enthesitis ❑ Axial disease
❑ None of the above

Initiation

28. Has the patient ever received or is currently receiving a biologic or targeted synthetic drug (e.g., Rinvoq, Otezla) indicated for active psoriatic arthritis (excluding receiving the drug via samples or a manufacturer's patient assistance program)? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried and no further questions.*** ❑ Yes ❑ No

29. What is the patient's disease severity? ❑ Mild to moderate ❑ Severe *If Severe, no further questions.*

30. Does the patient have enthesitis or predominantly axial disease? *If Yes, no further questions.* ❑ Yes ❑ No

31. Has the patient had an inadequate response to methotrexate, leflunomide, or another conventional synthetic drug (e.g., sulfasalazine) administered at an adequate dose and duration? ***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

32. Has the patient had an intolerance to methotrexate, leflunomide, or another conventional synthetic drug (e.g., sulfasalazine)? ***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. Does the patient have a contraindication to methotrexate or leflunomide? ***ACTION REQUIRED: If Yes, please attach documentation of clinical reason to avoid therapy and no further questions.*** ❑ Yes ❑ No

34. Please indicate the contraindication to methotrexate or leflunomide.
❑ Clinical diagnosis of alcohol use disorder, alcoholic liver disease, or other chronic liver disease
❑ Drug interaction
❑ Risk of treatment-related toxicity
❑ Pregnancy or currently planning pregnancy
❑ Breastfeeding
❑ Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension)
❑ Hypersensitivity
❑ History of intolerance or adverse event
❑ Other: _____

35. Does the patient have a contraindication to another conventional synthetic drug (e.g., sulfasalazine)? ***ACTION REQUIRED: If Yes, please attach documentation of clinical reason to avoid therapy.***
❑ Yes ❑ No

Section E: Ankylosing Spondylitis or Non-radiographic Axial Spondyloarthritis

Continuation

36. 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

37. Has the patient ever receivedor is currently receiving a biologic (e.g., Humira) or targeted synthetic drug (e.g., Rinvoq, Xeljanz) that is indicated for active ankylosing spondylitis or active non-radiographic axial spondyloarthritis (excluding receiving the drug via samples or a manufacturer's patient assistance program)? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried and no further questions.*** ❑ Yes ❑ No

38. 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 (if applicable), including response to therapy. If therapy is not advisable, please attach documentation of clinical reason to avoid therapy.*** ❑ Yes ❑ No

Section F: Crohn's Disease

Continuation

39. 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

40. 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
    ❑ Appearance of the mucosa on endoscopy, computed tomography enterography (CTE), magnetic resonance enterography (MRE), or intestinal ultrasound
    ❑ Improvement on a disease activity scoring tool (e.g., Crohn's Disease Activity Index [CDAI] score)
    ❑ None of the above

Section G: Plaque Psoriasis

Continuation

41. 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

42. 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

43. Has the patient ever received or is currently receiving a biologic (e.g., Humira) or targeted synthetic drug (e.g., Sotyktu, Otezla) indicated for the treatment of moderate to severe plaque psoriasis (excluding receiving the drug via samples or a manufacturer's patient assistance program)? ***ACTION REQUIRED: If Yes, attach chart notes, medical record documentation, or claims history supporting previous medications tried and no further questions.*** ❑ Yes ❑ No

44. 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 no further questions.*** ❑ Yes ❑ No

45. What is the percentage of body surface area (BSA) affected (prior to starting the requested medication)? Indicate percentage. ***ACTION REQUIRED: Please attach chart notes or medical record documentation of body surface area affected.*** _____ % *If greater than or equal to 10% of BSA, no further questions.*

46. 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

47. 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

48. Please indicate the contraindication to methotrexate or leflunomide.
❑ Clinical diagnosis of alcohol use disorder, alcoholic liver disease, or other chronic liver disease
❑ Drug interaction
❑ Risk of treatment-related toxicity
❑ Pregnancy or currently planning pregnancy
❑ Breastfeeding
❑ Cannot be used due to risk of treatment-related toxicity
❑ Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension)
❑ Hypersensitivity
❑ History of intolerance or adverse event
❑ Other: _____

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