Cosentyx

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

Criteria Questions:

1. What is the diagnosis?
   - ❑ Moderate to severe plaque psoriasis
   - ❑ Active axial spondyloarthritis
   - ❑ Active ankylosing spondylitis (AS)
   - ❑ Active psoriatic arthritis (PsA) with co-existent plaque psoriasis
   - ❑ Active psoriatic arthritis (PsA) WITHOUT co-existent plaque psoriasis
   - ❑ Other _____
2. What is the ICD-10 code? _____
3. 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
4. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic DMARD (e.g., Olumiant, Xeljanz)? *If Yes, skip to #6* ❑ Yes ❑ No
5. Has the patient had a tuberculosis (TB) test (e.g., tuberculosis skin test [PPD], an interferon-release assay [IGRA], or a chest x-ray) within 6 months of initiating therapy? *If Yes, skip to #8* ❑ Yes ❑ No
6. 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 #11*
7. Has the patient been tested for tuberculosis (TB) within the previous 12 months? ❑ Yes ❑ No
8. What were the results of the tuberculosis (TB) test?
   ❑ Positive for TB ❑ Negative for TB, *skip to #11* ❑ Unknown
9. Does the patient have latent or active tuberculosis (TB)? ❑ Latent ❑ Active ❑ Unknown
10. Has treatment for latent tuberculosis (TB) infection been initiated or completed?
    ❑ Yes - treatment initiated ❑ Yes - treatment completed ❑ No
11. Is this request for continuation of therapy with the requested drug?
    ❑ Yes ❑ No *If No, skip to diagnosis section.*
12. 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
13. 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
14. *If diagnosis is plaque psoriasis,* 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 skip to #23*** ❑ Yes ❑ No
15. *If diagnosis is plaque psoriasis,* 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 and skip to #23*** ❑ Yes ❑ No
16. *If diagnosis is ankylosing spondylitis or axial spondyloarthritis,* which of the following has the patient experienced an improvement in from baseline?

ACTION REQUIRED: Please attach chart notes or medical record documentation of improvement in signs and symptoms. *After question answered, skip to section B1 or B2 depending on diagnosis.*

❑ Functional status
❑ Inflammation (e.g., morning stiffness)
❑ Total spinal pain
❑ None of the above

17. *If diagnosis is psoriatic arthritis,* 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.*** *After question answered, skip to diagnosis section.*
    ❑ Number of swollen joints
    ❑ Dactylitis
    ❑ Skin and/or nail involvement
    ❑ Enthesitis
    ❑ Number of tender joints
    ❑ None of the above

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

Section A: Plaque Psoriasis

18. 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', please attach chart notes, medical record documentation, or claims history supporting previous medications tried and skip to #23.***
    ❑ Yes ❑ No

19. 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 skip to #23*** ❑ Yes ❑ No.

20. 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 area and body surface area affected.*** _____ *% If greater than or equal to 10% of BSA, skip to #23*

21. 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 skip to #23*** ❑ Yes ❑ No

22. 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:*** _____

23. Is the patient currently receiving Cosentyx? ❑ Yes ❑ No *If No, skip to #26*

24. Does the prescribed dose exceed 300 mg? ❑ Yes ❑ No

25. Is the prescribed frequency for the maintenance dose more frequent than one dose every 4 weeks?
    ❑ Yes ❑ No *No further questions*

26. Does the prescribed dose exceed a loading dose of 300 mg at weeks 0, 1, 2, 3, and 4, and a maintenance dose of 300 mg thereafter? ❑ Yes ❑ No

27. Is the prescribed frequency for the maintenance dose more frequent than one dose every 4 weeks?
    ❑ Yes ❑ No

Section B: Ankylosing Spondylitis and Axial Spondyloarthritis (see section B1 and B2 for additional questions based on specific diagnosis)

28. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) indicated for the treatment of 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.*** *If Yes,skip to section B1 or B2 depending on diagnosis* ❑ Yes ❑ No

29. 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 *Go to section B1 or B2 depending on diagnosis.* ❑ Yes ❑ No

Section B1: Ankylosing spondylitis

30. Is the patient currently receiving Cosentyx? ❑ Yes ❑ No *If No, skip to #36*

31. Does the prescribed dose exceed 150 mg? *If Yes, skip to #33* ❑ Yes ❑ No

32. Is the prescribed frequency for the maintenance dose more frequent than one dose every 4 weeks?
❑ Yes ❑ No *No further questions*

33. Did the patient continue to have active ankylosing spondylitis at the 150 mg dose? ❑ Yes ❑ No

34. Does the prescribed dose exceed 300 mg? ❑ Yes ❑ No

35. Is the prescribed frequency for the maintenance dose more frequent than one dose every 4 weeks?
❑ Yes ❑ No *No further questions*

36. Does the prescribed dose exceed a loading dose of 150 mg at weeks 0, 1, 2, 3, and 4, and a maintenance dose of 150 mg thereafter? ❑ Yes ❑ No

37. Is the prescribed frequency for the maintenance dose more frequent than one dose every 4 weeks?
❑ Yes ❑ No

Section B2: Axial spondyloarthritis

38. Is the patient currently receiving Cosentyx? ❑ Yes ❑ No *If No, skip to #41*

39. Does the prescribed dose exceed 150 mg? ❑ Yes ❑ No

40. Is the prescribed frequency for the maintenance dose more frequent than one dose every 4 weeks?
❑ Yes ❑ No *No further questions*

41. Does the prescribed dose exceed a loading dose of 150 mg at weeks 0, 1, 2, 3, and 4, and a maintenance dose of 150 mg thereafter? ❑ Yes ❑ No

42. Is the prescribed frequency for the maintenance dose more frequent than one dose every 4 weeks?
❑ Yes ❑ No

Section C: Psoriatic Arthritis WITHOUT co-existent plaque psoriasis

43. Does the prescribed dose exceed a loading dose of 150 mg at weeks 0, 1, 2, 3, and 4, and a maintenance dose of 150 mg thereafter? ❑ Yes ❑ No

44. Is the prescribed frequency for the maintenance dose more frequent than one dose every 4 weeks? ❑ Yes ❑ No

Section D: Psoriatic Arthritis WITH co-existent plaque psoriasis

45. Is the patient currently receiving Cosentyx? ❑ Yes ❑ No *If No, skip to #48*

46. Does the prescribed dose exceed 300 mg? ❑ Yes ❑ No

47. Is the prescribed frequency for the maintenance dose more frequent than one dose every 4 weeks?
❑ Yes ❑ No *No further questions*

48. Does the prescribed dose exceed a loading dose of 300 mg at weeks 0, 1, 2, 3, and 4, and a maintenance dose of 300 mg thereafter? ❑ Yes ❑ No

49. Is the prescribed frequency for the maintenance dose more frequent than one dose every 4 weeks?
❑ 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