CVS caremark™ {{PANUMCODE}}

# Enbrel

## 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?
   a) **Loading dose:**
   ❑ Enbrel 50 mg Quantity and Frequency: _____
   ❑ Enbrel 25 mg Quantity and Frequency: _____
   ❑ Other _____
   b) **Maintenance dose:**
   ❑ Enbrel 50 mg Quantity and Frequency: _____
   ❑ Enbrel 25 mg Quantity and Frequency: _____
   ❑ Other _____

2. Is the requested quantity supported by dosing guidelines found in the compendia or current literature (e.g., Micromedex DrugDex, NCCN compendia, current treatment guidelines)? ❑ Yes ❑ No

3. Has the patient been diagnosed with any of the following?
   ❑ Moderately to severely active rheumatoid arthritis (RA)
   ❑ Moderate to severe plaque psoriasis
   ❑ Active psoriatic arthritis (PsA)
   ❑ Active ankylosing spondylitis (AS)
   ❑ Active axial spondyloarthritis
   ❑ Pyoderma gangrenosum
   ❑ Reactive arthritis
   ❑ Active articular juvenile idiopathic arthritis
   ❑ Behcet's disease
   ❑ Graft versus host disease
   ❑ Severe, refractory hidradenitis suppurativa
   ❑ Moderately to severely active **polyarticular** juvenile idiopathic arthritis (pJIA)
   ❑ Moderately to severely active **oligoarticular** juvenile idiopathic arthritis
   ❑ Other _____

4. What is the ICD-10 code? _____

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

6. Does the patient have a latex allergy? ❑ Yes ❑ No

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

Section A: Preferred Product - For Plaque Psoriasis

7. These are the preferred products for which coverage is provided for the treatment of plaque psoriasis: **Humira, Otezla, Remicade, Skyrizi, Stelara, Taltz, Tremfya.**
   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 other than plaque psoriasis, *skip to Section B: All Requests*

8. Does the patient have a documented inadequate response or intolerable adverse event to any of the preferred products indicated for plaque psoriasis (Humira, Otezla, Skyrizi, Stelara, Taltz, Tremfya)?
   ***ACTION REQUIRED: If Yes, attach supporting chart note(s).*** *Indicate ALL that apply.*

| | | |
|---|---|---|
| ❑ Humira: | ❑ Inadequate response | ❑ Intolerable adverse event |
| ❑ Otezla: | ❑ Inadequate response | ❑ Intolerable adverse event |
| ❑ Skyrizi: | ❑ Inadequate response | ❑ Intolerable adverse event |
| ❑ Stelara: | ❑ Inadequate response | ❑ Intolerable adverse event |
| ❑ Taltz: | ❑ Inadequate response | ❑ Intolerable adverse event |
| ❑ Tremfya: | ❑ Inadequate response | ❑ Intolerable adverse event |

   ❑ No - none of the above

9. Does the patient have one of the following documented clinical reasons to avoid the preferred product that is a TNF inhibitor (Humira)? ***ACTION REQUIRED: If Yes, attach supporting chart note(s).***
   ❑ 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
   ❑ Not applicable - requested medication is a TNF inhibitor

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 anti-rheumatic 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., Rinvoq, Xeljanz) associated with an increased risk of tuberculosis? *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 #18*

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 #18* ❑ 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

18. Is this request for continuation of therapy with the requested drug? ❑ Yes ❑ No *If No, skip to #21*

19. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program? *If Yes or Unknown, skip to #21* ❑ Yes ❑ No ❑ Unknown

20. 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 *No further questions*

21. Has the patient ever received any of the following (including current utilizers)?
***Indicate ALL that apply and skip to diagnosis section.***
❑ A biologic medication (e.g. Humira) indicated for the diagnosis
❑ Targeted synthetic DMARD (e.g., Rinvoq, Xeljanz) indicated for the diagnosis
❑ Otezla
❑ No - None of the above

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

Section C: Rheumatoid Arthritis and Reactive Arthritis

22. 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

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

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

Section D: Juvenile Idiopathic Arthritis

25. 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

26. 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

27. 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 E: Ankylosing Spondylitis or Axial Spondyloarthritis

28. 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? ❑ Yes ❑ No

Section F: Plaque Psoriasis

29. Are crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) affected? *If Yes, no further questions.* ❑ Yes ❑ No

30. What is the percentage of body surface area (BSA) affected (prior to starting the requested medication)?
_____ % *If greater than or equal to 10% of BSA, no further questions.*

31. 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?
*If Yes, no further questions.* ❑ Yes ❑ No

32. Does the patient have a clinical reason to avoid pharmacologic treatment with methotrexate, cyclosporine, and acitretin? ❑ Yes ❑ No
***If Yes, indicate the clinical reason:*** _____

Section G: Hidradenitis Suppurativa

33. Has the patient experienced an inadequate response after at least 90 days of treatment with oral antibiotics?
*If Yes, no further questions.* ❑ Yes ❑ No

34. Has the patient experienced an intolerable adverse effect to oral antibiotics?
*If Yes, no further questions.* ❑ Yes ❑ No

35. Does the patient have a contraindication to oral antibiotics? ❑ Yes ❑ No

Section H: Graft Versus Host Disease

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

37. Has the patient experienced an intolerance or contraindication to corticosteroids? ❑ Yes ❑ No

Section I: Behcet's Disease

38. Has the patient had an inadequate response to at least one nonbiologic medication for Behçet's disease (e.g., colchicine, systemic glucocorticoids, azathioprine)? ❑ Yes ❑ No

Section J: Pyoderma Gangrenosum

39. Has the patient experienced an inadequate response to corticosteroids or immunosuppressive therapy (e.g., cyclosporine, mycophenolate mofetil)? *If Yes, no further questions.* ❑ Yes ❑ No

40. Has the patient experienced an intolerance to corticosteroids and immunosuppressive therapy (e.g., cyclosporine, mycophenolate mofetil)? *If Yes, no further questions.* ❑ Yes ❑ No

41. Does the patient have a contraindication to corticosteroids and immunosuppressive therapy (e.g., cyclosporine, mycophenolate mofetil)? ❑ 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**