CVS caremark™ {{PANUMCODE}}

Humira

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:**
      - ❑ Humira pediatric Crohn's starter pack
      - ❑ Humira adult Crohn's/UC/HS starter pack
      - ❑ Humira psoriasis, uveitis, adolescent HS starter pack
      - ❑ Other _____

   b) **Maintenance dose:**
      - ❑ Humira 10 mg PFS/Pen Quantity and Frequency: _____
      - ❑ Humira 20 mg PFS/Pen Quantity and Frequency: _____
      - ❑ Humira 40 mg PFS/Pen Quantity and Frequency: _____
      - ❑ Humira 80 mg PFS/Pen Quantity and Frequency: _____
      - ❑ Other _____

2. Has the patient been diagnosed with any of the following?
   - ❑ Moderately to severely active rheumatoid arthritis (RA)
   - ❑ Moderately to severely active Crohn's disease (CD)
   - ❑ Moderate to severe plaque psoriasis
   - ❑ Moderately to severely active ulcerative colitis (UC)
   - ❑ Active psoriatic arthritis (PsA)
   - ❑ Active ankylosing spondylitis (AS)
   - ❑ Active axial spondyloarthritis
   - ❑ Moderately to severely active polyarticular juvenile idiopathic arthritis (pJIA)
   - ❑ Oligoarticular juvenile idiopathic arthritis
   - ❑ Active systemic juvenile idiopathic arthritis
   - ❑ Moderate to severe hidradenitis suppurativa
   - ❑ Behcet's disease
   - ❑ Pyoderma gangrenosum
   - ❑ Non-infectious intermediate, posterior or panuveitis uveitis
   - ❑ Other _____

3. What is the ICD-10 code? _____

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

4. What is the patient's weight? _____ kg or lbs ***(circle one)***
5. Will the requested drug be used in combination with any other biologic or targeted synthetic disease-modifying antirheumatic drug (DMARD) (e.g., Olumiant, Xeljanz)? ❑ Yes ❑ No
6. Has the patient ever received (including current utilizers) a biologic or targeted synthetic DMARD (e.g., Rinvoq, 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 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? *If Yes or Unknown, skip to diagnosis section.* ❑ Yes ❑ No ❑ Unknown
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 A: Rheumatoid Arthritis

16. Has the patient ever received (including current utilizers) a biologic or targeted synthetic DMARD (e.g., Rinvoq, Xeljanz) that is indicated for moderately to severely active rheumatoid arthritis?
    If Yes, no further questions. ❑ Yes ❑ No
17. Has the patient experienced an inadequate response after at least 3 months of treatment with methotrexate dose greater than or equal to 20 mg per week? *If Yes, no further questions.* ❑ Yes ❑ No
18. Has the patient experienced intolerance to methotrexate? *If Yes, no further questions.* ❑ Yes ❑ No
19. Does the patient have a contraindication to methotrexate? ❑ Yes ❑ No
    If Yes, indicate contraindication: _____

Section B: Polyarticular Juvenile Idiopathic Arthritis, Oligoarticular Juvenile Idiopathic Arthritis

20. Has the patient ever received (including current utilizers) a biologic or targeted synthetic DMARD indicated for moderately to severely active articular juvenile idiopathic arthritis? *If Yes, no further questions.* ❑ Yes ❑ No
21. 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
22. Does the patient have any of the following risk factors: a) positive rheumatoid factor, b) positive anti-cyclic citrullinated peptide antibodies, or c) pre-existing joint damage? ❑ Yes ❑ No

23. Does the patient meet any of the following: a) high-risk joints are involved (e.g., cervical spine, wrist, or hip), b) high disease activity, or c) high risk for disabling joint disease? ❑ Yes ❑ No

Section C: Ankylosing Spondylitis or Axial Spondyloarthritis

24. Has the patient ever received (including current utilizers) a biologic indicated for active ankylosing spondylitis or active axial spondyloarthritis? *If Yes, no further questions.* ❑ Yes ❑ No

25. 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 D: Crohn's Disease

26. Has the patient ever received (including current utilizers) a biologic indicated for Crohn's disease? *If Yes, no further questions.* ❑ Yes ❑ No

27. Does the patient have fistulizing Crohn's disease? *If Yes, no further questions.* ❑ Yes ❑ No

28. Has the patient tried and had an inadequate response to at least one conventional therapy option? ***If Yes, indicate below and no further questions.***
    - ❑ Yes - Sulfasalazine (Azulfidine, Sulfazine)
    - ❑ Yes - Metronidazole (Flagyl)
    - ❑ Yes - Ciprofloxacin (Cipro)
    - ❑ Yes - Prednisone
    - ❑ Yes - Budesonide (Entocort EC)
    - ❑ Yes - Methotrexate intramuscular (IM) or subcutaneous (SC)
    - ❑ Yes - Mercaptopurine (Purinethol)
    - ❑ Yes - Azathioprine (Azasan, Imuran)
    - ❑ Yes - Methylprednisolone (Solu-Medrol)
    - ❑ Yes - Rifaximin (Xifaxan)
    - ❑ Yes - Tacrolimus
    - ❑ No

29. 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)? ❑ Yes ❑ No

Section E: Ulcerative Colitis

30. Has the patient ever received (including current utilizers) a biologic or targeted synthetic disease modifying drug (e.g., Xeljanz) indicated for moderately to severely active ulcerative colitis? *If Yes, no further questions.* ❑ Yes ❑ No

31. Has the patient ever been hospitalized for acute severe ulcerative colitis (e.g., continuous bleeding, severe toxic symptoms, including fever and anorexia)? *If Yes, no further questions.* ❑ Yes ❑ No

32. Has the patient tried and had an inadequate response to at least one conventional therapy option? ***If Yes, indicate below and no further questions.***
    - ❑ Yes - Azathioprine (Azasan, Imuran)
    - ❑ Yes - Corticosteroid (e.g., budesonide [Entocort, Uceris], hydrocortisone [Cortifoam, Colocort, Solu-Cortef, Cortef], methylprednisolone [Medrol, Solu-Medrol], prednisone)
    - ❑ Yes - Cyclosporine (Sandimmune)
    - ❑ Yes - Mesalamine (e.g., Asacol, Lialda, Pentasa, Canasa, Rowasa, balsalazide, olsalazine)
    - ❑ Yes - Mercaptopurine (Purinethol)
    - ❑ Yes - Sulfasalazine
    - ❑ Yes - Tacrolimus (Prograf)
    - ❑ Yes - Metronidazole (Flagyl) or Ciprofloxacin (Cipro) (for pouchitis only)
    - ❑ No

33. Does the patient have a contraindication or intolerance to at least one conventional therapy option (e.g., azathioprine [Azasan, Imuran], corticosteroid [e.g., budesonide, [Entocort, Uceris], hydrocortisone, methylprednisolone, prednisone, cyclosporine [Sandimmune], mesalamine [Asacol, Lialda, Pentasa, Canasa, Rowasa], balsalazide, olsalazine, mercaptopurine [Purinethol], sulfasalazine, tacrolimus [Prograf], metronidazole/ciprofloxacin [for pouchitis only])? ❑ Yes ❑ No

Section F: Plaque Psoriasis

34. Has the patient ever received (including current utilizers) Otezla or a biologic indicated for the treatment of moderate to severe plaque psoriasis? *If Yes, no further questions* ❑ Yes ❑ No

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

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

38. 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

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

Section G: Hidradenitis Suppurativa

40. Has the patient ever received (including current utilizers) a biologic medication indicated for the treatment of moderate to severe hidradenitis suppurativa? *If Yes, no further questions.* ❑ Yes ❑ No

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

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

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

Section H: Behcet's Disease

44. Has the patient ever received (including current utilizers) Otezla or a biologic indicated for the treatment of Behcet's disease? *If Yes, no further questions.* ❑ Yes ❑ No

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

Section I: Uveitis

46. Has the patient ever received (including current utilizers) a biologic indicated for the treatment of non-infectious intermediate, posterior, and panuveitis? *If Yes, no further questions.* ❑ Yes ❑ No

47. Has the patient experienced an inadequate response with corticosteroids or immunosuppressive therapy (e.g., azathioprine, cyclosporine, methotrexate)? *If Yes, no further questions.* ❑ Yes ❑ No

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

49. Does the patient have a contraindication to corticosteroids and immunosuppressive therapy (e.g., azathioprine, cyclosporine, methotrexate)? ❑ Yes ❑ No

Section J: Pyoderma Gangrenosum

50. Has the patient ever received (including current utilizers) a biologic indicated for the treatment of pyoderma gangrenosum? *If Yes, no further questions.* ❑ Yes ❑ No

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

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

53. 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