Kevzara (for Maryland only)

Prior Authorization Request

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

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 diagnosis? ❑ Moderately to severely active rheumatoid arthritis (RA) ❑ Other _____
2. What is the ICD-10 code? _____
3. Would the prescriber like to request an override of the step therapy requirement? ❑ Yes ❑ No *If No, skip to #6*
4. Has the member received the medication through a pharmacy or medical benefit within the past 180 days? ***ACTION REQUIRED: Please provide documentation to substantiate the member had a prescription paid for within the past 180 days (i.e. PBM medication history, pharmacy receipt, EOB etc.)*** ❑ Yes ❑ No
5. Is the medication effective in treating the member's condition? ❑ Yes ❑ No *Continue to #6 and complete this form in its entirety.*
6. These are the formulary preferred product for which coverage is provided for treatment of Rheumatoid arthritis: **Humira or Enbrel.** Can the patient's treatment be switched to a preferred product?
   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.

   ❑ Yes - Enbrel ❑ Yes - Humira ❑ No - Continue request for Kevzara
   ❑ Not applicable - Patient does not have the above condition(s), *skip to #10*
7. Is the patient currently receiving the requested product through insurance coverage? *Note: If the patient is receiving the product through samples or a manufacturer's patient assistance program, please answer 'No'. If Yes, skip to #10* ❑ Yes ❑ No

8. Has the patient had an inadequate response to treatment with ALL applicable preferred products for the requested indication (Humira and Enbrel)? ***Indicate ALL that apply. ACTION REQUIRED: If Yes, attach chart notes detailing the outcomes of treatment with Humira and/or Enbrel and skip to #10.***
   ❑ Yes - Humira ❑ Yes - Enbrel ❑ No

9. Has the patient experienced an intolerable adverse event with ALL applicable preferred products for the requested indication (Humira and Enbrel)? ***Indicate ALL that apply. ACTION REQUIRED: If Yes, attach chart notes describing the intolerable adverse event(s) experienced from treatment with Humira and/or Enbrel.*** ❑ Yes - Humira ❑ Yes - Enbrel ❑ No

10. Has the patient received any of the following medications in a paid claim through a pharmacy or medical benefit in the previous 120 days?
    If Yes, please specify the most recent medication.
    ❑ Actemra ❑ Cimzia ❑ Cosentyx ❑ Enbrel ❑ Humira ❑ Inflectra ❑ Kevzara ❑ Kineret ❑ Orencia
    ❑ Remicade ❑ Rituxan ❑ Simponi ❑ Simponi Aria ❑ Stelara ❑ Taltz ❑ Xeljanz ❑ Xeljanz XR
    ❑ Unknown, *skip to#6* ❑ No *If No, skip to #13*

11. *If patient is continuing therapy*, how long has the patient been receiving the requested medication?
    _____ weeks / months ***(circle one) If the patient has NOT received KEVZARA in a paid claim through a pharmacy or medical benefit in the previous 120 days, skip to #13.***

12. Has the patient achieved or maintained positive clinical response to treatment as evidenced by low disease activity or improvement in signs and symptoms of RA? ❑ Yes ❑ No *No further questions*

13. Has the patient undergone pretreatment screening for latent tuberculosis (TB) infection with either a TB skin test or an interferon gamma release assay (e.g., QFT-GIT, T-SPOT.TB)? ❑ Yes ❑ No

14. Has the patient experienced an inadequate response after at least 3 months of treatment with methotrexate?
    ❑ Yes ❑ No *If No, skip to #16*

16. What was the MAXIMUM titrated methotrexate dose? _____ mg per week
    If greater than or equal to 20 mg per week, no further questions.

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

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

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)**