

Member Name: {{MEMFIRST}} {{MEMLAST}} DOB: {{MEMBERDOB}} PA Number: {{PANUMBER}}



{{PANUMCODE}}

Kevzara

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 patient's diagnosis?
 Moderately to severely active rheumatoid arthritis (RA)
 Other _____
2. What is the ICD-10 code? _____
3. These are the preferred products for which coverage is provided for the treatment of rheumatoid arthritis are **Enbrel, Humira, 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 Kevzara
 Not applicable - Requested for condition other than rheumatoid arthritis, *skip to #7*
4. Is this request for continuation of therapy with the requested product? Yes No *If No, skip to #6*
5. Is the patient currently receiving the requested product through samples or a manufacturer's patient assistance program? If unknown, answer Yes. Yes No *If No, skip to #7*
6. Does the patient have a documented inadequate response or intolerable adverse event with at least two of the preferred products (Enbrel, Humira, Rinvoq, and Xeljanz/Xeljanz XR)? **ACTION REQUIRED: If Yes, attach supporting chart note(s).** Yes No *If No, complete this form in its entirety and State Step Therapy section.*
7. Will the requested drug be used in combination with any other biologic (e.g., Humira) or targeted synthetic disease-modifying antirheumatic drug (DMARD) (e.g., Olumiant, Otezla, Xeljanz)? Yes No
8. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic DMARD (e.g., Olumiant, Xeljanz) associated with an increased risk of tuberculosis? *If Yes, skip to #10* Yes No
9. 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 #12* Yes No

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

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10. 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 #15*
11. Has the patient been tested for tuberculosis (TB) within the previous 12 months? Yes No
12. What were the results of the tuberculosis (TB) test?
 Positive for TB Negative for TB, *skip to #15* Unknown
13. Does the patient have latent or active tuberculosis (TB)? Latent Active Unknown
14. Has treatment for latent tuberculosis (TB) infection been initiated or completed?
 Yes - treatment initiated
 Yes - treatment completed
 No
15. Is this request for continuation of therapy with the requested drug? Yes No *If No, skip to #18*
16. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program? *If Yes or Unknown, skip to #18* Yes No Unknown
17. Has the patient achieved or maintained positive clinical response to treatment as evidenced by low disease activity or improvement in signs and symptoms since starting treatment with the requested drug?
 Yes No *No further questions*
18. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic DMARD (e.g., Xeljanz) that is indicated for moderately to severely active rheumatoid arthritis?
If Yes, no further questions. Yes No
19. 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
20. Has the patient experienced an intolerance to methotrexate? *If Yes, no further questions.* Yes No
21. Does the patient have a contraindication to methotrexate? Yes No
If Yes, indicate the contraindication: _____

State Step Therapy

1. Is the requested drug being used for an FDA-approved indication or an indication supported in the compendia of current literature (examples: AHFS, Lexicomp, Clinical Pharmacology, Micromedex, current accepted guidelines)? Yes No
2. Does the prescribed quantity fall within the manufacturer's published dosing guidelines or within dosing guidelines found in the compendia of current literature (examples: package insert, AHFS, Lexicomp, Clinical Pharmacology, Micromedex, current accepted guidelines)? Yes No
3. Does the patient reside in Maryland? Yes No *If No, skip to #7*
4. Is the alternate drug (see below) FDA-approved for the medical condition being treated? Yes No *If No, please specify:* _____
5. Has the prescriber provided proof, documented in the patient's chart notes, indicating that the requested drug was ordered for the patient in the past 180 days? Yes No *If No, skip to #7*
6. Has the prescriber provided proof, documented in the patient chart notes, that in their opinion the requested drug is effective for the patient's condition? Yes No *No further questions*

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7. Are any of the following conditions met for the alternate drug (see below):
- The alternate drug is contraindicated
 - The alternate drug is likely to cause an adverse reaction, physical or mental harm
 - The alternate drug is expected to be ineffective
 - The alternate drug was previously tried or a drug in the same class or with the same action was previously tried and was stopped due to ineffectiveness or an adverse event
 - The alternate drug is not in the patient's best interest
 - The alternate drug was tried while covered by the current or the previous health benefit plan
 - None of the above
- If Yes, please specify:* _____
8. Is the patient stable or currently receiving a positive therapeutic outcome with the requested drug and a change in the prescription drug is expected to be ineffective or cause harm to the patient? Yes No

Alternate drugs based on diagnosis:

- a) Rheumatoid arthritis: **Enbrel, Humira, Remicade, Rinvoq, Simponi Aria, Xeljanz/Xeljanz XR**

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)

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