CVS caremark™ {{PANUMCODE}}

Kineret

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 diagnosis?
   - ❑ Moderately to severely active rheumatoid arthritis (RA)
   - ❑ Adult-onset Still's disease (AOSD)
   - ❑ Active systemic juvenile idiopathic arthritis (sJIA)
   - ❑ Cryopyrin-Associated Periodic Syndrome (CAPS), including Neonatal-Onset Multisystem Inflammatory Disease (NOMID), (also known as chronic infantile neurologic cutaneous and articular syndrome [CINCA])
   - ❑ Recurrent pericarditis
   - ❑ Multicentric Castleman's disease
   - ❑ Hyperimmunoglobulin D Syndrome (HIDS)/Mevalonate Kinase Deficiency (MKD)
   - ❑ Schnitzler's syndrome
   - ❑ Gout flares
   - ❑ Management of flares for gout or pseudogout (also known as calcium pyrophosphate deposition disease)
   - ❑ Polyarticular juvenile idiopathic arthritis
   - ❑ Other _____
2. What is the ICD-10 code? _____
3. What is the patient's body weight? _____ kg/lbs (circle one)

Section A: Preferred Product

4. These are the preferred products for which coverage is provided for the treatment of the following indication: Rheumatoid arthritis: **Enbrel, Humira, Kevzara, Orencia (SC)/Orencia Clickject, Rinvoq, 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
   ❑ Not applicable - Requested for condition not listed above, *skip to Section B: All Requests*

5. Is this request for continuation of therapy with the requested product? ❑ Yes ❑ No *If No, skip to #7*

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

6. 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 Section B: All Requests*

7. Does the patient have a documented inadequate response or intolerable adverse event with any of the following preferred products indicated for rheumatoid arthritis? ***ACTION REQUIRED: If Yes, attach supporting chart note(s).*** *Indicate ALL that apply.*

❑ Enbrel:	❑ Inadequate response	❑ Intolerable adverse event
❑ Humira:	❑ Inadequate response	❑ Intolerable adverse event
❑ Kevzara:	❑ Inadequate response	❑ Intolerable adverse event
❑ Orencia (SC/Clickject):	❑ Inadequate response	❑ Intolerable adverse event
❑ Rinvoq:	❑ Inadequate response	❑ Intolerable adverse event
❑ Xeljanz/Xeljanz XR:	❑ Inadequate response	❑ Intolerable adverse event

❑ No - None of the above

8. Does the patient have one of the following documented clinical reasons to avoid the preferred products that are TNF inhibitors (Enbrel and Humira)? ***ACTION REQUIRED: If Yes, attach supporting chart note(s).***
   ❑ Yes - History of demyelinating disorder
   ❑ Yes - History of congestive heart failure
   ❑ Yes - Autoantibody formation/lupus-like syndrome (attributed to TNF inhibitor)
   ❑ Yes - History of hepatitis B virus infection
   ❑ Yes - Risk of lymphoma
   ❑ No - none of the above
   ❑ Not applicable - requested medication is a TNF inhibitor

Section B: All Requests

9. 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

10. 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 #12* ❑ Yes ❑ No

11. 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 #14* ❑ Yes ❑ No

12. 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 #17*

13. Has the patient been tested for tuberculosis (TB) within the previous 12 months? ❑ Yes ❑ No

14. What were the results of the tuberculosis (TB) test?
    ❑ Positive for TB ❑ Negative for TB, *skip to #17* ❑ Unknown

15. Does the patient have latent or active tuberculosis (TB)? ❑ Latent ❑ Active ❑ Unknown

16. Has treatment for latent tuberculosis (TB) infection been initiated or completed?
    ❑ Yes – treatment initiated ❑ Yes – treatment completed ❑ No

17. Is this request for continuation of therapy with Kineret? ❑ Yes ❑ No *If No, skip to diagnosis section*

18. 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

19. *If diagnosis is Multicentric Castleman's disease,* has the patient experienced disease progression or an unacceptable toxicity? ❑ Yes ❑ No *No further questions.*

20. Has the patient achieved or maintained a 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*

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

Section C: Rheumatoid Arthritis

21. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic disease modifying drug (e.g., Xeljanz) that is indicated for moderately to severely active rheumatoid arthritis?
    If Yes, no further questions ❑ Yes ❑ No

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, skip to #25* ❑ Yes ❑ No

23. Has the patient experienced intolerance to methotrexate? *If Yes, skip to #25* ❑ Yes ❑ No

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

25. Has the patient experienced an inadequate response after at least 3 months of treatment OR intolerance to a biologic (e.g., Humira) or targeted synthetic DMARD (e.g., Xeljanz)? ❑ Yes ❑ No

Section D: Adult-Onset Still's Disease

26. Has the patient experienced an inadequate response after at least 3 months of treatment with methotrexate or corticosteroids? ❑ Yes ❑ No *If No, skip to #28*

27. Will the patient receive Kineret concurrently with methotrexate or corticosteroids?
    If Yes, no further questions ❑ Yes ❑ No

28. Does the patient have intolerance or a contraindication to low-dose corticosteroids? ❑ Yes ❑ No

29. Does the patient have intolerance or a contraindication to methotrexate?
    ❑ Yes - Intolerance, *no further questions*
    ❑ Yes - Contraindication, ***indicate the contraindication:*** _____
    ❑ No

Section E: Systemic Juvenile Idiopathic Arthritis

30. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) indicated for active systemic juvenile idiopathic arthritis? *If Yes, no further questions* ❑ Yes ❑ No

31. Has the patient experienced an inadequate response to any of the following medications after treatment for the specified duration?
    ❑ Yes - At least a 1-month trial of nonsteroidal anti-inflammatory drugs (NSAIDs)
    ❑ Yes - At least a 2-week trial of corticosteroids (e.g. prednisone, methylprednisolone)
    ❑ Yes - At least a 3-month trial of methotrexate or leflunomide
    ❑ No

Section F: Recurrent Pericarditis

32. Has the patient failed a first-line therapy agent for the treatment of recurrent pericarditis (i.e., colchicine)?
    ACTION REQUIRED: If Yes, please attach medical record documentation stating that the patient has experienced an inadequate response to colchicine. ❑ Yes ❑ No

Section G: Multicentric Castleman's Disease

33. Will the requested drug be used as a single-agent? ❑ Yes ❑ No

34. Has the disease progressed following treatment of relapsed, refractory or progressive disease? ❑ Yes ❑ No

Section H: Hyperimmunoglobulin D Syndrome (HIDS)/Mevalonate Kinase Deficiency (MKD)

35. Has the patient had active flares within the last 6 months? ❑ Yes ❑ No

36. What is the patient's Physician's Global Assessment score? _____ ❑ Unknown
    If greater than or equal to 2, no further questions.

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

37. What is the patient's C-reactive protein (CRP) level in mg/L? _____ ❑ Unknown

Section I: Schnitzler's Syndrome

38. Does the patient have an urticarial rash and monoclonal IgM (or IgG) gammopathy? ❑ Yes ❑ No

39. Does the patient have at least 2 of the following signs and symptoms? *If Yes, indicate all that apply.*
    - ❑ Fever
    - ❑ Joint pain or inflammation
    - ❑ Bone Pain
    - ❑ Palpable lymph nodes
    - ❑ Enlargement of the liver or spleen
    - ❑ Elevated numbers of white blood cells (leukocytosis)
    - ❑ Elevated red blood cell (erythrocyte) sedimentation rate
    - ❑ Abnormalities on bone morphological study (e.g., increased bone density)
    - ❑ No

40. Have other possible causes of the signs and symptoms been ruled out, including but not limited to: hyperimmunoglobulin D syndrome, adult-onset Still disease, urticarial hypocomplementemic vasculitis, acquired C1 inhibitor deficiency and cryoglobulinemia? ❑ Yes ❑ No

Section J: Gout/Pseudogout Flares

41. Has the patient had an inadequate response or intolerance to maximum tolerated doses of non-steroidal anti-inflammatory drugs (NSAIDs) or has a contraindication to NSAIDs? ❑ Yes ❑ No

42. Has the patient had an inadequate response or intolerance to maximum tolerated doses of colchicine or has a contraindication to colchicine? ❑ Yes ❑ No

43. Has the patient had an inadequate response or intolerance to maximum tolerated doses of oral and injectable corticosteroid? *If Yes, no further questions* ❑ Yes ❑ No

44. Does the patient have a clinical reason to avoid repeated courses of corticosteroids? ❑ 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