Olumiant

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: _____ **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 prescribed dose and frequency?
   - ❑ Olumiant 1 mg Quantity and Frequency: _____
   - ❑ Olumiant 2 mg Quantity and Frequency: _____
   - ❑ Olumiant 4 mg Quantity and Frequency: _____
   - ❑ Other: _____

2. What is the diagnosis?
   - ❑ Rheumatoid arthritis
   - ❑ Alopecia areata
   - ❑ Other_____

3. What is the ICD-10 code? _____

4. These are the preferred products for which coverage is provided for the treatment of rheumatoid arthritis: **Enbrel, Humira, Kevzara, Orencia (SC)/Orencia Clickject, Remicade, Rinvoq, Simponi Aria, Xeljanz/Xeljanz XR, Cimzia syringe (secondary)*.**
   Note: Secondary preferred product for RA is Cimzia syringe. The secondary preferred product option only applies to members who have had a documented inadequate response or intolerable adverse event with two primary preferred products.

   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 #9*

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

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 #9*

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

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

❑ Cimzia syringe:	❑ Inadequate response	❑ Intolerable adverse event
❑ Enbrel:	❑ Inadequate response	❑ Intolerable adverse event
❑ Humira:	❑ Inadequate response	❑ Intolerable adverse event
❑ Kevzara:	❑ Inadequate response	❑ Intolerable adverse event
❑ Orencia (SC)/Orencia Clickject):	❑ Inadequate response	❑ Intolerable adverse event
❑ Remicade:	❑ Inadequate response	❑ Intolerable adverse event
❑ Rinvoq:	❑ Inadequate response	❑ Intolerable adverse event
❑ Simponi Aria:	❑ 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, Humira, Cimzia syringe)? ***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 - History or risk of lymphoma or other malignancy
   ❑ Yes - History of being a primary non-responder to a TNF inhibitor (i.e., no clinical response with initial treatment)
   ❑ No - None of the above

9. 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) or potent immunosuppressant such as azathioprine or cyclosporine? ❑ Yes ❑ No

10. 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 #14* ❑ 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? ❑ Yes ❑ No

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

13. Which of the following applies to the patient?
    ❑ Patient has latent TB and treatment for latent TB has been initiated
    ❑ Patient has latent TB and treatment for latent TB has been completed
    ❑ Patient has latent TB and treatment for latent TB has not been initiated
    ❑ Patient has active TB

14. Is this request for continuation of therapy with the requested drug?
    ❑ Yes ❑ No *If No, skip to diagnosis section*

15. 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

16. Has the patient achieved or maintained positive clinical response 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

Continuation

17. What is the percent of disease activity improvement from baseline in tender joint count, swollen joint count, pain, or disability? ***ACTION REQUIRED: Please attach chart notes or medical record documentation supporting positive clinical response. _____%***

Initiation

18. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic DMARD (e.g., Rinvoq, Xeljanz) that is indicated for moderately to severely active rheumatoid arthritis? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried and no further questions.*** ❑ Yes ❑ No

19. Does the patient meet either of the following? ***ACTION REQUIRED: If Yes, please attach laboratory results, chart notes, or medical record documentation of biomarker testing and skip to #16.***
    ❑ Yes - the patient was tested for the rheumatoid factor (RF) biomarker and the RF biomarker test was positive
    ❑ Yes - the patient was tested for the anti-cyclic citrullinated peptide (anti-CCP) biomarker and the anti-CCP biomarker test was positive
    ❑ None of the above

20. Has the patient been tested for all of the following biomarkers: a) rheumatoid factor (RF), b) anti-cyclic citrullinated peptide (anti-CCP), and c) C-reactive protein (CRP) and/or erythrocyte sedimentation rate (ESR)? ***ACTION REQUIRED: If Yes, please attach laboratory results, chart notes, or medical record documentation of biomarker testing.*** ❑ Yes ❑ No

21. Has the patient had an inadequate response to at least one tumor necrosis factor (TNF) inhibitor? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy.*** ❑ Yes ❑ No

Section B: Alopecia Areata

Continuation

22. Has the patient experienced an improvement in signs and symptoms of the condition from baseline (e.g., increased scalp hair coverage)? ❑ Yes ❑ No

23. Does the patient have a Severity of Alopecia Tool (SALT) score of 20 or less? ***ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation of SALT score.*** ❑ Yes ❑ No

Initiation

24. Does the patient have at least 50% scalp hair loss as measured by the Severity of Alopecia Tool (SALT)? ***ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation of SALT score.***
    ❑ Yes ❑ No

25. Does the patient have primarily "diffuse" pattern alopecia (characterized by diffuse hair shedding)?
    ❑ Yes ❑ No

26. Does the patient have other forms of alopecia (e.g., androgenetic alopecia, trichotillomania, telogen effluvium, chemotherapy-induced hair loss, tinea capitis)? ❑ Yes ❑ No

27. *If the prescribed dose exceeds 4 mg*, did the patient experience an inadequate response at the 2 mg dose?
    If Yes or NA, no further questions ❑ Yes ❑ No ❑ N/A, prescribed dose does not exceed 4mg

28. Does the patient have nearly complete or complete scalp hair loss, with or without substantial eyelash or eyebrow hair loss? ❑ 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)**

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