CVS caremark™ {{PANUMCODE}}

Orencia

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 prescribed quantity and frequency?
   - **a) Loading dose:**
     - a. ❑ Orencia IV 250 mg Quantity and frequency: _____
     - b. ❑ Orencia SQ 125 mg Quantity and frequency: _____
     - c. ❑ Orencia SQ 87.5 mg Quantity and frequency: _____
     - d. ❑ Orencia SQ 50 mg Quantity and frequency: _____
     - e. ❑ Other _____
   - **b) Maintenance dose:**
     - a. ❑ Orencia IV 250 mg Quantity and frequency: _____
     - b. ❑ Orencia SQ 125 mg Quantity and frequency: _____
     - c. ❑ Orencia SQ 87.5 mg Quantity and frequency: _____
     - d. ❑ Orencia SQ 50 mg Quantity and frequency: _____
     - e. ❑ Other _____
2. Has the patient been diagnosed with any of the following?
   - ❑ Moderately to severely active rheumatoid arthritis (RA)
   - ❑ Moderately to severely active **polyarticular** juvenile idiopathic arthritis (pJIA)
   - ❑ Moderately to severely active **oligoarticular** juvenile idiopathic arthritis
   - ❑ Active psoriatic arthritis (PsA)
   - ❑ Chronic graft versus host disease
   - ❑ Immune checkpoint inhibitor-related toxicity
   - ❑ Systemic juvenile idiopathic arthritis (sJIA)
   - ❑ Other _____
3. What is the ICD-10 code? _____
4. What is the patient's weight? _____ kg

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Section A: Preferred Product

5. These are the preferred products for which coverage is provided for the treatment of the following indications:
   a) Rheumatoid arthritis: **Enbrel, Humira, Kevzara, Orencia (SC)/Orencia Clickject, Remicade, Rinvoq, Simponi Aria, Xeljanz/Xeljanz XR**, *skip to #10 if Orencia (SC)/Orencia Clickject is being prescribed.*
   b) Psoriatic arthritis: **Cosentyx, Enbrel, Humira, Otezla, Remicade, Simponi Aria**
   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 #10*

6. Is this request for continuation of therapy with the requested product? ❑ Yes ❑ No *If No, skip to #8*

7. 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 #10*

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

❑ Cosentyx:	❑ Inadequate response	❑ Intolerable adverse event
❑ Enbrel:	❑ Inadequate response	❑ Intolerable adverse event
❑ Humira:	❑ Inadequate response	❑ Intolerable adverse event
❑ Remicade:	❑ Inadequate response	❑ Intolerable adverse event
❑ Otezla:	❑ Inadequate response	❑ Intolerable adverse event
❑ Simponi Aria:	❑ Inadequate response	❑ Intolerable adverse event

   ❑ No - none of the above

9. 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, *specify product(s):* _____
   ❑ Yes - History of hepatitis B virus infection, *specify product(s):* _____
   ❑ Yes - History of congestive heart failure, *specify product(s):* _____
   ❑ Yes - Risk of lymphoma, *specify product(s):* _____
   ❑ Yes - Autoantibody formation/lupus-like syndrome (attributed to TNF inhibitor), *specify product(s):* _____
   ❑ No - none of the above
   ❑ Not applicable - requested drug is a TNF inhibitor

10. 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

11. 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 #13* ❑ Yes ❑ No

12. 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 #15* ❑ Yes ❑ No

13. 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 #18*

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

15. What were the results of the tuberculosis (TB) test?
   ❑ Positive for TB ❑ Negative for TB, *skip to #18* ❑ Unknown

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

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

18. Is the patient currently receiving Orencia? ❑ Yes ❑ No

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

20. 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

21. 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 *No further questions*

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

Section B: Rheumatoid Arthritis

22. 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

23. 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

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

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

Section C: Articular Juvenile Idiopathic Arthritis

26. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic disease-modifying antirheumatic drug (DMARD) indicated for moderately to severely active articular juvenile idiopathic arthritis? *If Yes, no further questions* ❑ Yes ❑ No

27. 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

28. Does the patient have any of the following risk factors?
❑ Positive rheumatoid factor
❑ Positive anti-cyclic citrullinated peptide antibodies
❑ Pre-existing joint damage
❑ None of the above

29. Does the patient meet any of the following?
❑ High-risk joints are involved (e.g., cervical spine, wrist, or hip)
❑ High risk for disabling joint disease
❑ High disease activity
❑ None of the above

Section D: Chronic Graft Versus Host Disease

30. Has the patient experienced an inadequate response to systemic corticosteroids?
If Yes, no further questions ❑ Yes ❑ No

31. Does the patient have an intolerance or contraindication to corticosteroids? ❑ Yes ❑ No

Section E: Immune Checkpoint Inhibitor-Related Toxicity

32. Does the patient have cardiac toxicity? ❑ 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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