CVS caremark™ {{PANUMCODE}}

Otezla

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 dose and frequency?
   a) Loading dose:
   ❑ Otezla 30 mg Quantity and Frequency: _____
   ❑ Otezla starter pack
   ❑ Other: _____
   b) Maintenance dose:
   ❑ Otezla 30 mg Quantity and Frequency: _____
   ❑ Other: _____

2. Does the prescribed dose exceed 10 mg in the morning on day 1, 10 mg in the morning and evening on day 2, 10 mg in the morning and 20 mg in the evening on day 3, 20 mg in the morning and evening on day 4, 20 mg in the morning and 30 mg in the evening on day 5, and 30 mg in the morning and evening thereafter? ❑ Yes ❑ No

3. Has the patient been diagnosed with any of the following?
   ❑ Moderate to severe plaque psoriasis
   ❑ Active psoriatic arthritis (PsA) WITH co-existent plaque psoriasis
   ❑ Active psoriatic arthritis (PsA) WITHOUT co-existent plaque psoriasis
   ❑ Oral ulcers associated with Behcet's disease
   ❑ Other _____

4. What is the ICD-10 code? _____

5. 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, Xeljanz)? ❑ Yes ❑ No

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

7. 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

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

8. Has the patient achieved or maintained positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition since starting treatment with the requested drug?
   ❑ Yes ❑ No
   If patient's diagnosis is plaque psoriasis, skip to appropriate section below;
   If patient's diagnosis is Behcet's Disease, no further questions.

9. Has the patient experienced an improvement in from baseline? ***ACTION REQUIRED: Please attach chart notes or medical record documentation supporting positive clinical response.*** ❑ Yes ❑ No
   If Yes, indicate improvement: _____

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

Section A: Plaque Psoriasis

Initial Request

10. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) indicated for the treatment of plaque psoriasis? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried and no further questions.*** ❑ Yes ❑ No

11. Has the patient experienced an inadequate response to, or has an intolerance to phototherapy (e.g., UVB, PUVA) or topical therapies (e.g., medium or higher potency topical corticosteroids [see Appendix A], calcineurin inhibitors, vitamin D analogs)? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy and no further questions.*** ❑ Yes ❑ No

12. Does the patient have a contraindication or clinical reason to avoid phototherapy (e.g., UVB, PUVA)? ***ACTION REQUIRED: If Yes, please attach documentation of contraindication or clinical reason to avoid phototherapy.*** ❑ Yes ❑ No *If No, skip to #14*

13. Does the patient have a contraindication or clinical reason to avoid topical therapies (e.g., medium or higher potency topical corticosteroids [see Appendix A], calcineurin inhibitors, vitamin D analogs)? ***ACTION REQUIRED: If Yes, please attach documentation of contraindication or clinical reason to avoid topical therapies and no further questions.*** ❑ Yes ❑ No

14. Has the patient experienced an inadequate response to, or has an intolerance to pharmacologic treatment with ONE of the following medications: methotrexate, cyclosporine, or acitretin? ***ACTION REQUIRED: If Yes, please attach chart notes, medication record documentation, or claims history supporting previous medications tried, including response to therapy and no further questions.*** ❑ Yes ❑ No

15. Does the patient have a clinical reason to avoid pharmacologic treatment with ALL of the following medications: methotrexate, cyclosporine and acitretin? ***ACTION REQUIRED: If Yes, please attach documentation of clinical reason to avoid therapy.***
    ❑ Yes ❑ No ***If Yes, indicate clinical reason:*** _____

Continuation of Therapy

16. Has the patient experienced a reduction in body surface area (BSA) affected from baseline? ***ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation of decreased body surface area affected and no further questions.*** ❑ Yes ❑ No

17. Has the patient experienced an improvement in signs and symptoms of the condition from baseline (e.g., itching, redness, flaking, scaling, burning, cracking, pain)? ***ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation of improvement in signs and symptoms.*** ❑ Yes ❑ No

Section B: Psoriatic Arthritis WITH or WITHOUT Co-Existent Plaque Psoriasis

Continuation

18. Which of the following has the patient experienced an improvement in from baseline? ***ACTION REQUIRED: Please attach chart notes or medical record documentation supporting positive clinical response.***
    ❑ Number of swollen joints ❑ Dactyliti ❑ Skin and/or nail involvement
    ❑ Number of tender joints ❑ Enthesitis ❑ None of the above

Section C: Oral Ulcers Associated with Behcet's Disease

19. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) indicated for the treatment of Behcet's disease? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried and no further questions.*** ❑ Yes ❑ No

20. Is this request for the treatment of oral ulcers associated with Behcet's disease? ❑ Yes ❑ No

21. Has the patient had an inadequate response to at least one nonbiologic medication for Behcet's disease (e.g., colchicine, systemic glucocorticoids, azathioprine)? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy.*** ❑ Yes ❑ No

APPENDIX A: Table. Relative potency of select topical corticosteroid products

Potency	Drug	Dosage form	Strength
I. Super-high potency (group 1)	Augmented betamethasone dipropionate	Ointment, Lotion, Gel	0.05%
	Clobetasol propionate	Cream, Gel, Ointment, Solution, Cream (emollient), Lotion, Shampoo, Foam, Spray	0.05%
	Fluocinonide	Cream	0.1%
	Flurandrenolide	Tape	4 mcg/cm^2
	Halobetasol propionate	Cream, Lotion, Ointment, Foam	0.05%
II. High potency (group 2)	Amcinonide	Ointment	0.1%
	Augmented betamethasone dipropionate	Cream	0.05%
	Betamethasone dipropionate	Ointment	0.05%
	Clobetasol propionate	Cream	0.025%
	Desoximetasone	Cream, Ointment, Spray	0.25%
		Gel	0.05%
	Diflorasone diacetate	Ointment, Cream (emollient)	0.05%
	Fluocinonide	Cream, Ointment, Gel, Solution	0.05%
	Halcinonide	Cream, Ointment	0.1%
	Halobetasol propionate	Lotion	0.01%
Potency	**Drug**	**Dosage form**	**Strength**
III. High potency (group 3)	Amcinonide	Cream, Lotion	0.1%
	Betamethasone dipropionate	Cream, hydrophilic emollient	0.05%
	Betamethasone valerate	Ointment	0.1%
		Foam	0.12%
	Desoximetasone	Cream, Ointment	0.05%
	Diflorasone diacetate	Cream	0.05%
	Fluocinonide	Cream, aqueous emollient	0.05%
	Fluticasone propionate	Ointment	0.005%
	Mometasone furoate	Ointment	0.1%
	Triamcinolone acetonide	Cream, Ointment	0.5%
IV. Medium potency (group 4)	Betamethasone dipropionate	Spray	0.05%
	Clocortolone pivalate	Cream	0.1%
	Fluocinolone acetonide	Ointment	0.025%
	Flurandrenolide	Ointment	0.05%
	Hydrocortisone valerate	Ointment	0.2%
	Mometasone furoate	Cream, Lotion, Solution	0.1%
	Triamcinolone acetonide	Cream	0.1%
		Ointment	0.05% and 0.1%
		Aerosol Spray	0.2 mg per 2-second spray

V. Lower-mid potency (group 5)	Betamethasone dipropionate	Lotion	0.05%
	Betamethasone valerate	Cream	0.1%
	Desonide	Ointment, Gel	0.05%
	Fluocinolone acetonide	Cream	0.025%
	Flurandrenolide	Cream, Lotion	0.05%
	Fluticasone propionate	Cream, Lotion	0.05%
	Hydrocortisone butyrate	Cream, Lotion, Ointment, Solution	0.1%
	Hydrocortisone probutate	Cream	0.1%
	Hydrocortisone valerate	Cream	0.2%
	Prednicarbate	Cream (emollient), Ointment	0.1%
	Triamcinolone acetonide	Lotion	0.1%
		Ointment	0.025%
VI. Low potency (group 6)	Alclometasone dipropionate	Cream, Ointment	0.05%
	Betamethasone valerate	Lotion	0.1%
	Desonide	Cream, Lotion, Foam	0.05%
	Fluocinolone acetonide	Cream, Solution, Shampoo, Oil	0.01%
	Triamcinolone acetonide	Cream, lotion	0.025%
VII. Least potent (group 7)	Hydrocortisone (base, less than 2%)	Cream, Ointment, Solution	2.5%
		Lotion	2%
		Cream, Ointment, Gel, Lotion, Spray, Solution	1%
		Cream, Ointment	0.5%
	Hydrocortisone acetate	Cream	2.5%
		Lotion	2%
		Cream	1%

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