Remicade and biosimilars

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 1-855-330-1720**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-888-877-0518.** 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:** _____

Referring Provider Info: ❑ Same as Requesting Provider
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ Same as Referring Provider ❑ Same as Requesting Provider
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____*kg*

Patient Height: _____*cm*

Site of Service Questions:

A. Where will this drug be administered?
- ❑ Ambulatory surgical, *skip to Clinical Questions*
- ❑ Home infusion, *skip to Clinical Questions*
- ❑ Off-campus Outpatient Hospital
- ❑ On-campus Outpatient Hospital
- ❑ Physician office, *skip to Clinical Questions*
- ❑ Pharmacy, *skip to Clinical Questions*

B. Is this request to continue previously established treatment with the requested medication?
- ❑ Yes – This is a continuation of an existing treatment
- ❑ Yes – This is a continuation request, however a gap in therapy of greater than 2 doses has occurred. *Skip to Clinical Criteria Questions*
- ❑ No – This is a new therapy request (patient has not received requested medication in the last 6 months). *Skip to Clinical Criteria Questions*
- ❑ No – This is a request for a different brand infliximab product that the patient has not received previously. *Skip to Clinical Criteria Questions*

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

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C. Has the patient experienced an adverse event with the requested product that has not responded to conventional interventions (eg acetaminophen, steroids, diphenhydramine, fluids, other pre- medications or slowing of infusion rate) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after an infusion? ***ACTION REQUIRED: If Yes, please attach supporting clinical documentation.*** ❑ Yes, *skip to Clinical Criteria Questions* ❑ No

D. Does the patient have laboratory confirmed antibodies to infliximab? ***ACTION REQUIRED: If Yes, please attach supporting clinical documentation.*** ❑ Yes, *skip to Clinical Criteria Questions* ❑ No

E. Is the patient medically unstable which may include respiratory, cardiovascular, or renal conditions that may limit the member's ability to tolerate a large volume or load or predispose the member to a severe adverse event that cannot be managed in an alternate setting without appropriate medical personnel and equipment? ***ACTION REQUIRED: If Yes, please attach supporting clinical documentation.*** ❑ Yes, *skip to Clinical Criteria Questions* ❑ No

F. Does the patient have severe venous access issues that require the use of a special interventions only available in the outpatient hospital setting? ***ACTION REQUIRED: If Yes, please attach supporting clinical documentation***. ❑ Yes, *skip to Clinical Criteria Questions* ❑ No

G. Does the patient have significant behavioral issues and/or physical or cognitive impairment that would impact the safety of the infusion therapy AND the patient does not have access to a caregiver? ***ACTION REQUIRED: If Yes, please attach supporting clinical documentation.*** ❑ Yes ❑ No

Criteria Questions:

What is the ICD-10 code? _____

What product is being requested? ❑ Remicade ❑ Avsola ❑ Inflectra ❑ Renflexis

1. Will the requested drug be used in combination with any other biologic (e.g., Humira) or targeted synthetic drug (e.g., Olumiant, Otezla, Xeljanz)?
❒ Yes, *Continue to 2*
❒ No, *Continue to 2*

2. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic drug (e.g., Olumiant, Xeljanz) associated with an increased risk of tuberculosis (TB)?
❒ Yes, *Continue to 6*
❒ No, *Continue to 3*

3. 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, *Continue to 4*
❒ No, *No further questions*

4. What were the results of the tuberculosis (TB) test?

❒ Positive for TB, *Continue to 5*

❒ Negative for TB, *Continue to 6*

❒ Unknown, *No further questions*

5. Which of the following applies to the patient?

❒ Patient has latent TB and treatment for latent TB has been initiated, *Continue to 6*

❒ Patient has latent TB and treatment for latent TB has been completed, *Continue to 6*

❒ Patient has latent TB and treatment for latent TB has not been initiated, *Continue to 6*

❒ Patient has active TB, *Continue to 6*

6. What is the diagnosis?

❒ Crohn's disease, *Continue to 8*

❒ Ulcerative colitis, *Continue to 16*

❒ Rheumatoid arthritis, *Continue to 23*

❒ Ankylosing spondylitis, *Continue to 42*

❒ Non-radiographic axial spondyloarthritis, *Continue to 42*

❒ Psoriatic arthritis, *Continue to 51*

❒ Psoriatic arthritis WITH co-existent plaque psoriasis, *Continue to 7*

❒ Plaque psoriasis, *Continue to 66*

❒ Behcet's disease, *Continue to 80*

❒ Hidradenitis suppurativa, *Continue to 86*

❒ Pyoderma gangrenosum, *Continue to 96*

❒ Sarcoidosis, *Continue to 104*

❒ Takayasu's arteritis, *Continue to 111*

❒ Uveitis, *Continue to 119*

❒ Reactive arthritis, *Continue to 128*

❒ Immune checkpoint inhibitor (e.g., CTLA-4, PD-L1 inhibitor) toxicity, *Continue to 138*

❒ Immune checkpoint inhibitor (e.g., CTLA-4, PD-L1 inhibitor) toxicity - Inflammatory arthritis, *Continue to 143*

❒ Acute graft versus host disease, *Continue to 148*

❒ Other, please specify. _____, *No further questions*

7. What is the primary diagnosis being treated?

❒ Psoriatic arthritis, *Continue to 51*

❒ Plaque psoriasis, *Continue to 66*

8. Has the patient been diagnosed with moderately to severely active Crohn's disease (CD)?

❒ Yes, *Continue to 9*

❒ No, *Continue to 9*

9. Is the patient 6 years of age or older?

❒ Yes, *Continue to 10*

❒ No, *Continue to 10*

10. Is the requested drug being prescribed by or in consultation with a gastroenterologist?

❒ Yes, *Continue to 11*

❒ No, *Continue to 11*

11. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug?

❒ Yes, *Continue to 12*

❒ No, *Continue to 152*

12. Has the patient achieved or maintained remission? ***ACTION REQUIRED***: If Yes, please attach chart notes or medical record documentation of remission. ***ACTION REQUIRED***: Submit supporting documentation

❒ Yes, *Continue to 152*
❒ No, *Continue to 13*

13. Has the patient achieved or maintained a 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 or a biosimilar of the requested drug?
❒ Yes, *Continue to 14*
❒ No, *Continue to 15*

14. 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 to therapy.

❒ Abdominal pain or tenderness ***ACTION REQUIRED****: Submit supporting documentation, Continue to 152*

❒ Diarrhea ***ACTION REQUIRED****: Submit supporting documentation, Continue to 152*

❒ Body weight ***ACTION REQUIRED****: Submit supporting documentation, Continue to 152*

❒ Abdominal mass ***ACTION REQUIRED****: Submit supporting documentation, Continue to 152*

❒ Hematocrit ***ACTION REQUIRED****: Submit supporting documentation, Continue to 152*
❒ Appearance of the mucosa on endoscopy, computed tomography enterography (CTE), magnetic resonance enterography (MRE), or intestinal ultrasound ***ACTION REQUIRED****: Submit supporting documentation, Continue to 152*
❒ Improvement on a disease activity scoring tool (e.g., Crohn's Disease Activity Index [CDAI] score) ***ACTION REQUIRED****: Submit supporting documentation, Continue to 152*

❒ None of the above, *Continue to 15*

15. Is this request for an increase in dosing regimen due to the patient not achieving an adequate clinical response at the current dose?
❒ Yes, *Continue to 152*
❒ No, *Continue to 152*

16. Has the patient been diagnosed with moderately to severely active ulcerative colitis (UC)?
❒ Yes, *Continue to 17*
❒ No, *Continue to 17*

17. Is the patient 6 years of age or older?
❒ Yes, *Continue to 18*
❒ No, *Continue to 18*

18. Is the requested drug being prescribed by or in consultation with a gastroenterologist?
❒ Yes, *Continue to 19*
❒ No, *Continue to 19*

19. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 20*
❒ No, *Continue to 152*

20. Has the patient achieved or maintained remission? ***ACTION REQUIRED***: If Yes, please attach chart notes or medical record documentation of remission. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 152*
❒ No, *Continue to 21*

21. Has the patient achieved or maintained a 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 or a biosimilar of the requested drug?
❒ Yes, *Continue to 22*
❒ No, *Continue to 22*

22. 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 to therapy.

❒ Stool frequency ***ACTION REQUIRED****: Submit supporting documentation, Continue to 152*

❒ Rectal bleeding ***ACTION REQUIRED****: Submit supporting documentation, Continue to 152*

❒ Urgency of defecation ***ACTION REQUIRED****: Submit supporting documentation, Continue to 152*

❒ C-reactive protein (CRP) ***ACTION REQUIRED****: Submit supporting documentation, Continue to 152*

❒ Fecal calprotectin (FC) ***ACTION REQUIRED****: Submit supporting documentation, Continue to 152*
❒ Appearance of the mucosa on endoscopy, computed tomography enterography (CTE), magnetic resonance enterography (MRE), or intestinal ultrasound ***ACTION REQUIRED****: Submit supporting documentation, Continue to 152*
❒ Improvement on a disease activity scoring tool (e.g., Ulcerative Colitis Endoscopic Index of Severity [UCEIS], Mayo Score) ***ACTION REQUIRED****: Submit supporting documentation, Continue to 152*

❒ None of the above, *Continue to 152*

23. Has the patient been diagnosed with moderately to severely active rheumatoid arthritis (RA)?
❒ Yes, *Continue to 24*
❒ No, *Continue to 24*

24. Is the patient an adult (18 years of age or older)?
❒ Yes, *Continue to 25*
❒ No, *Continue to 25*

25. Is the requested drug being prescribed by or in consultation with a rheumatologist?
❒ Yes, *Continue to 26*
❒ No, *Continue to 26*

26. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 27*
❒ No, *Continue to 31*

27. Is the patient currently receiving the requested drug or a biosimilar of the requested drug through samples or a manufacturer's patient assistance program?

❒ Yes, *Continue to 31*

❒ No, *Continue to 28*

❒ Unknown, *Continue to 31*

28. Has the patient achieved or maintained a positive clinical response since starting treatment with the requested drug or a biosimilar of the requested drug?

❒ Yes, *Continue to 29*
❒ No, *Continue to 30*

29. Has the patient experienced substantial disease activity improvement (e.g., at least 20% from baseline) in tender joint count, swollen joint count, pain, or disability? ***ACTION REQUIRED***: If Yes, please attach chart notes or medical record documentation supporting positive clinical response and substantial disease activity improvement. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 152*
❒ No, *Continue to 30*

30. Is this a request for an increase in dosing regimen due to the patient not achieving an adequate clinical response at the current dose or frequency?
❒ Yes, *Continue to 152*
❒ No, *Continue to 152*

31. Has the patient ever received or is currently receiving a biologic (e.g., Humira) or targeted synthetic drug (e.g., Rinvoq, Xeljanz) indicated for moderately to severely active rheumatoid arthritis (excluding receiving the drug via samples or a manufacturer's patient assistance program)? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 32*
❒ No, *Continue to 34*

32. Is the requested medication being prescribed in combination with methotrexate or leflunomide?
❒ Yes, *Continue to 152*
❒ No, *Continue to 33*

33. Please indicate a clinical reason for the patient to not use methotrexate or leflunomide.
❒ Clinical diagnosis of alcohol use disorder, alcoholic liver disease, or other chronic liver disease, *Continue to 152*

❒ Drug interaction, *Continue to 152*

❒ Risk of treatment-related toxicity, *Continue to 152*

❒ Pregnancy or currently planning pregnancy, *Continue to 152*

❒ Breastfeeding, *Continue to 152*
❒ Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension), *Continue to 152*

❒ Hypersensitivity, *Continue to 152*

❒ History of intolerance or adverse event, *Continue to 152*

❒ Other, please specify. _____, *Continue to 152*

❒ No clinical reason not to use methotrexate or leflunomide, *Continue to 152*

34. Does the patient meet either of the following: a) the patient was tested for the rheumatoid factor (RF) biomarker and the RF biomarker test was positive, or b) the patient was tested for the anti-cyclic citrullinated peptide (anti-CCP) biomarker and the anti-CCP biomarker test was positive? ***ACTION REQUIRED***: If Yes, please attach laboratory results, chart notes, or medical record documentation of biomarker testing. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 36*
❒ No, *Continue to 35*

35. 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. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 36*
❒ No, *Continue to 36*

36. Is the requested medication being prescribed in combination with methotrexate or leflunomide?
❒ Yes, *Continue to 38*
❒ No, *Continue to 37*

37. Please indicate a clinical reason for the patient to not use methotrexate or leflunomide.

❒ Clinical diagnosis of alcohol use disorder, alcoholic liver disease, or other chronic liver disease, *Continue to 38*

❒ Drug interaction, *Continue to 38*

❒ Risk of treatment-related toxicity, *Continue to 38*

❒ Pregnancy or currently planning pregnancy, *Continue to 38*

❒ Breastfeeding, *Continue to 38*
❒ Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension), *Continue to 38*

❒ Hypersensitivity, *Continue to 38*

❒ History of intolerance or adverse event, *Continue to 38*

❒ Other, please specify. _____, *Continue to 38*

❒ No clinical reason not to use methotrexate or leflunomide, *Continue to 38*

38. Has the patient experienced an inadequate response after at least 3 months of treatment with methotrexate at a dose greater than or equal to 15 mg per week? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 152*
❒ No, *Continue to 39*

39. Has the patient experienced an intolerance to methotrexate? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 152*
❒ No, *Continue to 40*

40. Does the patient have a contraindication to methotrexate? ***ACTION REQUIRED***: If Yes, please attach documentation of clinical reason to avoid therapy. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 41*
❒ No, *Continue to 41*

41. Please indicate the contraindication to methotrexate.
❒ Clinical diagnosis of alcohol use disorder, alcoholic liver disease, or other chronic liver disease, *Continue to 152*

❒ Drug interaction, *Continue to 152*

❒ Risk of treatment-related toxicity, *Continue to 152*

❒ Pregnancy or currently planning pregnancy, *Continue to 152*

❒ Breastfeeding, *Continue to 152*

❒ Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension), *Continue to 152*

❒ Hypersensitivity, *Continue to 152*

❒ History of intolerance or adverse event, *Continue to 152*

❒ Other, please specify. _____, *Continue to 152*

42. Has the patient been diagnosed with active ankylosing spondylitis (AS) or active non-radiographic axial spondyloarthritis (nr-axSpA)?

❒ Yes - Active ankylosing spondylitis, *Continue to 43*

❒ Yes - Active non-radiographic axial spondyloarthritis, *Continue to 43*

❒ No, *Continue to 43*

43. Is the patient an adult (18 years of age or older)?

❒ Yes, *Continue to 44*

❒ No, *Continue to 44*

44. Is the requested drug being prescribed by or in consultation with a rheumatologist?

❒ Yes, *Continue to 45*

❒ No, *Continue to 45*

45. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug?

❒ Yes, *Continue to 46*

❒ No, *Continue to 49*

46. Is the patient currently receiving the requested drug or a biosimilar of the requested drug through samples or a manufacturer's patient assistance program?

❒ Yes, *Continue to 49*

❒ No, *Continue to 47*

❒ Unknown, *Continue to 49*

47. Has the patient achieved or maintained a 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 or a biosimilar of the requested drug?

❒ Yes, *Continue to 48*

❒ No, *Continue to 48*

48. 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.

❒ Functional status ***ACTION REQUIRED****: Submit supporting documentation, Continue to 152*

❒ Total spinal pain ***ACTION REQUIRED****: Submit supporting documentation, Continue to 152*

❒ Inflammation (e.g., morning stiffness) ***ACTION REQUIRED****: Submit supporting documentation, Continue to 152*

❒ None of the above, *Continue to 152*

49. Has the patient ever received or is currently receiving a biologic (e.g., Humira) or targeted synthetic drug (e.g., Rinvoq, Xeljanz) that is indicated for active ankylosing spondylitis or active non-radiographic axial spondyloarthritis (excluding receiving the drug via samples or a manufacturer's patient assistance program)? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 152*
❒ No, *Continue to 50*

50. Has the patient experienced an inadequate response with at least TWO nonsteroidal anti-inflammatory drugs (NSAIDs), or has an intolerance or contraindication to at least two NSAIDs? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy. If therapy is not advisable, please attach documentation of clinical reason to avoid therapy. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 152*
❒ No, *Continue to 152*

51. Is the patient an adult (18 years of age or older)?
❒ Yes, *Continue to 52*
❒ No, *Continue to 52*

52. Is the requested drug being prescribed by or in consultation with a rheumatologist or dermatologist?
❒ Yes, *Continue to 53*
❒ No, *Continue to 53*

53. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 54*
❒ No, *Continue to 57*

54. Is the patient currently receiving the requested drug or a biosimilar of the requested drug through samples or a manufacturer's patient assistance program?

❒ Yes, *Continue to 57*

❒ No, *Continue to 55*

❒ Unknown, *Continue to 57*

55. Has the patient achieved or maintained a 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 or a biosimilar of the requested drug?
❒ Yes, *Continue to 56*
❒ No, *Continue to 56*

56. 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 ***ACTION REQUIRED****: Submit supporting documentation, Continue to 152*

❒ Number of tender joints ***ACTION REQUIRED****: Submit supporting documentation, Continue to 152*

❒ Dactylitis ***ACTION REQUIRED****: Submit supporting documentation, Continue to 152*

❒ Enthesitis ***ACTION REQUIRED****: Submit supporting documentation, Continue to 152*

❒ Axial disease ***ACTION REQUIRED****: Submit supporting documentation, Continue to 152*

❒ Skin and/or nail involvement ***ACTION REQUIRED****: Submit supporting documentation, Continue to 152*

❒ None of the above, *Continue to 152*

57. Has the patient been diagnosed with active psoriatic arthritis (PsA)?
❒ Yes, *Continue to 58*
❒ No, *Continue to 58*

58. Has the patient ever received or is currently receiving a biologic (e.g., Humira) or targeted synthetic drug (e.g., Rinvoq, Otezla) indicated for active psoriatic arthritis (excluding receiving the drug via samples or a manufacturer's patient assistance program)? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 152*
❒ No, *Continue to 59*

59. What is the patient's disease severity?

❒ Mild to moderate, *Continue to 60*

❒ Severe, *Continue to 152*

60. Does the patient have enthesitis or predominantly axial disease?
❒ Yes, *Continue to 152*
❒ No, *Continue to 61*

61. Has the patient had an inadequate response to methotrexate, leflunomide, or another conventional synthetic drug (e.g., sulfasalazine) administered at an adequate dose and duration? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 152*
❒ No, *Continue to 62*

62. Has the patient had an intolerance to methotrexate, leflunomide, or another conventional synthetic drug (e.g., sulfasalazine)? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 152*
❒ No, *Continue to 63*

63. Does the patient have a contraindication to methotrexate or leflunomide? ***ACTION REQUIRED***: If Yes, please attach documentation of clinical reason to avoid therapy. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 64*
❒ No, *Continue to 65*

64. Please indicate the contraindication to methotrexate or leflunomide.
❒ Clinical diagnosis of alcohol use disorder, alcoholic liver disease, or other chronic liver disease, *Continue to 152*

❒ Drug interaction, *Continue to 152*

❒ Risk of treatment-related toxicity, *Continue to 152*

❒ Pregnancy or currently planning pregnancy, *Continue to 152*

❒ Breastfeeding, *Continue to 152*

❒ Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension), *Continue to 152*

❒ Hypersensitivity, *Continue to 152*

❒ History of intolerance or adverse event, *Continue to 152*

❒ Other, please specify. _____, *Continue to 152*

65. Does the patient have a contraindication to another conventional synthetic drug (e.g., sulfasalazine)? ***ACTION REQUIRED***: If Yes, please attach documentation of clinical reason to avoid therapy. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 152*
❒ No, *Continue to 152*

66. Has the patient been diagnosed with moderate to severe plaque psoriasis?
❒ Yes, *Continue to 67*
❒ No, *Continue to 67*

67. Is the patient an adult (18 years of age or older)?
❒ Yes, *Continue to 68*
❒ No, *Continue to 68*

68. Is the requested drug being prescribed by or in consultation with a dermatologist?
❒ Yes, *Continue to 69*
❒ No, *Continue to 69*

69. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 70*
❒ No, *Continue to 74*

70. Is the patient currently receiving the requested drug or a biosimilar of the requested drug through samples or a manufacturer's patient assistance program?

❒ Yes, *Continue to 74*

❒ No, *Continue to 71*

❒ Unknown, *Continue to 74*

71. Has the patient achieved or maintained a 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 or a biosimilar of the requested drug?
❒ Yes, *Continue to 72*
❒ No, *Continue to 72*

72. 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. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 152*
❒ No, *Continue to 73*

73. 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. ***ACTION REQUIRED***: Submit supporting documentation

❒ Yes, *Continue to 152*
❒ No, *Continue to 152*

74. Has the patient ever received or is currently receiving a biologic (e.g., Humira) or targeted synthetic drug (e.g., Sotyktu, Otezla) indicated for the treatment of moderate to severe plaque psoriasis (excluding receiving the drug via samples or a manufacturer's patient assistance program)? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 152*
❒ No, *Continue to 75*

75. Are crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) affected? ***ACTION REQUIRED***: If Yes, please attach chart notes or medical record documentation of affected areas. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 152*
❒ No, *Continue to 76*

76. What is the percentage of body surface area (BSA) affected (prior to starting the requested medication)? Indicate percentage. ***ACTION REQUIRED***: Please attach chart notes or medical record documentation of affected areas and body surface area affected.
❒ Greater than or equal to 3% to less than 10% of BSA _____ ***ACTION REQUIRED****: Submit supporting documentation, Continue to 77*
❒ Greater than or equal to 10% of BSA _____ ***ACTION REQUIRED****: Submit supporting documentation, Continue to 152*
❒ Less than 3% of BSA _____, *No further questions*

77. Has the patient experienced an inadequate response, or has an intolerance to phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine or acitretin? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 152*
❒ No, *Continue to 78*

78. Does the patient have a clinical reason to avoid pharmacologic treatment with methotrexate, cyclosporine, and acitretin? ***ACTION REQUIRED***: If Yes, please attach documentation of clinical reason to avoid therapy. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 79*
❒ No, *Continue to 79*

79. Please indicate clinical reason to avoid pharmacologic treatment with methotrexate, cyclosporine, and acitretin.
❒ Clinical diagnosis of alcohol use disorder, alcoholic liver disease, or other chronic liver disease, *Continue to 152*
❒ Drug interaction, *Continue to 152*
❒ Risk of treatment-related toxicity, *Continue to 152*
❒ Pregnancy or currently planning pregnancy, *Continue to 152*
❒ Breastfeeding, *Continue to 152*
❒ Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension), *Continue to 152*
❒ Hypersensitivity, *Continue to 152*
❒ History of intolerance or adverse event, *Continue to 152*

❒ Other, please specify. _____, *Continue to 152*

80. Is the requested drug being prescribed by or in consultation with a rheumatologist?
❒ Yes, *Continue to 81*
❒ No, *Continue to 81*

81. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 82*
❒ No, *Continue to 84*

82. Is the patient currently receiving the requested drug or a biosimilar of the requested drug through samples or a manufacturer's patient assistance program?

❒ Yes, *Continue to 84*

❒ No, *Continue to 83*

❒ Unknown, *Continue to 84*

83. Has the patient achieved or maintained a 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 or a biosimilar of the requested drug?
❒ Yes, *Continue to 152*
❒ No, *Continue to 152*

84. Has the patient ever received or is currently receiving Otezla or a biologic (e.g., Humira) indicated for the treatment of Behcet's disease (excluding receiving the drug via samples or a manufacturer's patient assistance program)? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 152*
❒ No, *Continue to 85*

85. Has the patient had an inadequate response to at least one non-biologic medication for Behcet's disease (e.g., apremilast, 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. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 152*
❒ No, *Continue to 152*

86. Has the patient been diagnosed with severe, refractory hidradenitis suppurativa?
❒ Yes, *Continue to 87*
❒ No, *Continue to 87*

87. Is the requested drug being prescribed by or in consultation with a rheumatologist or dermatologist?
❒ Yes, *Continue to 88*
❒ No, *Continue to 88*

88. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 89*
❒ No, *Continue to 92*

89. Is the patient currently receiving the requested drug or a biosimilar of the requested drug through samples or a manufacturer's patient assistance program?

❒ Yes, *Continue to 92*

❒ No, *Continue to 90*

❒ Unknown, *Continue to 92*

90. Has the patient achieved or maintained a 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 or a biosimilar of the requested drug?
❒ Yes, *Continue to 91*
❒ No, *Continue to 91*

91. Which of the following has the patient experienced since starting treatment with the requested drug or a biosimilar of the requested drug? ***ACTION REQUIRED***: Please attach chart notes or medical record documentation supporting positive clinical response.
❒ Reduction in abscess and inflammatory nodule count from baseline ***ACTION REQUIRED****: Submit supporting documentation, Continue to 152*
❒ Reduced formation of new sinus tracts and scarring ***ACTION REQUIRED****: Submit supporting documentation, Continue to 152*
❒ Decrease in frequency of inflammatory lesions from baseline ***ACTION REQUIRED****: Submit supporting documentation, Continue to 152*

❒ Reduction in pain from baseline ***ACTION REQUIRED****: Submit supporting documentation, Continue to 152*
❒ Reduction in suppuration from baseline ***ACTION REQUIRED****: Submit supporting documentation, Continue to 152*
❒ Improvement in frequency of relapses from baseline ***ACTION REQUIRED****: Submit supporting documentation, Continue to 152*
❒ Improvement in quality of life from baseline ***ACTION REQUIRED****: Submit supporting documentation, Continue to 152*
❒ Improvement on a disease severity assessment tool from baseline ***ACTION REQUIRED****: Submit supporting documentation, Continue to 152*

❒ None of the above, *Continue to 152*

92. Has the patient ever received or is currently receiving a biologic (e.g., Humira) indicated for the treatment of severe, refractory hidradenitis suppurativa (excluding receiving the drug via samples or a manufacturer's patient assistance program)? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 152*
❒ No, *Continue to 93*

93. Has the patient experienced an inadequate response after at least 90 days of treatment with an oral antibiotic? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 152*
❒ No, *Continue to 94*

94. Has the patient experienced an intolerance to oral antibiotics? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 152*
❒ No, *Continue to 95*

95. Does the patient have a contraindication to oral antibiotics? ***ACTION REQUIRED***: If Yes, please attach documentation of clinical reason to avoid therapy. ***ACTION REQUIRED***: Submit supporting documentation

❒ Yes, *Continue to 152*
❒ No, *Continue to 152*

96. Is the requested drug being prescribed by or in consultation with a dermatologist?
❒ Yes, *Continue to 97*
❒ No, *Continue to 97*

97. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 98*
❒ No, *Continue to 100*

98. Is the patient currently receiving the requested drug or a biosimilar of the requested drug through samples or a manufacturer's patient assistance program?

❒ Yes, *Continue to 100*

❒ No, *Continue to 99*

❒ Unknown, *Continue to 100*

99. Has the patient achieved or maintained a 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 or a biosimilar of the requested drug?
❒ Yes, *Continue to 152*
❒ No, *Continue to 152*

100. Has the patient ever received or is currently receiving a biologic (e.g., Humira) indicated for the treatment of pyoderma gangrenosum (excluding receiving the drug via samples or a manufacturer's patient assistance program)? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 152*
❒ No, *Continue to 101*

101. Has the patient experienced an inadequate response with corticosteroids or immunosuppressive therapy (e.g., cyclosporine, mycophenolate mofetil)? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 152*
❒ No, *Continue to 102*

102. Has the patient experienced an intolerance to corticosteroids and immunosuppressive therapy (e.g., cyclosporine, mycophenolate mofetil)? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 152*
❒ No, *Continue to 103*

103. Does the patient have a contraindication to corticosteroids and immunosuppressive therapy (e.g., cyclosporine, mycophenolate mofetil)?
ACTION REQUIRED: If Yes, please attach documentation of clinical reason to avoid therapy. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 152*
❒ No, *Continue to 152*

104. Is the requested drug being prescribed by or in consultation with a dermatologist or pulmonologist?
❒ Yes, *Continue to 105*
❒ No, *Continue to 105*

105. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 106*
❒ No, *Continue to 108*

106. Is the patient currently receiving the requested drug or a biosimilar of the requested drug through samples or a manufacturer's patient assistance program?

❒ Yes, *Continue to 108*

❒ No, *Continue to 107*

❒ Unknown, *Continue to 108*

107. Has the patient achieved or maintained a 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 or a biosimilar of the requested drug?
❒ Yes, *Continue to 152*
❒ No, *Continue to 152*

108. Has the patient experienced an inadequate response with corticosteroids or immunosuppressive therapy (e.g., azathioprine, methotrexate)? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 152*
❒ No, *Continue to 109*

109. Has the patient experienced an intolerance to corticosteroids and immunosuppressive therapy (e.g., azathioprine, methotrexate)? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 152*
❒ No, *Continue to 110*

110. Does the patient have a contraindication to corticosteroids and immunosuppressive therapy (e.g., azathioprine, methotrexate)? ***ACTION REQUIRED***: If Yes, please attach documentation of clinical reason to avoid therapy. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 152*
❒ No, *Continue to 152*

111. Has the patient been diagnosed with refractory Takayasu's arteritis?
❒ Yes, *Continue to 112*
❒ No, *Continue to 112*

112. Is the requested drug being prescribed by or in consultation with a rheumatologist?
❒ Yes, *Continue to 113*
❒ No, *Continue to 113*

113. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug?

❒ Yes, *Continue to 114*
❒ No, *Continue to 116*

114. Is the patient currently receiving the requested drug or a biosimilar of the requested drug through samples or a manufacturer's patient assistance program?

❒ Yes, *Continue to 116*

❒ No, *Continue to 115*

❒ Unknown, *Continue to 116*

115. Has the patient achieved or maintained a 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 or a biosimilar of the requested drug?
❒ Yes, *Continue to 152*
❒ No, *Continue to 152*

116. Has the patient experienced an inadequate response with corticosteroids or immunosuppressive therapy (e.g., methotrexate, azathioprine, mycophenolate mofetil)? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 152*
❒ No, *Continue to 117*

117. Has the patient experienced an intolerance to corticosteroids and immunosuppressive therapy (e.g., methotrexate, azathioprine, mycophenolate mofetil)? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 152*
❒ No, *Continue to 118*

118. Does the patient have a contraindication to corticosteroids and immunosuppressive therapy (e.g., methotrexate, azathioprine, mycophenolate mofetil)? ***ACTION REQUIRED***: If Yes, please attach documentation of clinical reason to avoid therapy. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 152*
❒ No, *Continue to 152*

119. Is the requested drug being prescribed by or in consultation with an ophthalmologist or rheumatologist?
❒ Yes, *Continue to 120*
❒ No, *Continue to 120*

120. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 121*
❒ No, *Continue to 124*

121. Is the patient currently receiving the requested drug or a biosimilar of the requested drug through samples or a manufacturer's patient assistance program?

❒ Yes, *Continue to 124*

❒ No, *Continue to 122*

❒ Unknown, *Continue to 124*

122. Has the patient achieved or maintained a 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 or a

biosimilar of the requested drug?

❒ Yes, *Continue to 123*
❒ No, *Continue to 123*

123. Which of the following has the patient experienced since starting treatment with the requested drug or a biosimilar of the requested drug? ***ACTION REQUIRED***: Please attach chart notes or medical record documentation supporting positive clinical response.
❒ Reduced frequency of recurrence compared to baseline ***ACTION REQUIRED****: Submit supporting documentation, Continue to 152*
❒ Zero anterior chamber inflammation or reduction in anterior chamber inflammation compared to baseline ***ACTION REQUIRED****: Submit supporting documentation, Continue to 152*
❒ Decreased reliance on topical corticosteroids ***ACTION REQUIRED****: Submit supporting documentation, Continue to 152*

❒ None of the above, *Continue to 152*

124. Has the patient ever received or is currently receiving a biologic (e.g., Humira) indicated for the treatment of uveitis (excluding receiving the drug via samples or a manufacturer's patient assistance program)? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 152*
❒ No, *Continue to 125*

125. Has the patient experienced an inadequate response with corticosteroids or immunosuppressive therapy (e.g., methotrexate, azathioprine, mycophenolate mofetil)? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medication tried, including response to therapy. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 152*
❒ No, *Continue to 126*

126. Has the patient experienced an intolerance to corticosteroids and immunosuppressive therapy (e.g., methotrexate, azathioprine, mycophenolate mofetil)? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 152*
❒ No, *Continue to 127*

127. Does the patient have a contraindication to corticosteroids and immunosuppressive therapy (e.g., methotrexate, azathioprine, mycophenolate mofetil)? ***ACTION REQUIRED***: If Yes, please attach documentation of clinical reason to avoid therapy. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 152*
❒ No, *Continue to 152*

128. Is the requested drug being prescribed by or in consultation with a rheumatologist?
❒ Yes, *Continue to 129*
❒ No, *Continue to 129*

129. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 130*
❒ No, *Continue to 132*

130. Is the patient currently receiving the requested drug or a biosimilar of the requested drug through samples or a manufacturer's patient assistance program?

❒ Yes, *Continue to 132*

❒ No, *Continue to 131*

❒ Unknown, *Continue to 132*

131. Has the patient achieved or maintained a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition (e.g., tender joint count, swollen joint count, pain) since starting treatment with the requested drug or a biosimilar of the requested drug? ***ACTION REQUIRED***: If Yes, please attach chart notes or medical record documentation supporting positive clinical response. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 152*
❒ No, *Continue to 152*

132. Has the patient ever received or is currently receiving a biologic (e.g., Enbrel) indicated for the treatment of reactive arthritis (excluding receiving the drug via samples or a manufacturer's patient assistance program)? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 152*
❒ No, *Continue to 133*

133. Has the patient experienced an inadequate response after at least 3 months of treatment with either of the following: a) sulfasalazine at a dose of 1000 mg twice daily or maximally tolerated dose, or b) methotrexate at a dose greater than or equal to 15 mg per week or maximally tolerated dose? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 152*
❒ No, *Continue to 134*

134. Has the patient experienced an intolerance to sulfasalazine and methotrexate? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 152*
❒ No, *Continue to 135*

135. Does the patient have a contraindication to sulfasalazine (e.g., porphyria, intestinal or urinary obstruction)? ***ACTION REQUIRED***: If Yes, please attach documentation of clinical reason to avoid therapy. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 136*
❒ No, *Continue to 136*

136. Does the patient have a contraindication to methotrexate? ***ACTION REQUIRED***: If Yes, please attach documentation of clinical reason to avoid therapy. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 137*
❒ No, *Continue to 137*

137. Please indicate the contraindication to methotrexate.
❒ Clinical diagnosis of alcohol use disorder, alcoholic liver disease, or other chronic liver disease, *Continue to 152*

❒ Drug interaction, *Continue to 152*

❒ Risk of treatment-related toxicity, *Continue to 152*

❒ Pregnancy or currently planning pregnancy, *Continue to 152*

❒ Breastfeeding, *Continue to 152*

❒ Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension), *Continue to 152*

❒ Hypersensitivity, *Continue to 152*

❒ History of intolerance or adverse event, *Continue to 152*

❒ Other, please specify. _____, *Continue to 152*

138. Is the requested drug being prescribed by or in consultation with an oncologist or hematologist?
❒ Yes, *Continue to 139*
❒ No, *Continue to 139*

139. Has the patient experienced an inadequate response to corticosteroids? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 152*
❒ No, *Continue to 140*

140. Has the patient experienced an intolerance to corticosteroids? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 152*
❒ No, *Continue to 141*

141. Does the patient have a contraindication to corticosteroids? ***ACTION REQUIRED***: If Yes, please attach documentation of clinical reason to avoid therapy. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 152*
❒ No, *Continue to 142*

142. Does the patient have moderate or severe diarrhea or colitis?
❒ Yes, *Continue to 152*
❒ No, *Continue to 152*

143. Does the patient have severe disease?
❒ Yes, *Continue to 144*
❒ No, *Continue to 144*

144. Is the requested drug being prescribed by or in consultation with an oncologist or hematologist?
❒ Yes, *Continue to 145*
❒ No, *Continue to 145*

145. Has the patient experienced an inadequate response to corticosteroids? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 152*
❒ No, *Continue to 146*

146. Has the patient experienced an intolerance to corticosteroids? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 152*
❒ No, *Continue to 147*

147. Does the patient have a contraindication to corticosteroids? ***ACTION REQUIRED***: If Yes, please attach documentation of clinical reason to avoid therapy. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 152*
❒ No, *Continue to 152*

148. Is the requested drug being prescribed by or in consultation with an oncologist or hematologist?
❒ Yes, *Continue to 149*
❒ No, *Continue to 149*

149. Has the patient experienced an inadequate response to systemic corticosteroids? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 152*
❒ No, *Continue to 150*

150. Has the patient experienced an intolerance to corticosteroids? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 152*
❒ No, *Continue to 151*

151. Does the patient have contraindication to corticosteroids? ***ACTION REQUIRED***: If Yes, please attach documentation of clinical reason to avoid therapy. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 152*
❒ No, *Continue to 152*

152. What is the diagnosis?

❒ Crohn's disease, *Continue to 153*

❒ Ulcerative colitis, *Continue to 171*

❒ Rheumatoid arthritis, *Continue to 187*

❒ Ankylosing spondylitis, *Continue to 203*

❒ Non-radiographic axial spondyloarthritis, *Continue to 203*

❒ Psoriatic arthritis, *Continue to 210*

❒ Psoriatic arthritis WITH co-existent plaque psoriasis, *Continue to 210*

❒ Plaque psoriasis, *Continue to 210*

❒ Behcet's disease, *Continue to 217*

❒ Hidradenitis suppurativa, *Continue to 217*

❒ Pyoderma gangrenosum, *Continue to 217*

❒ Sarcoidosis, *Continue to 217*

❒ Takayasu's arteritis, *Continue to 217*

❒ Uveitis, *Continue to 221*

❒ Reactive arthritis, *Continue to 217*

❒ Immune checkpoint inhibitor (e.g., CTLA-4, PD-L1 inhibitor) toxicity, *Continue to 225*
❒ Immune checkpoint inhibitor (e.g., CTLA-4, PD-L1 inhibitor) toxicity - Inflammatory arthritis, *Continue to 217*

❒ Acute graft versus host disease, *Continue to 217*

153. Is the patient currently receiving the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 154*
❒ No, *Continue to 164*

154. Does the prescribed dose exceed 5 mg per kg?
❒ Yes, *Continue to 157*
❒ No, *Continue to 155*

155. Is the prescribed frequency for the maintenance dose more frequent than one dose every 8 weeks?
❒ Yes, *Continue to 156*
❒ No, *Continue to 156*

156. What is the patient's weight?
_____kg., *No further questions*

157. Does the prescribed dose exceed 10 mg per kg?
❒ Yes, *Continue to 158*
❒ No, *Continue to 158*

158. What is the patient's age?
❒ Less than 18 years old, *Continue to 159*
❒ 18 years old or older, *Continue to 160*

159. Does the prescriber recognize that a dose above 5 mg per kg is a higher dose and the prescriber confirms that appropriate monitoring will be done?
❒ Yes, *Continue to 162*
❒ No, *Continue to 162*

160. Please select the situation that applies to the patient.
❒ Patient is continuing therapy on current dose, *Continue to 162*
❒ Prescriber is increasing dose, *Continue to 161*
❒ Prescriber is decreasing dose, *Continue to 162*

161. Does the patient require a dose above 5 mg per kg due to loss of response at the current dose?
❒ Yes, *Continue to 162*
❒ No, *Continue to 162*

162. Is the prescribed frequency for the maintenance dose more frequent than one dose every 8 weeks?
❒ Yes, *Continue to 163*
❒ No, *Continue to 163*

163. What is the patient's weight?
_____kg., *No further questions*

164. Is the prescribed frequency for the maintenance dose more frequent than one dose every 8 weeks?
❒ Yes, *Continue to 165*
❒ No, *Continue to 165*

165. Does the prescribed dose exceed an induction dose of 5 mg per kg at week 0, week 2, and week 6, and a maintenance dose of 5 mg per kg thereafter?
❒ Yes, *Continue to 167*
❒ No, *Continue to 166*

166. What is the patient's weight?
_____kg., *No further questions*

167. What is the patient's age?
❒ Less than 18 years old, *Continue to 168*
❒ 18 years of age or older, *Continue to 168*

168. Does the prescriber recognize that a dose above 5 mg per kg is a higher dose and the prescriber confirms that appropriate monitoring will be done?
❒ Yes, *Continue to 169*
❒ No, *Continue to 169*

169. Does the prescribed dose exceed an induction dose of 10 mg per kg at week 0, week 2, and week 6, and a maintenance dose of 10 mg per kg thereafter?
❒ Yes, *Continue to 170*
❒ No, *Continue to 170*

170. What is the patient's weight?
_____kg, *No further questions*

171. Is the patient currently receiving the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 172*
❒ No, *Continue to 180*

172. Is the prescribed frequency for the maintenance dose more frequent than one dose every 8 weeks?
❒ Yes, *Continue to 173*
❒ No, *Continue to 173*

173. Does the prescribed dose exceed 5 mg per kg?
❒ Yes, *Continue to 175*
❒ No, *Continue to 174*

174. What is the patient's weight?
_____kg, *No further questions*

175. Does the prescribed dose exceed 10 mg per kg?
❒ Yes, *Continue to 176*
❒ No, *Continue to 176*

176. What is the patient's age?
❒ Less than 18 years old, *Continue to 178*
❒ 18 years of age or older, *Continue to 177*

177. Was the patient on a dose exceeding 5 mg per kg as a pediatric patient and is continuing that dose into adulthood?
❒ Yes, *Continue to 178*
❒ No, *Continue to 178*

178. Does the prescriber recognize that a dose above 5 mg per kg is a higher dose and the prescriber confirms that appropriate monitoring will be done?
❒ Yes, *Continue to 179*
❒ No, *Continue to 179*

179. What is the patient's weight?
_____kg, *No further questions*

180. Is the prescribed frequency for the maintenance dose more frequent than one dose every 8 weeks?
❒ Yes, *Continue to 181*
❒ No, *Continue to 181*

181. Does the prescribed dose exceed an induction dose of 5 mg per kg at week 0, week 2, and week 6, and 5 mg per kg thereafter?
❒ Yes, *Continue to 183*
❒ No, *Continue to 182*

182. What is the patient's weight?
_____kg, *No further questions*

183. What is the patient's age?
❒ Less than 18 years old, *Continue to 184*
❒ 18 years of age or older, *Continue to 184*

184. Does the prescriber recognize that a dose above 5 mg per kg is a higher dose and the prescriber confirms that appropriate monitoring will be done?
❒ Yes, *Continue to 185*
❒ No, *Continue to 185*

185. Does the prescribed dose exceed an induction dose of 10 mg per kg at week 0, week 2, and week 6, and a maintenance dose of 10 mg per kg thereafter?
❒ Yes, *Continue to 186*
❒ No, *Continue to 186*

186. What is the patient's weight?
_____kg., *No further questions*

187. Is the patient currently receiving the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 188*
❒ No, *Continue to 200*

188. Does the prescribed dose exceed 3 mg per kg?
❒ Yes, *Continue to 195*
❒ No, *Continue to 189*

189. Is the prescribed frequency for the maintenance dose more frequent than one dose every 8 weeks?
❒ Yes, *Continue to 191*
❒ No, *Continue to 190*

190. What is the patient's weight?
_____kg, *No further questions*

191. Is the prescribed frequency for the maintenance dose more frequent than one dose every 4 weeks?
❒ Yes, *Continue to 192*
❒ No, *Continue to 192*

192. Please select the situation that applies to the patient.

❒ Patient is continuing therapy at current dosing frequency, *Continue to 194*

❒ Prescriber is increasing dosing frequency, *Continue to 193*

❒ Prescriber is decreasing dosing frequency, *Continue to 194*

193. Does the patient require dosing more frequent than every 8 weeks due to an incomplete response at the current dosing frequency?
❒ Yes, *Continue to 194*
❒ No, *Continue to 194*

194. What is the patient's weight?
_____kg, *No further questions*

195. Does the prescribed dose exceed 10 mg per kg?
❒ Yes, *Continue to 196*
❒ No, *Continue to 196*

196. Please select the situation that applies to the patient.

❒ Patient is continuing therapy on current dose, *Continue to 198*

❒ Prescriber is increasing dose, *Continue to 197*

❒ Prescriber is decreasing dose, *Continue to 198*

197. Does the patient require a dose above 3 mg per kg due to an incomplete response at the current dose?
❒ Yes, *Continue to 198*
❒ No, *Continue to 198*

198. Is the prescribed frequency for the maintenance dose more frequent than one dose every 8 weeks?
❒ Yes, *Continue to 199*
❒ No, *Continue to 199*

199. What is the patient's weight?
_____kg., *No further questions*

200. Is the prescribed frequency for the maintenance dose more frequent than one dose every 8 weeks?
❒ Yes, *Continue to 201*
❒ No, *Continue to 201*

201. Does the prescribed dose exceed an induction dose of 3 mg per kg at week 0, week 2, and week 6, and a maintenance dose of 3 mg per kg thereafter?
❒ Yes, *Continue to 202*
❒ No, *Continue to 202*

202. What is the patient's weight?
_____kg., *No further questions*

203. Is the patient currently receiving the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 204*
❒ No, *Continue to 207*

204. Is the prescribed frequency for the maintenance dose more frequent than one dose every 6 weeks?
❒ Yes, *Continue to 205*
❒ No, *Continue to 205*

205. Does the prescribed dose exceed 5 mg per kg?
❒ Yes, *Continue to 206*
❒ No, *Continue to 206*

206. What is the patient's weight?
_____kg., *No further questions*

207. Is the prescribed frequency for the maintenance dose more frequent than one dose every 6 weeks?
❒ Yes, *Continue to 208*
❒ No, *Continue to 208*

208. Does the prescribed dose exceed an induction dose of 5 mg per kg at week 0, week 2, and week 6, and 5 mg per kg thereafter?
❒ Yes, *Continue to 209*
❒ No, *Continue to 209*

209. What is the patient's weight?
_____kg., *No further questions*

210. Is the patient currently receiving the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 211*
❒ No, *Continue to 214*

211. Is the prescribed frequency for the maintenance dose more frequent than one dose every 8 weeks?
❒ Yes, *Continue to 212*
❒ No, *Continue to 212*

212. Does the prescribed dose exceed 5 mg per kg?
❒ Yes, *Continue to 213*
❒ No, *Continue to 213*

213. What is the patient's weight?
_____kg, *No further questions*

214. Is the prescribed frequency for the maintenance dose more frequent than one dose every 8 weeks?

❒ Yes, *Continue to 215*
❒ No, *Continue to 215*

215. Does the prescribed dose exceed an induction dose of 5 mg per kg at week 0, week 2, and week 6, and 5 mg per kg thereafter?
❒ Yes, *Continue to 216*
❒ No, *Continue to 216*

216. What is the patient's weight?
_____kg, *No further questions*

217. Is the requested quantity supported by dosing guidelines found in the compendia or current literature (e.g., Micromedex DrugDex, NCCN compendia, current treatment guidelines)?
❒ Yes, *Continue to 218*
❒ No, *Continue to 218*

218. Is the patient currently receiving the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 219*
❒ No, *Continue to 219*

219. What is the patient's weight?
_____kg, *No further questions*

221. Is the requested quantity supported by dosing guidelines found in the compendia or current literature (e.g., Micromedex DrugDex, NCCN compendia, current treatment guidelines)?
❒ Yes, *Continue to 222*
❒ No, *Continue to 222*

222. Is the patient currently receiving the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 223*
❒ No, *Continue to 223*

223. What is the patient's weight?
_____kg, *No further questions*

225. Is the requested quantity supported by dosing guidelines found in the compendia or current literature (e.g., Micromedex DrugDex, NCCN compendia, current treatment guidelines)?
❒ Yes, *Continue to 226*
❒ No, *Continue to 226*

226. Is the patient currently receiving the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 227*
❒ No, *Continue to 227*

227. What is the patient's weight?
_____kg, *No further questions*

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 Specialty Programs Fax: 1-855-330-1720

 Remicade and biosimilars SOC SGM 2182-A – 08/2023.