# Rinvoq

## 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 diagnosis?
   ❑ Moderately to severely active rheumatoid arthritis
   ❑ Other _____
2. What is the ICD-10 code? _____
3. Will the requested drug be used in combination with any other biologic, targeted synthetic DMARD (e.g., Olumiant, Xeljanz), or potent immunosuppressants such as azathioprine or cyclosporine? ❑ Yes ❑ No
4. Has the patient ever received (including current utilizers) a biologic or targeted synthetic DMARD (e.g., Rinvoq, Xeljanz)? *If Yes, skip to #6* ❑ Yes ❑ No
5. Has the patient had a TB test (e.g., a tuberculosis skin test [PPD], an interferon-release assay [IGRA], or a chest x-ray) within 6 months of initiating therapy? *If Yes, skip to #8* ❑ Yes ❑ No
6. Does the patient have risk factors for 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, or persons who work or reside with people who are at an increased risk for active TB)?
   ❑ Yes ❑ No *If No, skip to #11*
7. Has the patient been tested for tuberculosis (TB) within the previous 12 months? ❑ Yes ❑ No
8. What were the results of the TB test? ❑ Positive for TB ❑ Negative for TB, *skip to #11* ❑ Unknown
9. Does the patient have latent or active tuberculosis (TB)? ❑ Latent ❑ Active ❑ Unknown
10. Has treatment for latent tuberculosis (TB) infection been initiated or completed?
    ❑ Yes – treatment initiated ❑ Yes – treatment completed ❑ None of the above
11. Is this request for continuation of therapy? ❑ Yes ❑ No *If No, skip to #14*
12. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program? *If Yes or Unknown, skip to #14* ❑ Yes ❑ No ❑ Unknown

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

13. Has the patient achieved or maintained positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of RA since starting treatment with Rinvoq?
    ❑ Yes ❑ No *No further questions*

14. Has the patient received a biologic or targeted synthetic DMARD that is indicated for moderately to severely active rheumatoid arthritis? *If Yes, no further questions.* ❑ Yes ❑ No

15. Has the patient experienced an inadequate response after at least 3 months of treatment with a methotrexate dose greater than or equal to 20 mg per week? *If Yes, no further questions.* ❑ Yes ❑ No

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

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

***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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