

Siliq (for Maryland only)
Prior Authorization Request

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

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.

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Patient's Name: _____ **Date:** _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____ **NPI#:** _____
Specialty: _____ **Physician Office Fax:** _____
Physician Office Telephone: _____
Request Initiated For: _____

1. What is the diagnosis?
 Plaque psoriasis, moderate to severe Other _____
2. What is the ICD-10 code? _____
3. The primary preferred product for which coverage is provided for the treatment of plaque psoriasis is **Humira**. Can the patient's treatment be switched to the primary preferred product (Humira)?
 Yes *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
4. Is this request for continuation of therapy with the requested product? Yes No *If No, skip to #8*
5. Is the patient currently receiving the requested product through samples or a manufacturer's patient assistance program? If unknown, answer Yes. *If Yes, skip to #8* Yes No
6. The secondary preferred products for which coverage is provided for the treatment of plaque psoriasis are **Stelara or Taltz**. Can the patient's treatment be switched to either of these preferred products?
**Note: Secondary preferred products for plaque psoriasis are Stelara and Taltz. These preferred product options only apply to members who have had a documented inadequate response or intolerable adverse event with Humira, or who have a documented clinical reason to avoid TNF inhibitors.*
 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
7. Has the patient had a documented inadequate response or intolerable adverse event with the secondary preferred product **Taltz**? **ACTION REQUIRED: If Yes, attach supporting chart note(s) and skip to #10.**
 Yes - Inadequate response Yes - Intolerable adverse event

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No - none of the above

8. Has the patient had 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).**

Humira: Inadequate response Intolerable adverse event

Stelara: Inadequate response Intolerable adverse event

Taltz: Inadequate response Intolerable adverse event

No - none of the above, *complete this form in its entirety and also complete Maryland State Step Therapy Section*

9. Does the patient have one of the following documented clinical reasons to avoid Humira?

ACTION REQUIRED: If Yes, attach supporting chart note(s).

Yes - History of demyelinating disorder

Yes - History of congestive heart failure

Yes - History of hepatitis B virus infection

Yes - Autoantibody formation/lupus-like syndrome

Yes - Risk of lymphoma

No - none of the above, *complete this form in its entirety and also complete Maryland State Step Therapy Section*

10. Is this request for continuation of therapy? Yes No *If No, skip to #14*

11. Is the patient currently receiving Siliq through samples or a manufacturer's patient assistance program?

Yes No Unknown *If Yes or Unknown, skip to #14*

12. How long has the patient been receiving the requested medication? _____ months

If less than 3 months, no further questions.

13. Has the patient achieved or maintained positive clinical response to treatment as evidenced by low disease activity or improvement in signs and symptoms? *If Yes, no further questions* Yes No

14. Has the patient received any of the following medications? *If Yes, please indicate the most recent medication.*

Actemra Cimzia Cosentyx Enbrel Humira Inflectra Kevzara Orencia

Otezla Remicade Renflexis Siliq Simponi Simponi Aria Stelara Taltz

Tremfya Xeljanz Xeljanz XR No

15. Has the patient undergone pretreatment screening for latent tuberculosis (TB) infection with either a TB skin test or an interferon gamma release assay (e.g., QFT-GIT, T-SPOT.TB)? Yes No

16. What is the percentage of body surface area (BSA) affected? _____ % of BSA

17. *If less than 5% BSA affected*, are crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) affected? Yes No

18. Has the patient experienced an inadequate response, or has an intolerance to pharmacologic treatment with methotrexate, cyclosporine or acitretin? *If Yes, no further questions* Yes No

19. Does the patient have a clinical reason to avoid pharmacologic treatment with methotrexate, cyclosporine or acitretin? Yes No

If Yes, indicate the clinical reason: _____

Maryland State Step Therapy

1. Is the requested drug being used to treat stage four advanced metastatic cancer?

Yes No *If No, skip to #3*

2. Is the requested drug's use consistent with the FDA-approved indication or the National Comprehensive Cancer Network Drugs & Biologics Compendium indication for the treatment of stage four advanced metastatic cancer and is supported by peer-reviewed medical literature? Yes No

3. Is the requested drug being used for an FDA-approved indication OR an indication supported in the compendia of current literature (examples: AHFS, Lexicomp, Clinical Pharmacology, Micromedex, current accepted guidelines)? Yes No
4. Does the prescribed quantity fall within the manufacturer's published dosing guidelines or within dosing guidelines found in the compendia of current literature (examples: package insert, AHFS, Lexicomp, Clinical Pharmacology, Micromedex, current accepted guidelines)? Yes No
5. Do patient chart notes document the requested drug was ordered with a paid claim at the pharmacy, the pharmacy filled the prescription and delivered to the patient or other documentation that the requested drug was prescribed for the patient in the last 180 days? Yes No
6. Has the prescriber provided proof documented in the patient chart notes that in their opinion the requested drug is effective for the patient's condition? 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)