

**Siliq**  
**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/](http://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/](http://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.**

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- Yes - Inadequate response     Yes - Intolerable adverse event
- 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

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

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:*** \_\_\_\_\_

***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)**