CareFirst Family of health care plans

CVS caremark™

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.

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?
   ❑ 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
   ❑ 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)**