# Sotyktu

## 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 prescribed dose and frequency?
   ❑ Sotyktu 6mg Quantity and Frequency: _____
   ❑ Other: _____

2. What is the diagnosis?
   ❑ Moderate to severe plaque psoriasis ❑ Other _____

3. What is the ICD-10 code? _____

4. These are the preferred products for which coverage is provided for the treatment of the following indication: Plaque psoriasis: **Humira, Ilumya, Otezla, Remicade, Skyrizi SC, Stelara (SC), Taltz, Tremfya, Cimzia syringe (secondary*).** ***Secondary preferred product for plaque psoriasis is Cimzia syringe. Secondary product is preferred after failure with 2 primary preferred products.***
   Can the patient's treatment be switched to a preferred product?
   ❑ 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 - Continue request for Sotyktu
   ❑ Not applicable - Requested for condition other than plaque psoriasis, *skip to #7*

5. Does the patient have a documented inadequate response or intolerable adverse event to all of the preferred products indicated for plaque psoriasis? ***ACTION REQUIRED: If Yes, attach supporting chart note(s).***
   *Indicate ALL that apply.*

| | | |
|---|---|---|
| ❑ Humira | ❑ Inadequate response | ❑ Intolerable adverse event |
| ❑ Otezla | ❑ Inadequate response | ❑ Intolerable adverse event |
| ❑ Cimzia syringe | ❑ Inadequate response | ❑ Intolerable adverse event |
| ❑ Skyrizi SC | ❑ Inadequate response | ❑ Intolerable adverse event |
| ❑ Stelara SC | ❑ Inadequate response | ❑ Intolerable adverse event |
| ❑ Taltz | ❑ Inadequate response | ❑ Intolerable adverse event |
| ❑ Tremfya | ❑ Inadequate response | ❑ Intolerable adverse event |

   ❑ No - None of the above

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

6. Does the patient have one of the following documented clinical reasons to avoid both of the preferred products that are TNF inhibitors (Humira and Cimzia)? ***ACTION REQUIRED: If Yes, attach supporting chart note(s).***
   - ❑ Not applicable - requested medication is a TNF inhibitor
   - ❑ Yes - History of demyelinating disorder
   - ❑ Yes - History of congestive heart failure
   - ❑ Yes - History of hepatitis B virus infection
   - ❑ Yes - Autoantibody formation/lupus-like syndrome (attributed to TNF inhibitor)
   - ❑ Yes - History or risk of lymphoma or other malignancy
   - ❑ Yes - History of being a primary non-responder to a TNF inhibitor (i.e., no clinical response with initial treatment)
   - ❑ No - None of the above

7. 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 ❑ No

8. 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? *If Yes, skip to #12* ❑ Yes ❑ No

9. 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 ❑ No

10. What were the results of the TB test? ❑ Positive for TB ❑ Negative for TB, *skip to #12* ❑ Unknown

11. Which of the following applies to the patient?
    - ❑ Patient has latent TB and treatment for latent TB has been initiated
    - ❑ Patient has latent TB and treatment for latent TB has been completed
    - ❑ Patient has latent TB and treatment for latent TB has not been initiated
    - ❑ Patient has active TB

12. Is the requested drug prescribed by or in consultation with a dermatologist? ❑ Yes ❑ No

13. Is this request for continuation of therapy with the requested drug? ❑ Yes ❑ No *If No, skip to #18*

14. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program? *If Yes or Unknown, skip to #18* ❑ Yes ❑ Unknown ❑ No

15. Has the patient achieved or maintained 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? ❑ Yes ❑ No

16. Has the patient experienced a reduction in body surface area (BSA) affected from baseline? ***ACTION REQUIRED: Please attach chart notes or medical record documentation of decreased body surface area affected.*** *If Yes, no further questions.* ❑ Yes ❑ No

17. 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.*** ❑ Yes ❑ No *No further questions.*

18. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic drug (e.g., Otezla) indicated for the treatment of moderate to severe plaque psoriasis? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried and no further questions.*** ❑ Yes ❑ No

19. 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 and body surface area affected and no further questions.*** ❑ Yes ❑ No

20. What is the percentage of body surface area (BSA) affected (prior to starting the requested medication)? _____% ***ACTION REQUIRED: Please attach chart notes or medical record documentation of affected areas and body surface area affected.*** *If greater than or equal to 10% of BSA, no further questions.*

21. 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 and no further questions.*** ❑ Yes ❑ No

22. 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.***
❑ Yes ❑ No
***If Yes, indicate the 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)**

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