Stelara

Prior Authorization Request

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

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 1-855-330-1720**. 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: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____*kg*

*Patient Height:*_____*cm*

Please indicate the place of service for the requested drug:
❑ *Ambulatory Surgical* ❑ *Home* ❑ *Inpatient Hospital* ❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital* ❑ *Office* ❑ *Pharmacy*

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Exception Criteria Questions:

A. These are the preferred products for which coverage is provided for treatment of the following conditions:
- Rheumatoid arthritis, psoriatic arthritis: **Orencia, Remicade, and Simponi Aria**
- Plaque psoriasis, Crohn's disease, ulcerative colitis: **Remicade**
- Ankylosing spondylitis: **Remicade and Simponi Aria**
- Polyarticular juvenile idiopathic arthritis: **Orencia**

Can the patient's treatment be switched to a preferred product?
❑ Yes, *Please obtain Form for preferred product and submit for corresponding PA.*
❑ No

B. Is this request for continuation of therapy with the requested product? ❑ Yes ❑ No, *skip to Question D*

C. Is the patient currently receiving the requested product through samples or a manufacturer's patient assistance program? If unknown, answer Yes.
❑ Yes ❑ No, *skip to Clinical Criteria Questions*

D. What is the diagnosis?
❑ Rheumatoid Arthritis
❑ Crohn's disease, *skip to Question F.*
❑ Psoriatic arthritis
❑ Plaque psoriasis, *skip to Question F.*
❑ Ulcerative colitis, *skip to Question F.*
❑ Ankylosing spondylitis, *skip to Question I.*
❑ Polyarticular juvenile idiopathic arthritis, *skip to Question H.*
❑ Other, *skip to Clinical Criteria Questions*

E. Has the patient had a documented inadequate response or intolerable adverse event with all of the preferred products (Orencia, Remicade, or Simponi Aria)? **Action Required:** ***If 'Yes', attach supporting chart note(s).***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No, *skip to Clinical Criteria Questions*

F. Has the patient had a documented inadequate response or intolerable adverse event with the preferred product (Remicade)? **Action Required:** ***If 'Yes', attach supporting chart note(s).***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

G. Does the patient have one of the following documented clinical reasons to avoid Remicade? *Indicate below and skip to Clinical Criteria Questions.* **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

H. Has the patient had a documented inadequate response or intolerable adverse event with the preferred product (Orencia)? **Action Required:** ***If 'Yes', attach supporting chart note(s).***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No, *skip to Clinical Criteria Questions*

I. Has the patient had a documented inadequate response or intolerable adverse event with all preferred products (Remicade or Simponi Aria)? **Action Required:** ***If 'Yes', attach supporting chart note(s).*** ❑ Yes ❑ No

Criteria Questions:

1. What is the requested formulation? ❑ Stelara for subcutaneous injection ❑ Stelara for intravenous infusion

2. What is the diagnosis?
❑ Moderate to severe plaque psoriasis
❑ Active psoriatic arthritis (PsA)
❑ Moderately to severely active Crohn's disease (CD)
❑ Other _____

3. What is the ICD-10 code? _____

4. Is the patient currently receiving Stelara? ❑ Yes ❑ No

5. Is this request for continuation of therapy? ❑ Yes ❑ No *If No, skip to #9*

6. Is the patient currently receiving Stelara through samples or a manufacturer's patient assistance program? ❑ Yes ❑ No ❑ Unknown *If Yes or Unknown, skip to #9*

7. How long has the patient been receiving the requested medication? _____ months
If less than 4 months, no further questions.

8. 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

9. Has the patient received any of the following medications?
If Yes, please indicate the most recent medication and skip to diagnosis section.
❑ Actemra ❑ Cimzia ❑ Cosentyx ❑ Enbrel ❑ Humira ❑ Ilumya ❑ Inflectra ❑ Kevzara ❑ Orencia ❑ Otezla ❑ Remicade ❑ Renflexis ❑ Siliq ❑ Simponi ❑ Simponi Aria ❑ Taltz ❑ Tremfya ❑ Xeljanz
❑ Xeljanz XR ❑ No

10. 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

Complete the following section based on the patient's diagnosis if applicable.

Section A: Plaque Psoriasis

11. What is the percentage of body surface area (BSA) affected (prior to starting the requested medication)? _____ %

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

13. 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? *If Yes, no further questions* ❑ Yes ❑ No

14. Does the patient have a clinical reason to avoid pharmacologic treatment with methotrexate, cyclosporine or acitretin? ❑ Yes ❑ No ***If Yes, indicate clinical reason:***
_____

15. Does the patient have severe psoriasis that warrants a biologic DMARD as first-line therapy? ❑ Yes ❑ No

Section B: Crohn's Disease

16. Has the patient tried and had an inadequate response to at least one conventional therapy option?
If Yes, indicate below and no further questions.
❑ Yes - Sulfasalazine (Azulfidine, Sulfazine)
❑ Yes - Mesalamine, oral (Asacol, Pentasa, Delzicol, Lialda)
❑ Yes - Metronidazole (Flagyl)
❑ Yes - Ciprofloxacin (Cipro)
❑ Yes - Prednisone
❑ Yes - Budesonide (Entocort EC)
❑ Yes - Azathioprine (Azasan, Imuran)
❑ Yes - Mercaptopurine (Purinethol)
❑ Yes - Methotrexate
❑ Yes - Methylprednisolone (Solu-Medrol)
❑ Yes - Rifaximin (Xifaxan)
❑ No

19. Does the patient have a contraindication or intolerance to at least one conventional therapy option (e.g., azathioprine [Azasan, Imuran], budesonide [Entocort EC], ciprofloxacin [Cipro], mesalamine [Asacol, Delzicol, Pentasa, Lialda], mercaptopurine [Purinethol], methylprednisolone [Solu-Medrol], methotrexate, metronidazole

[Flagyl], prednisone, sulfasalazine [Azulfidine], rifaximin [Xifaxan])? *If Yes, no further questions* ❑ Yes ❑No

20. Has the patient tried and had an inadequate response to at least one TNF-alpha inhibitor indicated for Crohn's disease (e.g, Cimzia, Humira, or Remicade)? *If Yes, no further questions* ❑ Yes ❑ No

21. Does the patient have a contraindication or intolerance to at least one TNF-alpha inhibitor indicated for Crohn's disease (e.g., Cimzia, Humira, or Remicade)? ❑ Yes ❑ No

Step Therapy Override: Complete if Applicable.	Please Circle	
Is the requested drug being used to treat stage four advanced metastatic cancer?	Yes	No
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
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
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
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
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)**