

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

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Stelara SGM – 07/2018.

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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?
- | | |
|--|---|
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Plaque psoriasis, <i>skip to Question F.</i> |
| <input type="checkbox"/> Crohn's disease, <i>skip to Question F.</i> | <input type="checkbox"/> Ulcerative colitis, <i>skip to Question F.</i> |
| <input type="checkbox"/> Psoriatic arthritis | <input type="checkbox"/> Ankylosing spondylitis, <i>skip to Question I.</i> |
| <input type="checkbox"/> Polyarticular juvenile idiopathic arthritis, <i>skip to Question H.</i> | |
| <input type="checkbox"/> Other, <i>skip to Clinical Criteria Questions</i> | |
- 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).**
- | |
|---|
| <input type="checkbox"/> Yes – History of demyelinating disorder |
| <input type="checkbox"/> Yes – History of congestive heart failure |
| <input type="checkbox"/> Yes – History of hepatitis B virus infection |
| <input type="checkbox"/> Yes – Autoantibody formation/lupus-like syndrome |
| <input type="checkbox"/> Yes – Risk of lymphoma |
| <input type="checkbox"/> 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?
- | | |
|--|---|
| <input type="checkbox"/> Moderate to severe plaque psoriasis | <input type="checkbox"/> Moderately to severely active Crohn's disease (CD) |
| <input type="checkbox"/> Active psoriatic arthritis (PsA) | <input type="checkbox"/> 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

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)