CVS caremark™ {{PANUMCODE}}

Taltz

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: {{MEMFIRST}} {{MEMLAST}} **Date**: {{TODAY}}
Patient's ID: {{MEMBERID}} **Patient's Date of Birth:** {{MEMBERDOB}}
Physician's Name: {{PHYFIRST}} {{PHYLAST}}
Specialty: _____, NPI#: _____
Physician Office Telephone: {{PHYSICIANPHONE}} **Physician Office Fax:** {{PHYSICIANFAX}}
Request Initiated For: {{DRUGNAME}}

1. What is the prescribed quantity and frequency?

   a) **Loading dose:**
   ❑ Taltz 80mg syringes/autoinjectors Quantity and Frequency: _____

   b) **Maintenance dose:**
   ❑ Taltz 80mg syringes/autoinjectors Quantity and Frequency: _____
   ❑ Other _____

2. What is the diagnosis?
   ❑ Moderate to severe plaque psoriasis
   ❑ Psoriatic arthritis with co-existent plaque psoriasis
   ❑ Active psoriatic arthritis WITHOUT co-existent plaque psoriasis
   ❑ Active ankylosing spondylitis (AS)
   ❑ Active axial spondyloarthritis
   ❑ Other _____

3. What is the ICD-10 code? _____

4. What is the patient's weight? _____ kg

Section A: Preferred Product

5. These are the preferred products for which coverage is provided for the treatment of the following indications:
   a) Ankylosing spondylitis: **Cosentyx, Enbrel, Humira, Remicade, Simponi Aria**
   b) Non-radiographic axial spondyloarthritis: **Cimzia syringe, Cosentyx**
   c) Psoriatic arthritis: **Cosentyx, Enbrel, Humira, Otezla, Remicade, Simponi Aria, Stelara (SC), Tremfya**

   Can the patient's treatment be switched to a preferred product?
   ❑ Yes - Please indicate: _____ ***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 Section B: All Requests*

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

6. Is this request for continuation of therapy with the requested product? ❑ Yes ❑ No *If No, skip to #8*

7. Is the patient currently receiving the requested product through samples or a manufacturer's patient assistance program? If unknown, answer 'Yes'. ❑ Yes ❑ No *If No, skip to Section B: All Requests*

8. Does the patient have a documented inadequate response or intolerable adverse event with any of the following preferred products? ***ACTION REQUIRED: If Yes, attach supporting chart note(s).*** *Indicate ALL that apply.*

❑ Cimzia syringe:	❑ Inadequate response	❑ Intolerable adverse event
❑ Cosentyx:	❑ Inadequate response	❑ Intolerable adverse event
❑ Enbrel:	❑ Inadequate response	❑ Intolerable adverse event
❑ Humira:	❑ Inadequate response	❑ Intolerable adverse event
❑ Otezla:	❑ Inadequate response	❑ Intolerable adverse event
❑ Stelara SC:	❑ Inadequate response	❑ Intolerable adverse event
❑ Tremfya:	❑ Inadequate response	❑ Intolerable adverse event

❑ No - None of the above

9. Does the patient have one of the following documented clinical reasons to avoid the preferred products that are TNF inhibitors (Cimzia syringe, Enbrel and/or Humira)?
ACTION REQUIRED: If Yes, attach supporting chart note(s).
❑ Yes – History of demyelinating disorder, *please specify product(s):* _____
❑ Yes – History of congestive heart failure, *please specify product(s):* _____
❑ Yes – History of hepatitis B virus infection, *please specify product(s):* _____
❑ Yes – Autoantibody formation/lupus-like syndrome (attributed to TNF inhibitor), *please specify product(s):* _____
❑ Yes – Risk of lymphoma, *please specify product(s):* _____
❑ No – none of the above
❑ Not applicable – requested medication is a TNF inhibitor

Section B: All Requests

10. Will the requested drug be used in combination with any other biologic (e.g., Humira) or targeted synthetic disease-modifying anti-rheumatic drug (DMARD) (e.g., Olumiant, Otezla, Xeljanz)? ❑ Yes ❑ No

11. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic DMARD (e.g., Olumiant, Xeljanz)? *If Yes, skip to #13* ❑ Yes ❑ No

12. Has the patient had a tuberculosis (TB) test (e.g., tuberculosis skin test [PPD], an interferon-release assay [IGRA], or a chest x-ray) within 6 months of initiating therapy? *If Yes, skip to #15* ❑ Yes ❑ No

13. Does the patient have risk factors for tuberculosis (TB) (e.g., persons with close contact to people with infectious TB disease; persons who have recently immigrated from areas of the world with high rates of TB [e.g., Africa, Asia, Eastern Europe, Latin America, Russia]; children less than 5 years of age who have a positive TB test; groups with high rates of TB transmission [e.g., homeless persons, injection drug users, persons with HIV infection], or persons who work or reside with people who are at an increased risk for active TB [e.g., hospitals, long-term care facilities, correctional facilities, homeless shelters])? ❑ Yes ❑ No *If No, skip to #18*

14. Has the patient been tested for tuberculosis (TB) within the previous 12 months? ❑ Yes ❑ No

15. What were the results of the tuberculosis (TB) test?
❑ Negative for TB, *skip to #18* ❑ Positive for TB ❑ Unknown

16. Does the patient have latent or active tuberculosis (TB)? ❑ Latent ❑ Active ❑ Unknown

17. Has treatment for latent tuberculosis (TB) infection been initiated or completed?
❑ Yes - treatment initiated ❑ Yes - treatment completed ❑ No

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

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

20. 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

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

Section C: Plaque Psoriasis and Psoriatic Arthritis WITH Co-Existent Plaque Psoriasis

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

22. Has the patient been diagnosed with coexistent psoriatic arthritis? *If Yes, skip to section D* ❑ Yes ❑ No

23. Is the patient currently receiving therapy with the requested drug? *If Yes, skip to #29* ❑ Yes ❑ No

Initial Request

24. 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.*** ❑ Yes ❑ No

25. 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 area and body surface area affected.***

26. Has the patient ever received (including current utilizers) Otezla or a biologic (e.g., Humira) 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.*** ❑ Yes ❑ No

27. 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.*** ❑ Yes ❑ No

28. Does the patient have a clinical reason to avoid pharmacologic treatment with methotrexate, cyclosporine or acitretin? ***ACTION REQUIRED: If Yes, please attach documentation of clinical reason to avoid therapy.***
❑ Yes ❑ No
If Yes, indicate clinical reason: _____

Continuation of Therapy

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

30. 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

Section D: Psoriatic Arthritis - (*complete this section and Section E if applicable)*

Continuation of Therapy

31. Which of the following has the patient experienced an improvement in from baseline? ***ACTION REQUIRED: Please attach chart notes or medical record documentation supporting positive clinical response.***
❑ Number of swollen joints ❑ Number of tender joints
❑ Dactylitis ❑ Enthesitis
❑ Skin and/or nail involvement ❑ None of the above

Section E: Psoriatic Arthritis WITH Co-Existent Plaque Psoriasis

32. Has the patient ever received (including current utilizers) Otezla or a biologic (e.g., Humira) 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 *If request is for continuation of therapy, no further questions*

33. 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

34. What is the patient's psoriasis involvement in body surface area (BSA) percent (prior to starting the requested medication)? _____ % ***ACTION REQUIRED: Please attach chart notes or medical record documentation of affected area and body surface area affected.*** *If greater than or equal to 10%, no further questions*

35. 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

36. 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 clinical reason: _____

Section E: Ankylosing Spondylitis and Axial Spondyloarthritis

Continuation of Therapy

37. Which of the following has the patient experienced an improvement in from baseline? ***ACTION REQUIRED: Please attach chart notes or medical record documentation supporting positive clinical response.***
❑ Functional status ❑ Inflammation (e.g., morning stiffness)
❑ Total spinal pain ❑ None of the above

Initial Request

38. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) indicated for the treatment of active ankylosing spondylitis or active axial spondyloarthritis? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried and no further questions.*** ❑ Yes ❑ No

39. Has the patient experienced an inadequate response with at least TWO nonsteroidal anti-inflammatory drugs (NSAIDs), or has an intolerance or contraindication to at least two NSAIDs? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy. If therapy is if not advisable, please attach documentation of clinical reason to avoid therapy.*** ❑ 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)**

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