

Member Name: {{MEMFIRST}} {{MEMLAST}} DOB: {{MEMBERDOB}} PA Number: {{PANUMBER}}



[[PANUMCODE]]

## Tremfya

### 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.

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**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}}

- What is the diagnosis?  
 Moderate to severe plaque psoriasis  
 Active psoriatic arthritis (PsA)  
 Other \_\_\_\_\_
- What is the ICD-10 code? \_\_\_\_\_
- These are the preferred products for which coverage is provided for the treatment of psoriatic arthritis: **Cosentyx, Enbrel, Humira, Otezla, Remicade, Simponi Aria.** 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/](http://www.covermymeds.com/epa/caremark/) or call 1-866-452-5017.*  
 No  
 Not applicable - Requested for condition other than psoriatic arthritis, *skip to #8*
- Is this request for continuation of therapy with the requested product?  Yes  No *If No, skip to #6*
- 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 #8*
- Does the patient have a documented inadequate response or intolerable adverse event with any of the following preferred products indicated for psoriatic arthritis? **ACTION REQUIRED: If Yes, attach supporting chart note(s). Indicate ALL that apply.**  

<input type="checkbox"/> Cosentyx:	<input type="checkbox"/> Inadequate response	<input type="checkbox"/> Intolerable adverse event
<input type="checkbox"/> Enbrel:	<input type="checkbox"/> Inadequate response	<input type="checkbox"/> Intolerable adverse event
<input type="checkbox"/> Humira:	<input type="checkbox"/> Inadequate response	<input type="checkbox"/> Intolerable adverse event
<input type="checkbox"/> Otezla:	<input type="checkbox"/> Inadequate response	<input type="checkbox"/> Intolerable adverse event

  
 No - none of the above, *complete this form in its entirety and State Step Therapy section.*

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

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7. Does the patient have one of the following documented clinical reasons to avoid the preferred products that are TNF inhibitors (Enbrel and 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 (attributed to TNF inhibitor)
  - Yes - Risk of lymphoma
  - No - none of the above
  - Not applicable – requested medication is a TNF inhibitor
- If No or Not applicable, complete this form in its entirety and State Step Therapy section.*
8. 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
9. 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 #11*  Yes  No
10. 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 #13*  Yes  No
11. 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 #16*
12. Has the patient been tested for tuberculosis (TB) within the previous 12 months?  Yes  No
13. What were the results of the tuberculosis (TB) test?
- Positive for TB
  - Negative for TB, *skip to #16*
  - Unknown
14. Does the patient have latent or active tuberculosis (TB)?
- Latent  Active  Unknown
15. Has treatment for latent tuberculosis (TB) infection been initiated or completed?
- Yes - treatment initiated
  - Yes - treatment completed
  - No
16. Is the patient currently receiving Tremfya?  Yes  No
17. Is this request for continuation of therapy with the requested drug?
- Yes  No *If No, skip to #20, if applicable*
18. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program? *If Yes or Unknown, skip to #20, if applicable.*  Yes  No  Unknown
19. Has the patient achieved or maintained positive clinical response as evidenced by low disease activity or improvement in signs and symptoms since starting treatment with the requested drug?
- Yes  No *No further questions*

***Complete the following questions if patient has Plaque Psoriasis.***

20. 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? *If Yes, no further questions.*  Yes  No
21. Are crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) affected? *If Yes, no further questions.*  Yes  No

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22. What is the percentage of body surface area (BSA) affected (prior to starting the requested medication)?  
\_\_\_\_\_ % *If greater than or equal to 10% of BSA, no further questions.*
23. 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
24. Does the patient have a clinical reason to avoid pharmacologic treatment with methotrexate, cyclosporine or acitretin?  Yes  No  
*If Yes, indicate clinical reason:* \_\_\_\_\_

State Step Therapy

1. 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
2. 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
3. Does the patient reside in Maryland?  Yes  No *If No, skip to #7*
4. Is the alternate drug (see below) FDA-approved for the medical condition being treated?  
 Yes  No *If No, please specify:* \_\_\_\_\_
5. Has the prescriber provided proof, documented in the patient's chart notes, indicating that the requested drug was ordered for the patient in the past 180 days?  Yes  No *If No, skip to #7*
6. 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 *No further questions*
7. Are any of the following conditions met for the alternate drug (see below)?  
 The alternate drug is contraindicated  
 The alternate drug is likely to cause an adverse reaction, physical or mental harm  
 The alternate drug is expected to be ineffective  
 The alternate drug was previously tried or a drug in the same class or with the same action was previously tried and was stopped due to ineffectiveness or an adverse event  
 The alternate drug is not in the patient's best interest  
 The alternate drug was tried while covered by the current or the previous health benefit plan  
 None of the above  
*If Yes, please specify:* \_\_\_\_\_
8. Is the patient stable or currently receiving a positive therapeutic outcome with the requested drug and a change in the prescription drug is expected to be ineffective or cause harm to the patient?  Yes  No

*Alternate drugs based on diagnosis:*

Psoriatic arthritis: **Cosentyx, Enbrel, Humira, Otezla, Remicade, Simponi Aria**

***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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