



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: _____ **Date:** _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____ **NPI#:** _____
Specialty: _____ **Physician Office Fax:** _____
Physician Office Telephone: _____
Request Initiated For: _____

- What is the prescribed dose and frequency?
 - Loading dose:**

Tremfya 100mg Quantity and Frequency: _____
 Other: _____
 - Maintenance dose:**

Tremfya 100mg Quantity and Frequency: _____
 Other: _____
- What is the diagnosis?

Moderate to severe plaque psoriasis
 Active psoriatic arthritis WITH co-existent plaque psoriasis
 Please indicate primary diagnosis being treated: Psoriatic arthritis Plaque psoriasis
 Active psoriatic arthritis WITHOUT co-existent plaque psoriasis
 Other _____
- What is the ICD-10 code? _____
- Is the requested drug being prescribed by or in consultation with a dermatologist or rheumatologist?

Dermatologist Rheumatologist None of the above
- 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
- Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic DMARD (e.g., Olumiant, Xeljanz) associated with an increased risk of tuberculosis? *If Yes, skip to #10* Yes No
- 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
- What were the results of the tuberculosis (TB) test?

Positive for TB Negative for TB, *skip to #10* Unknown

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

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9. 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
10. Is the patient currently receiving Tremfya? Yes No
11. Is this request for continuation of therapy with the requested drug?
 Yes No *If No, skip to diagnosis section*
12. 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
13. 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 primary diagnosis, if applicable.

Section A: Plaque Psoriasis

Continuation

14. 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 and no further questions. Yes No
15. 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 and no further questions.*** Yes No

Initiation

16. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic drug (e.g., Sotyktu, 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
17. 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 no further questions. Yes No
18. 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. If greater than or equal to 10% of BSA, no further questions***
19. 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
20. 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 B: Psoriatic Arthritis

Continuation

21. 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
 - Axial disease
 - Skin and/or nail involvement
 - None of the above

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Initiation

22. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic drug (e.g., Rinvoq, Otezla) that is indicated for active psoriatic arthritis? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried and no further questions.*** Yes No
23. Does the patient have mild to moderate disease? Yes No *If No, skip to #29*
24. Does the patient have enthesitis or predominantly axial disease? *If Yes, no further questions.* Yes No
25. Has the patient had an inadequate response to methotrexate, leflunomide, or another conventional synthetic drug (e.g., sulfasalazine) administered at an adequate dose and duration? ***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
26. Has the patient had an intolerance to methotrexate, leflunomide, or another conventional synthetic drug (e.g., sulfasalazine)? ***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
27. Does the patient have a contraindication to methotrexate or leflunomide? ***ACTION REQUIRED: If Yes, please attach documentation of clinical reason to avoid therapy and no further questions.*** Yes No
If Yes, indicate clinical reason: _____
28. Does the patient have a contraindication to another conventional synthetic drug (e.g., sulfasalazine)? ***ACTION REQUIRED: If Yes, please attach documentation of clinical reason to avoid therapy.*** Yes No *No further questions.*
29. Does the patient have severe disease? 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)

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