CareFirst Family of health care plans

CVS caremark™

Xeljanz, Xeljanz XR (for Maryland only)

Prior Authorization Request

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

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

1. Which drug is being prescribed?
   ❑ Xeljanz ❑ Xeljanz XR ❑ Other _____

2. What is the diagnosis?
   ❑ Moderately to severely active rheumatoid arthritis (RA)
   ❑ Active psoriatic arthritis (PsA)
   ❑ Other _____

3. What is the ICD-10 code? _____

Section A: Preferred Product

4. These are the preferred products for which coverage is provided for treatment of the following conditions:
   a) Rheumatoid arthritis: **Enbrel, Humira, Kevzara, Orencia (subcutaneous)/Orencia ClickJect**
   b) Psoriatic arthritis: **Cosentyx, Enbrel, Humira, Otezla**
   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/ or call 1-866-452-5017.***
   ❑ No
   ❑ Not applicable - Requested for condition not listed above, *skip to Section B: All Requests*

5. Is this request for continuation of therapy with the requested product? ❑ Yes ❑ No *If No, skip to #7*

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 Section B: All Requests*

7. Has the patient had a documented inadequate response or intolerable adverse event with any of the following preferred products? Please indicate ALL that apply.
   ACTION REQUIRED: If Yes, attach supporting chart note(s).

❑ Cosentyx:	❑ Inadequate response	❑ Intolerable adverse event
❑ Enbrel:	❑ Inadequate response	❑ Intolerable adverse event
❑ Humira:	❑ Inadequate response	❑ Intolerable adverse event

❑ Kevzara: ❑ Inadequate response ❑ Intolerable adverse event
❑ Orencia (SC/ClickJect): ❑ Inadequate response ❑ Intolerable adverse event
❑ Otezla: ❑ Inadequate response ❑ Intolerable adverse event
❑ No - none of the above
If No - none of the above, complete this form in its entirety and Maryland State Step Therapy section.

8. Does the patient have one of the following documented clinical reasons to avoid 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
❑ Yes - Risk of lymphoma
❑ No - none of the above
If No - none of the above, complete this form in its entirety and Maryland State Step Therapy section.

Section B: All Requests

9. *If diagnosis is PsA,* is Xeljanz/Xeljanz XR being used in combination with a nonbiologic DMARD (e.g., methotrexate, leflunomide, sulfasalazine, etc.)? ❑ Yes ❑ No

10. Is this request for continuation of therapy? ❑ Yes ❑ No *If No, skip to #14*

11. Is the patient currently receiving Xeljanz or Xeljanz XR through samples or a manufacturer's patient assistance program? ❑ Yes - Xeljanz ❑ Yes - Xeljanz XR ❑ No ❑ Unknown
If Yes or Unknown, skip to #14

12. How long has the patient been receiving the requested medication? _____ months
If less than 3 months, no further questions.

13. 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

14. 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 ❑ Inflectra ❑ Kevzara ❑ Kineret
❑ Orencia ❑ Otezla ❑ Remicade ❑ Renflexis ❑ Rituxan ❑ Siliq ❑ Simponi ❑ Simponi Aria ❑ Stelara ❑ Taltz ❑ Tremfya ❑ No

15. 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.

Section C: Rheumatoid Arthritis

16. Has the patient experienced an inadequate response after at least 3 months of treatment with the methotrexate dose greater than or equal to 20 mg per week? *If Yes, no further questions* ❑ Yes ❑ No

17. Has the patient experienced intolerance to methotrexate? *If Yes, no further questions* ❑ Yes ❑ No

18. Does the patient have a contraindication to methotrexate? ❑ Yes ❑ No
If Yes, indicate the contraindication:
_____

Section D: Psoriatic Arthritis

19. Has the patient experienced an inadequate response to at least a 3-month trial of methotrexate (MTX) or other nonbiologic disease-modifying antirheumatic drug(s) (DMARDs) (e.g., leflunomide, sulfasalazine, etc.)? ❑ Yes ❑ No

Maryland Step Therapy

1. Is the requested drug being used to treat stage four advanced metastatic cancer?
   ❑ Yes ❑ No *If No, skip to #3*

2. 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?
   If Yes, no further questions ❑ Yes ❑ No

3. 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

4. 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

5. 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

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

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)**