CVS caremark™ {{PANUMCODE}}

Xeljanz, Xeljanz XR

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?
   - ❑ Xeljanz 5 mg Quantity and frequency: _____
   - ❑ Xeljanz 10 mg Quantity and frequency: _____
   - ❑ Xeljanz 1 mg/mL Quantity and frequency: _____
   - ❑ Xeljanz XR 11 mg Quantity and frequency: _____
   - ❑ Xeljanz XR 22 mg Quantity and frequency: _____
   - ❑ Other _____

2. What is the diagnosis?
   - ❑ Moderately to severely active rheumatoid arthritis (RA)
   - ❑ Moderately to severely active ulcerative colitis (UC)
   - ❑ Active articular juvenile idiopathic arthritis, *please specify:*
     - ❑ Polyarticular juvenile idiopathic arthritis
     - ❑ Oligoarticular juvenile idiopathic arthritis
   - ❑ Active ankylosing spondylitis
   - ❑ Active psoriatic arthritis (PsA)
   - ❑ Immune checkpoint inhibitor-related colitis
   - ❑ Other _____

3. What is the ICD-10 code? _____

4. What is 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) Psoriatic arthritis: **Cosentyx, Enbrel, Humira, Otezla, Remicade, Rinvoq, Simponi Aria, Skyrizi, Stelara (SC), Tremfya**
   c) Ulcerative colitis: **Humira, Remicade, Stelara (IV)**
   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 - Request 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 to any of the following 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
❑ Rinvoq:	❑ Inadequate response	❑ Intolerable adverse event
❑ Skyrizi:	❑ Inadequate response	❑ Intolerable adverse event
❑ Stelara (SC):	❑ Inadequate response	❑ Intolerable adverse event
❑ Stelara (IV):	❑ 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 - *Indicate drug(s):* _____
   ❑ Yes - History of congestive heart failure- *Indicate drug(s):* _____
   ❑ Yes - History of hepatitis B virus infection- *Indicate drug(s):* _____
   ❑ Yes - Autoantibody formation/lupus-like syndrome (attributed to TNF inhibitor)
   Indicate drug(s): _____
   ❑ Yes - Risk of lymphoma- *Indicate drug(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 drugs (e.g., Humira), targeted synthetic drugs (e.g., Otezla, Rinvoq, Olumiant), or potent immunosuppressant such as azathioprine or cyclosporine? ❑ Yes ❑ No

11. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic DMARD (e.g., Rinvoq, Olumiant) associated with an increased risk of tuberculosis? *If Yes, skip to #15* ❑ Yes ❑ No

12. 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

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

14. 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

15. Is this request for continuation of therapy with the requested drug? ❑ Yes ❑ No *If No, skip to #21*

16. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program? *If Yes or Unknown, skip to #21* ❑ Yes ❑ No ❑ Unknown

17. *If patient's diagnosis is ulcerative colitis,* has the patient achieved or maintained remission?
    ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation of remission.
    ❑ Yes ❑ No ❑ Not applicable, diagnosis is NOT ulcerative colitis, *continue to #18*

18. Indicate which applies:
    ❑ 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
    ❑ Patient achieved or maintained positive clinical response since starting treatment with the requested drug
    ❑ None of the above

19. What is the percent of disease activity improvement from baseline in tender joint count, swollen joint count, pain, or disability? ***ACTION REQUIRED: Please attach chart notes or medical record documentation supporting positive clinical response. _____%***

20. 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 ❑ Stool frequency
    ❑ Rectal bleeding ❑ Urgency of defecation ❑ C-reactive protein (CRP)
    ❑ Fecal calprotectin ❑ Endoscopic appearance of the mucosa ❑ Functional ability
    ❑ Inflammation (e.g., morning stiffness) ❑ Functional status ❑ Total spinal pain
    ❑ Number of joints with limitation of movement
    ❑ Number of joints with active arthritis (e.g., swelling, pain, limitation of motion)
    ❑ Improvement on a disease activity scoring tool (e.g., Ulcerative Colitis Endoscopic Index of Severity [UCEIS], Mayo Score]) ❑ None of the above

21. *If patient's diagnosis is psoriatic arthritis,* will the requested drug be used in combination with a conventional synthetic DMARD? ❑ Yes ❑ No
    ❑ Not applicable, diagnosis is NOT psoriatic arthritis, *continue to diagnosis section*

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

Section C: Rheumatoid Arthritis

22. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic DMARD (e.g., Rinvoq, Olumiant) that is indicated for moderately to severely active rheumatoid 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 meet either of the following: a) the patient was tested for the rheumatoid factor (RF) biomarker and the biomarker test was positive, or b) the patient was tested for the anti-cyclic citrullinated peptide (anti-CCP) biomarker and the anti-CCP biomarker test was positive? ***ACTION REQUIRED: If Yes, please attach laboratory results, chart notes, or medical record documentation of biomarker testing and skip to #25.*** ❑ Yes ❑ No

24. Has the patient been tested for all of the following biomarkers: a) rheumatoid factor (RF), b) anti-cyclic citrullinated peptide (anti-CCP), and c) C-reactive protein (CRP) and/or erythrocyte sedimentation rate (ESR)? ***ACTION REQUIRED: If Yes, please attach laboratory results, chart notes, or medical record documentation of biomarker testing.*** ❑ Yes ❑ No

25. Has the patient experienced an inadequate response or intolerance to at least one tumor necrosis factor (TNF) inhibitor? ***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

Section D: Ulcerative Colitis

26. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) indicated for the treatment of moderately to severely active ulcerative colitis? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried and skip to #31.*** ❑ Yes ❑ No

27. Has the patient been hospitalized for acute, severe ulcerative colitis (e.g., continuous bleeding, severe toxic symptoms, including fever and anorexia)? ***ACTION REQUIRED: If Yes, please attach supporting chart notes or medical record documentation of hospitalization and skip to #31.*** ❑ Yes ❑ No

28. Has the patient experienced an inadequate response or intolerance to at least one tumor necrosis factor (TNF) inhibitor? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy and skip to #31.*** ❑ Yes ❑ No

29. Has the patient experienced an intolerance with at least one tumor necrosis factor inhibitor (TNF-i)? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy and skip to #31.*** ❑ Yes ❑ No

30. Does the patient have a contraindication to a tumor necrosis factor inhibitor (TNF-i)? ***ACTION REQUIRED: If Yes, please attach documentation of clinical reason to avoid therapy.*** ❑ Yes ❑ No

31. Is the request for induction or maintenance of remission?
❑ Induction ❑ Maintenance *If Maintenance, skip to #33*

32. Will the prescribed treatment for induction of remission exceed a duration of 16 weeks?
❑ Yes ❑ No *No further questions*

33. Is the patient experiencing a loss of response during treatment for maintenance of remission? ❑ Yes ❑ No

34. Will the lowest effective dose be utilized and limited to the shortest duration needed? ❑ Yes ❑ No

Section E: Articular Juvenile Idiopathic Arthritis

35. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic disease-modifying antirheumatic drug indicated for active articular juvenile idiopathic 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

36. Has the patient experienced an inadequate response or intolerance to at least one tumor necrosis factor (TNF) inhibitor? ***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

Section F: Immune Checkpoint Inhibitor-Related Colitis

37. Has the patient experienced an inadequate response, intolerance, or contraindication to infliximab or vedolizumab? ***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 not advisable, include clinical reason to avoid therapy.*** ❑ Yes ❑ No

Section G: Ankylosing Spondylitis

Initiation

38. Has the patient ever received (including current utilizers) a biologic indicated for active ankylosing spondylitis? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried.*** ❑ Yes ❑ No

39. Has the patient experienced an inadequate response or intolerance to at least one TNF inhibitor? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to 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