Adbry

HMSACOM- 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 1-866-237-5512**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-808-254-4414.** 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:** _____
Patient's Phone Number: _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Additional Demographic Information:

Patient Weight: _____*kg*

Patient Height: _____*ft* _____*inches*

Indicate where the drug is being dispensed:

❑ Office ❑ Outpatient Hospital ❑ Ambulatory Surgical ❑ Inpatient Hospital
❑ Off Campus Outpatient Hospital ❑ Urgent Care ❑ Emergency Room ❑ Birthing Center
❑ Military Facility ❑ Skilled Nursing Facility ❑ Nursing Facility ❑ Hospice
❑ Inpatient Psychiatric ❑ Psychiatric Residential Treatment ❑ End Stage Renal Facility
❑ Psychiatric Facility ❑ Pharmacy ❑ Other

Indicate where the drug is being administered:

❑ Ambulatory surgical ❑ Home ❑ Inpatient Hospital
❑ Office ❑ Outpatient Hospital ❑ Pharmacy

What is the ICD-10 code? _____

Send completed form to: CVS Caremark Specialty Programs. Fax: 1-866-237-5512

 MR Adbry HMSACOM C29862-A,C25032-A – 04/2026.

Exception Criteria:

A. Is the product being requested for a diagnosis of moderate to severe atopic dermatitis?
❒ Yes, *Continue to Question B*
❒ No, *Skip to Clinical Criteria*

B. The preferred products for your patient's health plan are Dupixent, Ebglyss, Rinvoq
Can the patient's treatment be switched to the preferred product?
❒ Yes, *Please obtain form for preferred product and submit for corresponding PA*
❒ No, *Continue to Question C*

C. Has the patient experienced a documented inadequate response, intolerable adverse event or contraindication to ALL preferred products, Dupixent, Ebglyss and Rinvoq? ***Action Required***: If 'Yes', attach supporting chart note(s)
❒ Yes, *Continue to Clinical Criteria*
❒ No, *Continue to Clinical Criteria*

Clinical Criteria Questions:

1. What is the diagnosis?
❒ Atopic dermatitis, moderate-to-severe, *Continue to #2*
❒ Other, *Continue to #2*

2. Is the patient 12 years of age or older?
❒ Yes, *Continue to #3*
❒ No, *Continue to #3*

3. Will the requested drug be used in combination with any other biologic (e.g., Dupixent) or targeted synthetic drug (e.g., Cibinqo, Opzelura, Rinvoq) for the same indication?
❒ Yes, *Continue to #4*
❒ No, *Continue to #4*

4. Is the requested drug being prescribed by or in consultation with a dermatologist or allergist/immunologist?
❒ Yes, *Continue to #5*
❒ No, *Continue to #5*

5. Is this request for continuation of therapy with the requested drug?
❒ Yes, *Continue to #6*
❒ No, *Continue to #9*

6. Has the member been previously authorized by HMSA/CVS?
❒ Yes, *Continue to #7*
❒ No, *Continue to #9*

7. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program?
❒ Yes, *Continue to #9*
❒ No, *Continue to #8*
❒ Unknown, *Continue to #9*

8. Has the patient achieved or maintained a positive clinical response as evidenced by low disease activity (i.e., clear or almost clear skin) or improvement in signs and symptoms of atopic dermatitis (e.g., redness, itching, oozing/crusting)

since starting treatment with the requested drug? ***ACTION REQUIRED****: If Yes, please attach chart note(s) or medical record documentation supporting positive clinical response*
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

9. Has the patient received or is currently receiving a biologic (e.g., Dupixent) or targeted synthetic drug (e.g., Cibinqo, Rinvoq) within the past 180 days indicated for the treatment of moderate-to-severe atopic dermatitis (excluding receiving the drug via samples or a manufacturer's patient assistance program)? ***ACTION REQUIRED****: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried*
❒ Yes, *No Further Questions*
❒ No, *Continue to #10*

10. What is the percentage of body surface area (BSA) affected prior to initiation of the requested drug? _____%
ACTION REQUIRED*: Please attach chart note(s) or medical record documentation of body surface area affected*
❒ Less than 10% of BSA, *Continue to #11*
❒ Greater than or equal to 10% of BSA, *Continue to #12*

11. Are crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) affected? ***ACTION REQUIRED****: If Yes, please attach chart note(s) or medical record documentation of affected area(s)*
❒ Yes, *Continue to #12*
❒ No, *Continue to #12*

12. Has the member had an inadequate treatment response to TWO of the following in the past 180 days: A) High potency or super-high potency topical corticosteroid, B) Topical calcineurin inhibitor, C) Topical JAK inhibitor, or D) Topical PDE-4 inhibitor? ***ACTION REQUIRED****: Please attach chart note(s), medical record, or claims history supporting prerequisite therapies including drug name, dosage form, strength, and response to therapy*
❒ Yes, *No Further Questions*
❒ No, *Continue to #13*

13. Is the use of high potency or super-high potency topical corticosteroids, topical calcineurin inhibitors, topical JAK inhibitors, and topical PDE-4 inhibitors not advisable for the patient (e.g., due to contraindications, prior intolerances, potency not appropriate for member's age)? ***ACTION REQUIRED****: If Yes, please attach chart note(s) or medical record documentation of clinical reason to avoid therapy*
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

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: CVS Caremark Specialty Programs. Fax: 1-866-237-5512