Bimzelx

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

 Bimzelx C29412-A HMSACOM C18701-D – 2/2026.

Exception Criteria Questions:

A. Is the product being requested for the treatment of an ADULT patient (18 years of age or older) with one of the following indications?
- Ankylosing spondylitis
- Crohn's disease
- Plaque psoriasis
- Psoriatic arthritis
- Rheumatoid arthritis
- Ulcerative colitis

❑ Yes ❑ No *If No, skip to Criteria Questions*

B. These are the preferred products for which coverage is provided for treatment of the following indications:
- Ankylosing spondylitis: **adalimumab-adaz, Cosentyx IV/SQ, Enbrel, Hadlima, Hyrimoz (Cordavis brand), Inflectra, Rinvoq, Simponi Aria, Taltz, and unbranded infliximab**
- Crohn's disease: **adalimumab-adaz, Entyvio, Hadlima, Hyrimoz (Cordavis brand), Inflectra, Pyzchiva IV/SQ (Cordavis or Sandoz brand), Rinvoq, Skyrizi IV/SQ, Stelara IV/SQ, Tremfya IV/SQ, unbranded infliximab, and Yesintek IV/SQ**
- Plaque psoriasis: **adalimumab-adaz, Cosentyx SQ, Enbrel, Hadlima, Hyrimoz (Cordavis brand), Inflectra, Otezla, Pyzchiva SQ (Cordavis or Sandoz brand), Skyrizi SQ, Stelara SQ, Taltz, Tremfya SQ, unbranded infliximab, and Yesintek SQ**
- Psoriatic arthritis: **adalimumab-adaz, Cosentyx IV/SQ, Enbrel, Hadlima, Hyrimoz (Cordavis brand), Inflectra, Otezla, Pyzchiva SQ (Cordavis or Sandoz brand), Rinvoq, Simponi Aria, Skyrizi SQ, Stelara SQ, Taltz Tremfya SQ, unbranded infliximab, Xeljanz/Xeljanz XR, and Yesintek SQ**
- Rheumatoid arthritis: **adalimumab-adaz, Enbrel, Hadlima, Hyrimoz (Cordavis brand), Inflectra, Rinvoq, Simponi Aria, unbranded infliximab, and Xeljanz/Xeljanz XR**
- Ulcerative Colitis: **adalimumab-adaz, Entyvio, Hadlima, Hyrimoz (Cordavis brand), Inflectra, Pyzchiva IV/SQ (Cordavis or Sandoz brand), Rinvoq, Skyrizi IV/SQ, Stelara IV/SQ, Tremfya IV/SQ, unbranded infliximab, Velsipity, Xeljanz/Xeljanz XR, and Yesintek IV/SQ**

Can the patient's treatment be switched to a preferred product?
❑ Yes, *Please obtain Form for preferred product and submit for corresponding PA*.
❑ No

C. Is this request for continuation of therapy with the requested product? ❑ Yes ❑ No *If No, skip to Question E*

D. 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 Criteria Questions*

E. What is the diagnosis?
❑ Ankylosing spondylitis
❑ Crohn's disease, *Skip to Question I*
❑ Plaque psoriasis, *Skip to Question L*
❑ Psoriatic arthritis, *Skip to Question M*
❑ Rheumatoid arthritis, *Skip to Question P*
❑ Ulcerative colitis, *Skip to Question S*

F. Is the requested product self-administered (oral or self-injected)? ❑ Yes ❑ No *If No, Skip to Question H*

G. Does the patient have a documented inadequate response, intolerable adverse event or contraindication to all of the following preferred products indicated for ankylosing spondylitis: Cosentyx SQ, Enbrel, Rinvoq, Taltz, and adalimumab-adaz, Hyrimoz (Cordavis brand) or Hadlima? ***ACTION REQUIRED: Please submit supporting documentation.*** ❑ Yes ❑ No *If Yes or No, skip to Criteria Questions*

H. Does the patient have a documented inadequate response, intolerable adverse event or contraindication to all of the following preferred products indicated for ankylosing spondylitis: Cosentyx IV, Inflectra or unbranded infliximab and Simponi Aria? ***ACTION REQUIRED: Please submit supporting documentation.*** ❑ Yes ❑ No *If Yes or No, skip to Criteria Questions*

I. Is the requested product self-administered (oral or self-injected)? ❑ Yes ❑ No *If No, Skip to Question K*

J. Does the patient have a documented inadequate response, intolerable adverse event or contraindication to ALL of the following preferred products indicated for Crohn's disease? ***ACTION REQUIRED: Please submit supporting documentation.***
- Rinvoq, Skyrizi SQ, AND Tremfya SQ
- adalimumab-adaz, Hyrimoz (Cordavis brand) OR Hadlima
- Pyzchiva SQ (Cordavis or Sandoz brand), Yesintek SQ OR Stelara SQ

❑ Yes ❑ No *If Yes or No, skip to Criteria Questions*

K. Does the patient have a documented inadequate response, intolerable adverse event, or contraindication to ALL of the following preferred products indicated for Crohn's disease? ***ACTION REQUIRED: Please submit supporting documentation.***
- Entyvio, Skyrizi IV, AND Tremfya IV
- Pyzchiva IV (Cordavis or Sandoz brand), Yesintek IV OR Stelara IV
- Inflectra OR unbranded infliximab

❑ Yes ❑ No *If Yes or No, skip to Criteria Questions*

L. Does the patient have a documented inadequate response, intolerable adverse event or contraindication to ALL of the following preferred products indicated for plaque psoriasis? ***ACTION REQUIRED: Please submit supporting documentation.***
- Cosentyx SQ, Enbrel, Otezla, Skyrizi SQ, Taltz AND Tremfya SQ
- adalimumab-adaz, Hyrimoz (Cordavis brand) OR Hadlima
- Pyzchiva SQ (Cordavis or Sandoz brand), Yesintek SQ OR Stelara SQ

❑ Yes ❑ No *If Yes or No, skip to Criteria Questions*

M. Is the requested product self-administered (oral or self-injected)? ❑ Yes ❑ No *If No, Skip to Question O*

N. Does the patient have a documented inadequate response, intolerable adverse event, or contraindication to all of the following preferred products indicated for psoriatic arthritis? ***ACTION REQUIRED: Please submit supporting documentation.***
- Cosentyx SQ, Enbrel, Otezla, Rinvoq, Skyrizi SQ, Taltz, Tremfya SQ AND Xeljanz/Xeljanz XR
- adalimumab-adaz, Hyrimoz (Cordavis brand) OR Hadlima?
- Pyzchiva SQ (Cordavis or Sandoz brand), Yesintek SQ OR Stelara SQ

❑ Yes ❑ No *If Yes or No, skip to Criteria Questions*

O. Does the patient have a documented inadequate response, intolerable adverse event, or contraindication to all of the following preferred products indicated for psoriatic arthritis: Cosentyx IV, Inflectra or unbranded infliximab and Simponi Aria? ***ACTION REQUIRED: Please submit supporting documentation.*** ❑ Yes ❑ No *If Yes or No, skip to Criteria Questions*

P. Is the requested product self-administered (oral or self-injected)? ❑ Yes ❑ No, *skip to Question R*

Q. Does the patient have a documented inadequate response, intolerable adverse event or contraindication to all of the following preferred products indicated for rheumatoid arthritis: Enbrel, Rinvoq, Xeljanz/Xeljanz XR, and adalimumab-adaz, Hyrimoz (Cordavis brand) or Hadlima? ***ACTION REQUIRED: Please submit supporting documentation.*** ❑ Yes ❑ No *If Yes or No, skip to Criteria Questions*

R. Does the patient have a documented inadequate response, intolerable adverse event, or contraindication to both of the following preferred products indicated for rheumatoid arthritis: Inflectra or unbranded infliximab and Simponi Aria? ***ACTION REQUIRED: Please submit supporting documentation.*** ❑ Yes ❑ No *If Yes or No, skip to Criteria Questions*

S. Is the requested product self-administered (oral or self-injected)? ❑ Yes ❑ No *If No, Skip to Question U*

T. Does the patient have a documented inadequate response, intolerable adverse event, or contraindication to all of the following preferred products indicated for ulcerative colitis? ❑ Yes ❑ No ***ACTION REQUIRED: Please submit supporting documentation.***
- Rinvoq, Skyrizi SQ, Tremfya SQ, Velsipity, AND Xeljanz/Xeljanz XR
- adalimumab-adaz, Hyrimoz (Cordavis brand) OR Hadlima
- Pyzchiva SQ (Cordavis or Sandoz brand), Yesintek SQ OR Stelara SQ

❑ Yes ❑ No *If Yes or No, skip to Criteria Questions*

U. Does the patient have a documented inadequate response, intolerable adverse event, or contraindication to all of the following preferred products indicated for ulcerative colitis? ***ACTION REQUIRED: Please submit supporting documentation.***
- Entyvio, Skyrizi IV, AND Tremfya IV
- Pyzchiva IV (Cordavis or Sandoz brand), Yesintek IV OR Stelara IV
- Inflectra OR unbranded infliximab

❑ Yes ❑ No

Criteria Questions:

1. Will the requested drug be used in combination with any other biologic (e.g., Cosentyx, Humira) or targeted synthetic drug (e.g., Otezla, Sotyktu) for the same indication?
❒ Yes, *Continue to 2*
❒ No, *Continue to 2*

2. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic drug (e.g., Olumiant, Xeljanz) associated with an increased risk of tuberculosis?
❒ Yes, *Continue to 6*
❒ No, *Continue to 3*

3. Has the patient had a tuberculosis (TB) test (e.g., tuberculosis skin test [TST], interferon-release assay [IGRA]) within 12 months of initiating therapy?
❒ Yes, *Continue to 4*
❒ No, *Continue to 4*

4. What were the results of the tuberculosis (TB) test?
❒ Positive for TB, *Continue to 5*
❒ Negative for TB, *Continue to 6*
❒ Unknown, *No further questions*

5. Which of the following applies to the patient?
❒ Patient has latent TB and treatment for latent TB has been initiated, *Continue to 6*
❒ Patient has latent TB and treatment for latent TB has been completed, *Continue to 6*
❒ Patient has latent TB and treatment for latent TB has not been initiated, *Continue to 6*
❒ Patient has active TB, *Continue to 6*

6. What is the diagnosis?
❒ Ankylosing spondylitis, *Continue to 24*
❒ Hidradenitis suppurativa, *Continue to 48*
❒ Non-radiographic axial spondyloarthritis, *Continue to 24*
❒ Plaque psoriasis, *Continue to 9*
❒ Psoriatic arthritis WITH co-existent plaque psoriasis, *Continue to 7*
❒ Psoriatic arthritis, *Continue to 33*
❒ Other, please specify. _____, *No further questions*

7. Is the requested drug being prescribed by or in consultation with a rheumatologist or dermatologist?
❒ Yes, *Continue to 8*
❒ No, *Continue to 8*

8. What is the primary diagnosis being treated?
❒ Psoriatic arthritis, *Continue to 34*
❒ Plaque psoriasis, *Continue to 10*

9. Is the requested drug being prescribed by or in consultation with a dermatologist?
❒ Yes, *Continue to 10*
❒ No, *Continue to 10*

10. Has the patient been diagnosed with moderate to severe plaque psoriasis?
❒ Yes, *Continue to 11*
❒ No, *Continue to 11*

11. Is the patient an adult (18 years of age or older)?
❒ Yes, *Continue to 12*
❒ No, *Continue to 12*

12. Is this request for continuation of therapy with the requested drug?
❒ Yes, *Continue to 13*
❒ No, *Continue to 17*

13. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program?
❒ Yes, *Continue to 17*
❒ No, *Continue to 14*
❒ Unknown, *Continue to 17*

14. Has the patient achieved or maintained a 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, *Continue to 15*
❒ No, *Continue to 15*

15. 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. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *No Further Questions*
❒ No, *Continue to 16*

16. 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 ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

17. Has the patient ever received or is currently receiving a biologic or targeted synthetic drug (e.g., Sotyktu, Otezla) indicated for treatment of moderate to severe plaque psoriasis (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. ***ACTION REQUIRED***: Submit supporting documentation

❒ Yes, *No Further Questions*
❒ No, *Continue to 18*

18. 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. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *No Further Questions*
❒ No, *Continue to 19*

19. Is the percentage of body surface area (BSA) affected (prior to starting the requested medication) less than 3%?
❒ Yes, *No Further Questions*
❒ No, *Continue to 20*

20. What is the percentage of body surface area (BSA) affected (prior to starting the requested medication)? Indicate percentage. ***ACTION REQUIRED***: Please attach chart notes or medical record documentation of body surface area affected.
❒ Greater than or equal to 3% to less than 10% of BSA _____ % ***ACTION REQUIRED****: Submit supporting documentation, Continue to 21*
❒ Greater than or equal to 10% of BSA _____ % ***ACTION REQUIRED****: Submit supporting documentation, No further questions*

21. Has the patient had 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. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *No Further Questions*
❒ No, *Continue to 22*

22. 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 each therapy. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 23*
❒ No, *Continue to 23*

23. Please indicate the clinical reason to avoid pharmacologic treatment with methotrexate, cyclosporine, and acitretin.
❒ Clinical diagnosis of alcohol use disorder, alcoholic liver disease, or other chronic liver disease, *No further questions*
❒ Drug interaction, *No further questions*
❒ Risk of treatment-related toxicity, *No further questions*
❒ Pregnancy or currently planning pregnancy, *No further questions*
❒ Breastfeeding, *No further questions*
❒ Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension), *No further questions*
❒ Hypersensitivity, *No further questions*
❒ History of intolerance or adverse event, *No further questions*
❒ Other, please specify. _____, *No further questions*

24. Is the requested drug being prescribed by or in consultation with a rheumatologist?
❒ Yes, *Continue to 25*
❒ No, *Continue to 25*

25. Is the patient an adult (18 years of age or older)?
❒ Yes, *Continue to 26*
❒ No, *Continue to 26*

26. Is this request for continuation of therapy with the requested drug?
❒ Yes, *Continue to 27*
❒ No, *Continue to 30*

27. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program?
❒ Yes, *Continue to 30*
❒ No, *Continue to 28*
❒ Unknown, *Continue to 30*

28. Has the patient achieved or maintained a 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, *Continue to 29*
❒ No, *Continue to 29*

29. 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.
❒ Functional status ***ACTION REQUIRED****: Submit supporting documentation, No further questions*
❒ Total spinal pain ***ACTION REQUIRED****: Submit supporting documentation, No further questions*
❒ Inflammation (e.g., morning stiffness) ***ACTION REQUIRED****: Submit supporting documentation, No further questions*
❒ Swollen joints ***ACTION REQUIRED****: Submit supporting documentation, No further questions*
❒ Tender joints ***ACTION REQUIRED****: Submit supporting documentation, No further questions*
❒ C-reactive protein (CRP) ***ACTION REQUIRED****: Submit supporting documentation, No further questions*
❒ None of the above, *No further questions*

30. Has the patient been diagnosed with active ankylosing spondylitis (AS) or active non-radiographic axial spondyloarthritis (nr-axSpA)?
❒ Yes - active ankylosing spondylitis, *Continue to 31*
❒ Yes - active non-radiographic axial spondyloarthritis, *Continue to 31*
❒ No, *Continue to 31*

31. Has the patient ever received or is currently receiving a biologic (e.g., Humira) or targeted synthetic drug (e.g., Rinvoq, Xeljanz) indicated for active ankylosing spondylitis or active non-radiographic axial spondyloarthritis (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. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *No Further Questions*
❒ No, *Continue to 32*

32. Has the patient had an inadequate response with at least TWO nonsteroidal anti-inflammatory drugs (NSAIDs), or has an intolerance or contraindication to at least TWO NSAIDs? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy. If therapy is not advisable, please attach documentation of clinical reason to avoid therapy. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

33. Is the requested drug being prescribed by or in consultation with a rheumatologist or dermatologist?
❒ Yes, *Continue to 34*
❒ No, *Continue to 34*

34. Is the patient an adult (18 years of age or older)?
❒ Yes, *Continue to 35*
❒ No, *Continue to 35*

35. Is this request for continuation of therapy with the requested drug?
❒ Yes, *Continue to 36*
❒ No, *Continue to 39*

36. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program?
❒ Yes, *Continue to 39*
❒ No, *Continue to 37*
❒ Unknown, *Continue to 39*

37. Has the patient achieved or maintained a 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, *Continue to 38*
❒ No, *Continue to 38*

38. 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 ***ACTION REQUIRED****: Submit supporting documentation, No further questions*
❒ Number of tender joints ***ACTION REQUIRED****: Submit supporting documentation, No further questions*
❒ Dactylitis ***ACTION REQUIRED****: Submit supporting documentation, No further questions*
❒ Enthesitis ***ACTION REQUIRED****: Submit supporting documentation, No further questions*
❒ Axial disease ***ACTION REQUIRED****: Submit supporting documentation, No further questions*
❒ Skin and/or nail involvement ***ACTION REQUIRED****: Submit supporting documentation, No further questions*
❒ Functional status ***ACTION REQUIRED****: Submit supporting documentation, No further questions*
❒ C-reactive protein (CRP) ***ACTION REQUIRED****: Submit supporting documentation, No further questions*
❒ None of the above, *No further questions*

39. Has the patient been diagnosed with active psoriatic arthritis (PsA)?
❒ Yes, *Continue to 40*
❒ No, *Continue to 40*

40. Has the patient ever received or is currently receiving a biologic (e.g., Humira) or targeted synthetic drug (e.g., Rinvoq, Otezla) indicated for active psoriatic arthritis (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. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *No Further Questions*
❒ No, *Continue to 41*

41. What is the patient's disease severity?
❒ Mild to moderate disease, *Continue to 42*
❒ Severe disease, *No further questions*

42. Does the patient have enthesitis or predominantly axial disease?
❒ Yes, *No Further Questions*
❒ No, *Continue to 43*

43. 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. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *No Further Questions*
❒ No, *Continue to 44*

44. 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. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *No Further Questions*
❒ No, *Continue to 45*

45. Does the patient have a contraindication to methotrexate or leflunomide? ***ACTION REQUIRED***: If Yes, please attach documentation of clinical reason to avoid therapy. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 47*
❒ No, *Continue to 46*

46. 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. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

47. Please indicate the contraindication to methotrexate or leflunomide.
❒ Clinical diagnosis of alcohol use disorder, alcoholic liver disease, or other chronic liver disease, *No further questions*
❒ Drug interaction, *No further questions*
❒ Risk of treatment-related toxicity, *No further questions*
❒ Pregnancy or currently planning pregnancy, *No further questions*
❒ Breastfeeding, *No further questions*
❒ Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension), *No further questions*
❒ Hypersensitivity, *No further questions*
❒ History of intolerance or adverse event, *No further questions*
❒ Other, please specify _____, *No further questions*

48. Has the patient been diagnosed with moderate to severe hidradenitis suppurativa?
❒ Yes, *Continue to 49*
❒ No, *Continue to 49*

49. Is the patient an adult (18 years of age or older)?
❒ Yes, *Continue to 50*
❒ No, *Continue to 50*

50. Is the requested drug being prescribed by or in consultation with a rheumatologist or dermatologist?
❒ Yes, *Continue to 51*
❒ No, *Continue to 51*

51. Is this request for continuation of therapy with the requested drug?
❒ Yes, *Continue to 52*
❒ No, *Continue to 55*

52. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program?
❒ Yes, *Continue to 55*
❒ No, *Continue to 53*
❒ Unknown, *Continue to 55*

53. Has the patient achieved or maintained a 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, *Continue to 54*
❒ No, *Continue to 54*

54. Which of the following has the patient experienced an improvement in since starting treatment with the requested drug? ***ACTION REQUIRED***: Please attach chart notes or medical record documentation supporting positive clinical response.
❒ Reduction in abscess and inflammatory nodule count from baseline ***ACTION REQUIRED****: Submit supporting documentation, No further questions*
❒ Reduced formation of new sinus tracts and scarring ***ACTION REQUIRED****: Submit supporting documentation, No further questions*
❒ Decrease in frequency of inflammatory lesions from baseline ***ACTION REQUIRED****: Submit supporting documentation, No further questions*
❒ Reduction in pain from baseline ***ACTION REQUIRED****: Submit supporting documentation, No further questions*
❒ Reduction in suppuration from baseline ***ACTION REQUIRED****: Submit supporting documentation, No further questions*
❒ Improvement in frequency of relapses from baseline ***ACTION REQUIRED****: Submit supporting documentation, No further questions*
❒ Improvement in quality of life from baseline ***ACTION REQUIRED****: Submit supporting documentation, No further questions*
❒ Improvement on a disease severity assessment tool from baseline ***ACTION REQUIRED****: Submit supporting documentation, No further questions*
❒ None of the above, *No further questions*

55. Has the patient ever received or is currently receiving a biologic (e.g., Cosentyx, Humira) indicated for treatment of moderate to severe hidradenitis suppurativa (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 medication tried. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *No Further Questions*
❒ No, *Continue to 56*

56. Has the patient had an inadequate response after at least 90 days of treatment with an oral antibiotic used for the treatment of hidradenitis suppurativa (e.g., clindamycin, metronidazole, moxifloxacin, rifampin, tetracyclines)? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *No Further Questions*
❒ No, *Continue to 57*

57. Has the patient had an intolerance to oral antibiotics used for the treatment of hidradenitis suppurativa? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy. ***ACTION REQUIRED***: Submit supporting documentation

❒ Yes, *No Further Questions*
❒ No, *Continue to 58*

58. Does the patient have a contraindication to oral antibiotics used for the treatment of hidradenitis suppurativa? ***ACTION REQUIRED***: If Yes, please attach documentation of clinical reason to avoid therapy. ***ACTION REQUIRED***: Submit supporting documentation
❒ 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)**