Humira and biosimilars

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? _____

What product is being requested?
❑ Abrilada ❑ adalimumab-adaz, *Skip to Criteria Questions* ❑ adalimumab-ryvk ❑ Amjevita ❑ Cyltezo
❑ Hadlima, *Skip to Criteria Questions* ❑ Hulio ❑ Humira
❑ Hyrimoz (Cordavis brand), *Skip to Criteria Questions* ❑ Hyrimoz (not Cordavis brand)
❑ Idacio ❑ Simlandi ❑ Yuflyma ❑ Yusimry

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

 Humira and biosimilars HMSACOM C18701-D, C11248-A – 04/2025.

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, Rinvoq, Skyrizi IV/SQ, Stelara IV/SQ, and unbranded infliximab**
- Plaque psoriasis: **adalimumab-adaz, Cosentyx SQ, Enbrel, Hadlima, Hyrimoz (Cordavis brand), Inflectra, Otezla, Skyrizi SQ, Stelara SQ, Taltz, Tremfya SQ, and unbranded infliximab**
- Psoriatic arthritis: **adalimumab-adaz, Cosentyx IV/SQ, Enbrel, Hadlima, Hyrimoz (Cordavis brand), Inflectra, Otezla, Rinvoq, Simponi Aria, Skyrizi SQ, Stelara SQ, Taltz Tremfya SQ, unbranded infliximab, and Xeljanz/Xeljanz XR**
- 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, Rinvoq, Skyrizi IV/SQ, Stelara IV/SQ, Tremfya IV/SQ, unbranded infliximab, and Xeljanz/Xeljanz XR**

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 F*

D. Is the patient currently receiving the requested product through samples or a manufacturer's patient assistance program? If unknown, answer Yes. *If Yes, skip to Question F* ❑ Yes ❑ No

E. Is the requested product Humira or a non-preferred Humira biosimilar (Abrilada, adalimumab-ryvk, Amjevita, Cyltezo, Hulio, Hyrimoz, Idacio, Simlandi, Yuflyma, or Yusimry)? ❑ Yes ❑ No *If No, skip to Criteria Questions*

F. What is the diagnosis?
❑ Ankylosing spondylitis
❑ Crohn's disease, *Skip to Question H*
❑ Plaque psoriasis, *Skip to Question I*
❑ Psoriatic arthritis, *Skip to Question J*
❑ Rheumatoid arthritis, *Skip to Question K*
❑ Ulcerative colitis, *Skip to Question L*

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 Crohn's disease: Rinvoq, Skyrizi SQ, Stelara SQ, and adalimumab-adaz, Hyrimoz (Cordavis brand) or Hadlima? ***ACTION REQUIRED: Please submit supporting documentation.*** ❑ Yes ❑ No *If Yes or No, skip to Criteria Questions*

I. Does the patient have a documented inadequate response, intolerable adverse event or contraindication to all of the following preferred products indicated for plaque psoriasis: Cosentyx SQ, Enbrel, Otezla, Skyrizi SQ, Stelara SQ,

Taltz, Tremfya SQ, and adalimumab-adaz, Hyrimoz (Cordavis brand) or Hadlima? ***ACTION REQUIRED: Please submit supporting documentation.*** ❑ Yes ❑ No *If Yes or No, skip to Criteria Questions*

J. 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 SQ, Enbrel, Otezla, Rinvoq, Skyrizi SQ, Stelara SQ, Taltz, Tremfya SQ, 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*

K. 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*

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

Criteria Questions:

1. Will the requested drug be used in combination with any other biologic (e.g., Cimzia) or targeted synthetic drug (e.g., Olumiant, Otezla, Xeljanz)?

❒ Yes, *Continue to #2*

❒ No, *Continue to #2*

2. Has the patient ever received (including current utilizers) a biologic or targeted synthetic drug (e.g., Rinvoq, Xeljanz) associated with an increased risk of tuberculosis?

❒ Yes, *Continue to #9*

❒ No, *Continue to #3*

3. Has the patient had a tuberculosis (TB) test (e.g., tuberculosis skin test [PPD], interferon-release assay [IGRA]) within 6 months of initiating therapy?

❒ Yes, *Continue to #4*

❒ No, *Continue to #9*

4. What were the results of the tuberculosis (TB) test?

❒ Positive for TB, *Continue to #5*

❒ Negative for TB, *Continue to #9*

❒ Unknown, *Continue to #9*

5. Which of the following applies to the patient?

❒ Patient has latent TB and treatment for latent TB has been initiated, *Continue to #9*

❒ Patient has latent TB and treatment for latent TB has been completed, *Continue to #9*

❒ Patient has latent TB and treatment for latent TB has not been initiated, *Continue to #9*

❒ Patient has active TB, *Continue to #9*

Indication

9. What is the diagnosis?

❒ Rheumatoid arthritis, *Continue to #100*
❒ Crohn's disease, *Continue to #500*
❒ Plaque psoriasis, *Continue to #700*
❒ Ulcerative colitis, *Continue to #600*
❒ Psoriatic arthritis, *Continue to #300*
❒ Psoriatic arthritis WITH co-existent plaque psoriasis, *Continue to #10*
❒ Ankylosing spondylitis, *Continue to #400*
❒ Non-radiographic axial spondyloarthritis, *Continue to #400*
❒ Polyarticular juvenile idiopathic arthritis, *Continue to #200*
❒ Oligoarticular juvenile idiopathic arthritis, *Continue to #200*
❒ Systemic juvenile idiopathic arthritis, *No Further Questions*
❒ Hidradenitis suppurativa, *Continue to #800*
❒ Behcet's disease, *Continue to #855*
❒ Pyoderma gangrenosum, *Continue to #900*
❒ Uveitis, *Continue to #870*
❒ Immune checkpoint inhibitor-related toxicity – inflammatory arthritis, *Continue to #970*
❒ Other, *No Further Questions*

10. What is the primary diagnosis being treated?

❒ Psoriatic arthritis, *Continue to #300*
❒ Plaque psoriasis, *Continue to #700*

Rheumatoid Arthritis

100. Has the patient been diagnosed with moderately to severely active rheumatoid arthritis (RA)?

❒ Yes, *Continue to #101*
❒ No, *Continue to #101*

101. Is the patient an adult (18 years of age or older)?

❒ Yes, *Continue to #102*
❒ No, *Continue to #102*

102. Is the requested drug being prescribed by or in consultation with a rheumatologist?

❒ Yes, *Continue to #103*
❒ No, *Continue to #103*

Continuation of Therapy

103. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug?

❒ Yes, *Continue to #104*
❒ No, *Continue to #107*

104. Is the patient currently receiving the requested drug or a biosimilar of the requested drug through samples or a manufacturer's patient assistance program?

❒ Yes, *Continue to #107*

❒ No, *Continue to #105*

❒ Unknown, *Continue to #107*

105. Has the patient achieved or maintained positive clinical response since starting treatment with the requested drug or a biosimilar of the requested drug?

❒ Yes, *Continue to #106*

❒ No, *Continue to #106*

106. Has the patient experienced substantial disease activity improvement (e.g., at least 20% from baseline) in tender joint count, swollen joint count, pain, or disability?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

Prior treatment with another biologic or targeted synthetic drug

107. Has the patient ever received or is currently receiving a biologic (e.g., Enbrel) or targeted synthetic drug (e.g., Rinvoq, Xeljanz) that is indicated for moderately to severely active rheumatoid arthritis (excluding receiving the drug via samples or a manufacturer's patient assistance program)?

❒ Yes, *No Further Questions*

❒ No, *Continue to #108*

Requirements regarding prior therapy

108. Does the patient meet either of the following: a) the patient was tested for the rheumatoid factor (RF) biomarker and the RF 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?

❒ Yes, *Continue to #110*

❒ No, *Continue to #109*

109. 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)?

❒ Yes, *Continue to #110*

❒ No, *Continue to #110*

110. Has the patient had an inadequate response after at least 3 months of treatment with methotrexate at a dose greater than or equal to 15 mg per week?

❒ Yes, *No Further Questions*

❒ No, *Continue to #111*

111. Has the patient had an intolerance to methotrexate?

❒ Yes, *No Further Questions*

❒ No, *Continue to #112*

112. Does the patient have a contraindication to methotrexate?

❒ Yes, *Continue to #113*

❒ No, *Continue to #113*

113. Please indicate the contraindication

❒ 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, *No Further Questions*

Juvenile Idiopathic Arthritis

200. Has the patient been diagnosed with moderately to severely active articular juvenile idiopathic arthritis?

❒ Yes, *Continue to #201*

❒ No, *Continue to #201*

201. Is the patient 2 years of age or older?

❒ Yes, *Continue to #202*

❒ No, *Continue to #202*

202. Is the requested drug being prescribed by or in consultation with a rheumatologist?

❒ Yes, *Continue to #203*

❒ No, *Continue to #203*

Continuation of Therapy

203. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug?

❒ Yes, *Continue to #204*

❒ No, *Continue to #207*

204. Is the patient currently receiving the requested drug or a biosimilar of the requested drug through samples or a manufacturer's patient assistance program?

❒ Yes, *Continue to #207*

❒ No, *Continue to #205*

❒ Unknown, *Continue to #207*

205. Has the patient achieved or maintained a positive clinical response to treatment as evidenced by low disease activity or improvement in signs and symptoms of the condition since starting treatment with the requested drug or a biosimilar of the requested drug?

❒ Yes, *Continue to #206*

❒ No, *Continue to #206*

206. Which of the following has the patient experienced an improvement in from baseline?

❒ Number of joints with active arthritis (e.g., swelling, pain, limitation of motion), *No Further Questions*

❒ Number of joints with limitation of movement, *No Further Questions*

❒ Functional ability, *No Further Questions*

❒ None of the above, *No Further Questions*

Prior treatment with another biologic or targeted synthetic drug

207. Has the patient ever received or is currently receiving a biologic (e.g., Enbrel) or targeted synthetic drug (e.g., Xeljanz) indicated for the treatment of moderately to severely active articular juvenile idiopathic arthritis (excluding receiving the drug via samples or a manufacturer's patient assistance program)?

❒ Yes, *No Further Questions*

❒ No, *Continue to #208*

New starts

208. Has the patient had an inadequate response to methotrexate or another conventional synthetic drug (e.g., leflunomide, sulfasalazine, hydroxychloroquine) administered at an adequate dose and duration?

❒ Yes, *No Further Questions*

❒ No, *Continue to #209*

209. Has the patient had an inadequate response to a trial of scheduled non-steroidal anti-inflammatory drugs (NSAIDs) and/or intra-articular glucocorticoids (e.g., triamcinolone hexacetonide)?

❒ Yes, *Continue to #210*

❒ No, *Continue to #211*

210. Does the patient have any of the following risk factors for poor outcome: a) involvement of ankle, wrist, hip, sacroiliac joint, and/or temporomandibular joint (TMJ), b) presence of erosive disease or enthesitis, c) delay in diagnosis, d) elevated levels of inflammation markers, or e) symmetric disease?

❒ Yes, *No Further Questions*

❒ No, *Continue to #211*

211. Does the patient have any of the following risk factors for disease severity and potentially a more refractory disease course: a) positive rheumatoid factor, b) positive anti-cyclic citrullinated peptide antibodies, or c) pre-existing joint damage?

❒ Yes, *Continue to #212*

❒ No, *Continue to #212*

212. Does the patient meet any of the following: a) high-risk joints are involved (e.g., cervical spine, wrist, or hip), b) high disease activity, or c) high risk for disabling joint disease?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

Psoriatic Arthritis

300. Is the patient an adult (18 years of age or older)?

❒ Yes, *Continue to #301*

❒ No, *Continue to #301*

301. Is the requested drug being prescribed by or in consultation with a rheumatologist or dermatologist?

❒ Yes, *Continue to #302*

❒ No, *Continue to #302*

Continuation of Therapy

302. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug?

❒ Yes, *Continue to #303*

❒ No, *Continue to #306*

303. Is the patient currently receiving the requested drug or a biosimilar of the requested drug through samples or a manufacturer's patient assistance program?

❒ Yes, *Continue to #306*

❒ No, *Continue to #304*

❒ Unknown, *Continue to #306*

304. 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 or a biosimilar of the requested drug?

❒ Yes, *Continue to #305*

❒ No, *Continue to #305*

305. Which of the following has the patient experienced an improvement in from baseline?

❒ Number of swollen joints, *No Further Questions*

❒ Number of tender joints, *No Further Questions*

❒ Dactylitis, *No Further Questions*

❒ Enthesitis, *No Further Questions*

❒ Axial disease, *No Further Questions*

❒ Skin and/or nail involvement, *No Further Questions*

❒ None of the above, *No Further Questions*

306. Has the patient been diagnosed with active psoriatic arthritis (PsA)?

❒ Yes, *Continue to #307*

❒ No, *Continue to #307*

Prior treatment with another biologic or targeted synthetic drug

307. Has the patient ever received or is currently receiving a biologic 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)?

❒ Yes, *No Further Questions*

❒ No, *Continue to #308*

New starts

308. What is the patient's disease severity?

❒ Mild to moderate, *Continue to #309*

❒ Severe, *No Further Questions*

309. Does the patient have enthesitis or predominantly axial disease?

❒ Yes, *No Further Questions*

❒ No, *Continue to #310*

310. 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?

❒ Yes, *No Further Questions*

❒ No, *Continue to #311*

311. Has the patient had an intolerance to methotrexate, leflunomide, or another conventional synthetic drug (e.g., sulfasalazine)?

❒ Yes, *No Further Questions*

❒ No, *Continue to #312*

312. Does the patient have a contraindication to methotrexate or leflunomide?

❒ Yes, *Continue to #313*

❒ No, *Continue to #314*

313. Please indicate the contraindication

❒ 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, *No Further Questions*

314. Does the patient have a contraindication to another conventional synthetic drug (e.g., sulfasalazine)?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

Active ankylosing spondylitis and active non-radiographic axial spondyloarthritis

400. Is the patient an adult (18 years of age or older)?

❒ Yes, *Continue to #401*

❒ No, *Continue to #401*

401. Is the requested drug being prescribed by or in consultation with a rheumatologist?

❒ Yes, *Continue to #402*

❒ No, *Continue to #402*

Continuation of Therapy

402. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug?

❒ Yes, *Continue to #403*

❒ No, *Continue to #406*

403. Is the patient currently receiving the requested drug or a biosimilar of the requested drug through samples or a manufacturer's patient assistance program?

❒ Yes, *Continue to #406*

❒ No, *Continue to #404*

❒ Unknown, *Continue to #406*

404.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 or a biosimilar of the requested drug?

❒ Yes, *Continue to #405*

❒ No, *Continue to #405*

405. Which of the following has the patient experienced an improvement in from baseline?

❒ Functional status, *No Further Questions*

❒ Total spinal pain, *No Further Questions*

❒ Inflammation (e.g., morning stiffness), *No Further Questions*

❒ None of the above, *No Further Questions*

Prior treatment with another biologic or targeted synthetic drug

406. Has the patient been diagnosed with active ankylosing spondylitis (AS) or active non-radiographic axial spondyloarthritis (nr-axSpA)?

❒ Yes, active ankylosing spondylitis (AS), *Continue to #407*

❒ Yes, active non-radiographic axial spondyloarthritis (nr-axSpA), *Continue to #407*

❒ No, *Continue to #407*

407. Has the patient ever received or is currently receiving a biologic or targeted synthetic drug (e.g., Rinvoq, Xeljanz) indicated for the treatment of active ankylosing spondylitis or active non-radiographic axial spondyloarthritis (excluding receiving the drug via samples or a manufacturer's patient assistance program)?

❒ Yes, *No Further Questions*

❒ No, *Continue to #408*

Requirements regarding prior therapy

408. 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?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

Crohn's Disease

500. Has the patient been diagnosed with moderately to severely active Crohn's disease (CD)?

❒ Yes, *Continue to #501*

❒ No, *Continue to #501*

501. Is the patient 6 years of age or older?

❒ Yes, *Continue to #502*

❒ No, *Continue to #502*

502. Is the requested drug being prescribed by or in consultation with a gastroenterologist?

❒ Yes, *Continue to #503*

❒ No, *Continue to #503*

Continuation of Therapy

503. Is this request for continuation of therapy with the requested drug?

❒ Yes, *Continue to #504*

❒ No, *No Further Questions*

504. Has the patient achieved or maintained remission?

❒ Yes, *No Further Questions*

❒ No, *Continue to #505*

505. 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 #506*

❒ No, *Continue to #506*

506. Which of the following has the patient experienced an improvement in from baseline?

❒ Abdominal pain or tenderness, *No Further Questions*

❒ Diarrhea, *No Further Questions*

❒ Body weight, *No Further Questions*

❒ Abdominal mass, *No Further Questions*

❒ Hematocrit, *No Further Questions*

❒ Appearance of the mucosa on endoscopy, computed tomography enterography (CTE), magnetic resonance enterography (MRE), or intestinal ultrasound, *No Further Questions*

❒ Improvement on a disease activity scoring tool (e.g., Crohn's Disease Activity Index [CDAI] score, *No Further Questions*

❒ None of the above, *No Further Questions*

Ulcerative Colitis

600. Has the patient been diagnosed with moderately to severely active ulcerative colitis (UC)?

❒ Yes, *Continue to #601*

❒ No, *Continue to #601*

601. Is the patient 5 years of age or older?

❒ Yes, *Continue to #602*

❒ No, *Continue to #602*

602. Is the requested drug being prescribed by or in consultation with a gastroenterologist?

❒ Yes, *Continue to #603*

❒ No, *Continue to #603*

Continuation of Therapy

603. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug?

❒ Yes, *Continue to #604*

❒ No, *No Further Questions*

604. Has the patient achieved or maintained remission?

❒ Yes, *No Further Questions*

❒ No, *Continue to #605*

605. Has the patient achieved or maintained a positive clinical response to treatment as evidenced by low disease activity or improvement in signs and symptoms of the condition since starting treatment with the requested drug or a biosimilar of the requested drug?

❒ Yes, *Continue to #606*

❒ No, *Continue to #606*

606. Which of the following has the patient experienced an improvement in from baseline?

❒ Stool frequency, *No Further Questions*

❒ Rectal bleeding, *No Further Questions*

❒ Urgency of defecation, *No Further Questions*

❒ C-reactive protein (CRP), *No Further Questions*

❒ Fecal calprotectin (FC), *No Further Questions*

❒ Appearance of the mucosa on endoscopy, computed tomography enterography (CTE), magnetic resonance enterography (MRE), or intestinal ultrasound, *No Further Questions*

❒ Improvement on a disease activity scoring tool (e.g., Ulcerative Colitis Endoscopic Index of Severity [UCEIS], Mayo Score), *No Further Questions*

❒ None of the above, *No Further Questions*

Moderate to Severe Plaque Psoriasis

700. Has the patient been diagnosed with moderate to severe plaque psoriasis?

❒ Yes, *Continue to #701*

❒ No, *Continue to #701*

701. Is the patient an adult (18 years of age or older)?

❒ Yes, *Continue to #702*

❒ No, *Continue to #702*

702. Is the requested drug being prescribed by or in consultation with a dermatologist?

❒ Yes, *Continue to #703*

❒ No, *Continue to #703*

Continuation of Therapy

703. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug?

❒ Yes, *Continue to #704*

❒ No, *Continue to #708*

704. Is the patient currently receiving the requested drug or a biosimilar of the requested drug through samples or a manufacturer's patient assistance program?

❒ Yes, *Continue to #708*

❒ No, *Continue to #705*

❒ Unknown, *Continue to #708*

705. 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 or a biosimilar of the requested drug?

❒ Yes, *Continue to #706*

❒ No, *Continue to #706*

706. Has the patient experienced a reduction in body surface area (BSA) affected from baseline?

❒ Yes, *No Further Questions*

❒ No, *Continue to #707*

707. Has the patient experienced an improvement in signs and symptoms of the condition from baseline (e.g., itching, redness, flaking, scaling, burning, cracking, pain)?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

Prior treatment with another biologic or targeted synthetic drug

708. Has the patient ever received or is currently receiving a biologic or targeted synthetic drug (e.g., Sotyktu, Otezla) indicated for the treatment of moderate to severe plaque psoriasis (excluding receiving the drug via samples or a manufacturer's patient assistance program)?

❒ Yes, *No Further Questions*

❒ No, *Continue to #709*

Requirements regarding prior therapy

709. Are crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) affected?

❒ Yes, *No Further Questions*

❒ No, *Continue to #710*

710. 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 #711*

711. What is the percentage of body surface area (BSA) affected (prior to starting the requested medication)?

❒ Greater than or equal to 3% to less than 10% of BSA, *Continue to #712*

❒ Greater than or equal to 10% of BSA, *No Further Questions*

712. 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?

❒ Yes, *No Further Questions*

❒ No, *Continue to #713*

713. Does the patient have a clinical reason to avoid pharmacologic treatment with methotrexate, cyclosporine and acitretin?

❒ Yes, *Continue to #714*

❒ No, *Continue to #714*

714. Please indicate clinical reason to avoid pharmacologic treatment

❒ 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, *No Further Questions*

800. Has the patient been diagnosed with moderate to severe hidradenitis suppurativa?

❒ Yes, *Continue to #801*

❒ No, *Continue to #801*

Continuation of Therapy

801. Is the patient 12 years of age or older?

❒ Yes, *Continue to #802*

❒ No, *Continue to #802*

802. Is the requested drug being prescribed by or in consultation with a rheumatologist or dermatologist?

❒ Yes, *Continue to #803*

❒ No, *Continue to #803*

803. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug

❒ Yes, *Continue to #804*

❒ No, *Continue to #807*

804. Is the patient currently receiving the requested drug or a biosimilar of the requested drug through samples or a manufacturer's patient assistance program?

❒ Yes, *Continue to #807*

❒ No, *Continue to #805*

❒ Unknown, *Continue to #807*

805. 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 or a biosimilar of the requested drug?

❒ Yes, *Continue to #806*

❒ No, *Continue to #806*

806. Which of the following has the patient experienced an improvement in since starting treatment with the requested drug or a biosimilar of the requested drug?

❒ Reduction in abscess and inflammatory nodule count, *No Further Questions*

❒ Reduced formation of new sinus tracts and scarring, *No Further Questions*

❒ Decrease in frequency of inflammatory lesions from baseline, *No Further Questions*

❒ Reduction in pain from baseline, *No Further Questions*

❒ Reduction in suppuration from baseline, *No Further Questions*

❒ Improvement in frequency of relapses from baseline, *No Further Questions*

❒ Improvement in quality of life from baseline, *No Further Questions*

❒ Improvement on a disease severity assessment tool from baseline, *No Further Questions*

❒ None of the above, *No Further Questions*

Prior treatment with another biologic drug

807. Has the patient ever received or is currently receiving a biologic indicated for the treatment of moderate to severe hidradenitis suppurativa (excluding receiving the drug via samples or a manufacturer's patient assistance program)?

❒ Yes, *No Further Questions*

❒ No, *Continue to #808*

Requirements regarding prior therapy

808. 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)?

❒ Yes, *No Further Questions*

❒ No, *Continue to #809*

809. Has the patient had an intolerance to oral antibiotics used for the treatment of hidradenitis suppurativa?

❒ Yes, *No Further Questions*

❒ No, *Continue to #810*

810. Does the patient have a contraindication to oral antibiotics used for the treatment of hidradenitis suppurativa?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

Behcet's disease

855. Is the requested drug being prescribed by or in consultation with a rheumatologist?

❒ Yes, *Continue to #856*

❒ No, *Continue to #856*

Continuation of Therapy

856. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug?

❒ Yes, *Continue to #857*

❒ No, *Continue to #859*

857. Is the patient currently receiving the requested drug or a biosimilar of the requested drug through samples or a manufacturer's patient assistance program?

❒ Yes, *Continue to #859*

❒ No, *Continue to #858*

❒ Unknown, *Continue to #859*

858. 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 or a biosimilar of the requested drug?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

859.Has the patient ever received or is currently receiving Otezla or a biologic indicated for the treatment of Behcet's disease (excluding receiving the drug via samples or a manufacturer's patient assistance program)?

❒ Yes, *No Further Questions*

❒ No, *Continue to #860*

New Starts

860. Has the patient had an inadequate response to at least one non-biologic medication for Behçet's disease (e.g., azathioprine, colchicine, cyclosporine, systemic corticosteroids)?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

Uveitis

870. Has the patient been diagnosed with non-infectious intermediate, posterior, or panuveitis?

❒ Yes, *Continue to #871*

❒ No, *Continue to #871*

Continuation of Therapy

871. Is the patient 2 years of age or older?

❒ Yes, *Continue to #872*

❒ No, *Continue to #872*

872. Is the requested drug being prescribed by or in consultation with an ophthalmologist or rheumatologist?

❒ Yes, *Continue to #873*

❒ No, *Continue to #873*

873. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug?

❒ Yes, *Continue to #874*

❒ No, *Continue to #877*

874. Is the patient currently receiving the requested drug or a biosimilar of the requested drug through samples or a manufacturer's patient assistance program?

❒ Yes, *Continue to #877*

❒ No, *Continue to #875*

❒ Unknown, *Continue to #877*

875. 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 or a biosimilar of the requested drug?

❒ Yes, *Continue to #876*

❒ No, *Continue to #876*

876. Which of the following has the patient experienced an improvement in from baseline?

❒ Reduced frequency of disease flares compared to baseline, *No Further Questions*

❒ Stability or improvement in anterior chamber (AC) cell grade compared to baseline, *No Further Questions*

❒ Stability or improvement in vitreous haze (VH) grade compared to baseline, *No Further Questions*

❒ Stability or improvement in visual acuity compared to baseline, *No Further Questions*

❒ Reduction in glucocorticoid requirements from baseline, *No Further Questions*

❒ No new active inflammatory chorioretinal and/or inflammatory retinal vascular lesions relative to baseline, *No Further Questions*

❒ None of the above, *No Further Questions*

Prior treatment with another biologic drug

877. Has the patient ever received or is currently receiving a biologic indicated for the treatment of non-infectious intermediate, posterior, and panuveitis (excluding receiving the drug via samples or a manufacturer's patient assistance program)?

❒ Yes, *No Further Questions*

❒ No, *Continue to #878*

Requirements regarding prior therapy

878. Has the patient experienced an inadequate response with corticosteroids or immunosuppressive therapy (e.g., azathioprine, cyclosporine, methotrexate, mycophenolate mofetil)?

❒ Yes, *No Further Questions*

❒ No, *Continue to #879*

879. Has the patient experienced an intolerance to corticosteroids and immunosuppressive therapy (e.g., azathioprine, cyclosporine, methotrexate, mycophenolate mofetil)?

❒ Yes, *No Further Questions*

❒ No, *Continue to #880*

880. Does the patient have a contraindication to corticosteroids and immunosuppressive therapy (e.g., azathioprine, cyclosporine, methotrexate, mycophenolate mofetil)?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

Pyoderma gangrenosum

900. Is the requested drug being prescribed by or in consultation with a dermatologist?

❒ Yes, *Continue to #901*

❒ No, *Continue to #901*

Continuation of Therapy

901. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug?

❒ Yes, *Continue to #902*

❒ No, *Continue to #904*

902. Is the patient currently receiving the requested drug or a biosimilar of the requested drug through samples or a manufacturer's patient assistance program?

❒ Yes, *Continue to #904*

❒ No, *Continue to #903*

❒ Unknown, *Continue to #904*

903. 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 or a biosimilar of the requested drug?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

Prior treatment with another biologic drug

904. Has the patient ever received or is currently receiving a biologic indicated for the treatment of pyoderma gangrenosum (excluding receiving the drug via samples or a manufacturer's patient assistance program)?

❒ Yes, *No Further Questions*

❒ No, *Continue to #905*

Requirements regarding prior therapy

905. Has the patient experienced an inadequate response with corticosteroids or immunosuppressive therapy (e.g., cyclosporine, mycophenolate mofetil)?

❒ Yes, *No Further Questions*

❒ No, *Continue to #906*

906. Has the patient experienced an intolerance to corticosteroids and immunosuppressive therapy (e.g., cyclosporine, mycophenolate mofetil)?

❒ Yes, *No Further Questions*

❒ No, *Continue to #907*

907. Does the patient have a contraindication to corticosteroids and immunosuppressive therapy (e.g., cyclosporine, mycophenolate mofetil)?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

Immunotherapy-related inflammatory arthritis

Continuation of Therapy

970. Is the requested drug being prescribed by or in consultation with an oncologist, hematologist, or rheumatologist?

❒ Yes, *Continue to #971*

❒ No, *Continue to #971*

971. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug?

❒ Yes, *Continue to #972*

❒ No, *Continue to #974*

972. Is the patient currently receiving the requested drug or a biosimilar of the requested drug through samples or a manufacturer's patient assistance program?

❒ Yes, *Continue to #974*

❒ No, *Continue to #973*

❒ Unknown, *Continue to #974*

973. 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, *No Further Questions*

❒ No

974. Does the patient have severe immunotherapy-related inflammatory arthritis?

❒ Yes, *Continue to #975*

❒ No, *Continue to Criteria Exception Policy*

975. Has the patient had an inadequate response to corticosteroids or a conventional synthetic drug (e.g., methotrexate, sulfasalazine, leflunomide, hydroxychloroquine)?

❒ Yes, *No Further Questions*

❒ No, *Continue to #976*

976. Does the patient have an intolerance or contraindication to corticosteroids?

❒ Yes, *Continue to #977*

❒ No, *Continue to #977*

977. Does the patient have an intolerance or contraindication to a conventional synthetic drug (e.g., methotrexate, sulfasalazine, leflunomide, hydroxychloroquine)?

❒ 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)**