Avsola, Inflectra, infliximab, Remicade, Renflexis

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

 Infliximab MR HMSA C18701-D, C12296-A – 04/2026.

Exception Criteria Questions:
*If the requested product is Avsola or Inflectra, skip to 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, *Continue to Question B*
❒ No, *skip to Criteria Questions*

B. These are the preferred products for which coverage is provided for the treatment of the following indications:

- Ankylosing spondylitis: adalimumab-adaz, Avsola, Cosentyx IV/SQ, Enbrel, Hadlima, Hyrimoz (Cordavis brand), Inflectra, Rinvoq, Simponi Aria, and Taltz
- Crohn's disease: adalimumab-adaz, Avsola, Entyvio, Hadlima, Hyrimoz (Cordavis brand), Inflectra, Pyzchiva IV/SQ (Cordavis or Sandoz brand), Rinvoq, Skyrizi IV/SQ, Tremfya IV/SQ, and Yesintek IV/SQ
- Plaque psoriasis: adalimumab-adaz, Avsola, Cosentyx SQ, Enbrel, Hadlima, Hyrimoz (Cordavis brand), Inflectra, Otezla, Pyzchiva SQ (Cordavis or Sandoz brand), Skyrizi SQ, Taltz, Tremfya SQ, and Yesintek SQ
- Psoriatic arthritis: adalimumab-adaz, Avsola, Cosentyx IV/SQ, Enbrel, Hadlima, Hyrimoz (Cordavis brand), Inflectra, Otezla, Pyzchiva SQ (Cordavis or Sandoz brand), Rinvoq, Simponi Aria, Skyrizi SQ, Taltz, Tremfya SQ, Xeljanz/Xeljanz XR, and Yesintek SQ
- Rheumatoid arthritis: adalimumab-adaz, Avsola, Enbrel, Hadlima, Hyrimoz (Cordavis brand), Inflectra, Rinvoq, Simponi Aria, and Xeljanz/Xeljanz XR
- Ulcerative colitis: adalimumab-adaz, Avsola, Entyvio, Hadlima, Hyrimoz (Cordavis brand), Inflectra, Pyzchiva IV/SQ (Cordavis or Sandoz brand), Rinvoq, Skyrizi IV/SQ, Tremfya IV/SQ, 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, *Continue to Question C*

C. Is this request for continuation of therapy with the requested product?
❒ Yes, *Continue to Question D*
❒ No, *Continue 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'
❒ Yes, *Continue to Question F*
❒ No, *Continue to Question E*

E. Is the requested product Humira, a non-preferred Humira biosimilar (Abrilada, adalimumab-aacf, adalimumab-aaty, adalimumab-adbm, adalimumab-fkjp, Amjevita, Cyltezo, Hulio, Hyrimoz, Idacio, Simlandi, Yuflyma, or Yusimry), Remicade, a non-preferred Remicade biosimilar (Renflexis, unbranded infliximab, or Zymfentra), Stelara or a non-preferred Stelara biosimilar (Imuldosa, Otulfi, Selarsdi, Starjemza, Steqeyma, ustekinumab-aekn, ustekinumab-JJ, ustekinumab-ttwe, or Wezlana)?

❒ Yes, *Continue to Question F*
❒ No, *skip to Criteria Questions*

F. What is the diagnosis?
❒ Ankylosing spondylitis, *Continue to Question G*
❒ Crohn's disease, *Continue to Question K*
❒ Plaque psoriasis, *Continue to Question N*
❒ Psoriatic arthritis, *Continue to Question R*
❒ Rheumatoid arthritis, *Continue to Question V*
❒ Ulcerative colitis, *Continue to Question Z*

G. What is the requested product?
❒ Remicade, *Continue to Question J*
❒ Renflexis, *Continue to Question J*
❒ Unbranded infliximab, *Continue to Question J*
❒ Other, *Continue to Question H*

H. Is the requested product self-administered (oral or self-injected)?
❒ Yes, *Continue to Question I*
❒ No, *Continue to Question J*

I. 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, *skip to Criteria Questions*
❒ 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 ankylosing spondylitis: Cosentyx IV, Avsola or Inflectra IV, and Simponi Aria? ***ACTION REQUIRED****: Please submit supporting documentation*
❒ Yes, *skip to Criteria Questions*
❒ No, *skip to Criteria Questions*

K. What is the requested product?
❒ Remicade, *Continue to Question M*
❒ Renflexis, *Continue to Question M*
❒ Unbranded infliximab, *Continue to Question M*
❒ Zymfentra SQ, *Continue to Question L*
❒ Other, *Continue to Question L*

L. 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) OR Yesintek SQ

❒ Yes, *skip to Criteria Questions*
❒ No, *skip to Criteria Questions*

M. 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) OR Yesintek IV
- Avsola OR Inflectra

❒ Yes, *skip to Criteria Questions*
❒ No, *skip to Criteria Questions*

N. What is the requested product?
❒ Remicade, *Continue to Question Q*
❒ Renflexis, *Continue to Question Q*
❒ Unbranded infliximab, *Continue to Question Q*
❒ Other, *Continue to Question O*

O. Is the requested product self-administered (oral or self-injected)?
❒ Yes, *Continue to Question P*
❒ No, *Continue to Question Q*

P. 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) OR Yesintek SQ

❒ Yes, *skip to Criteria Questions*
❒ No, *skip to Criteria Questions*

Q. Does the patient have a documented inadequate response, intolerable adverse event, or contraindication to the following preferred products indicated for plaque psoriasis: Avsola OR Inflectra? ***ACTION REQUIRED****: Please submit supporting documentation*
❒ Yes, *skip to Criteria Questions*
❒ No, *skip to Criteria Questions*

R. What is the requested product?
❒ Remicade, *Continue to Question U*
❒ Renflexis, *Continue to Question U*
❒ Unbranded infliximab, *Continue to Question U*
❒ Other, *Continue to Question S*

S. Is the requested product self-administered (oral or self-injected)?
❒ Yes, *Continue to Question T*
❒ No, *Continue 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 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) OR Yesintek SQ

❒ Yes, *skip to Criteria Questions*
❒ 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 psoriatic arthritis: Cosentyx IV, Avsola OR Inflectra and Simponi Aria? ***ACTION REQUIRED****: Please submit supporting documentation*
❒ Yes, *skip to Criteria Questions*
❒ No, *skip to Criteria Questions*

V. What is the requested product?
❒ Remicade, *Continue to Question Y*
❒ Renflexis, *Continue to Question Y*
❒ Unbranded infliximab, *Continue to Question Y*
❒ Other, *Continue to Question W*

W. Is the requested product self-administered (oral or self-injected)?
❒ Yes, *Continue to Question X*
❒ No, *Continue to Question Y*

X. 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, *skip to Criteria Questions*
❒ No, *skip to Criteria Questions*

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

Z. What is the requested product?
❒ Remicade, *Continue to Question CC*
❒ Renflexis, *Continue to Question CC*
❒ Unbranded infliximab, *Continue to Question CC*
❒ Zymfentra SQ, *Continue to Question BB*
❒ Other, *Continue to Question AA*

AA. Is the requested product self-administered (oral or self-injected)?
❒ Yes, Continue to Question BB
❒ No, Continue to Question CC

BB. 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*

- Rinvoq, Skyrizi SQ, Tremfya SQ, Velsipity, AND Xeljanz/Xeljanz XR
- adalimumab-adaz, Hyrimoz (Cordavis brand) OR Hadlima
- Pyzchiva SQ (Cordavis or Sandoz brand) OR Yesintek SQ

❒ Yes, *skip to Criteria Questions*
❒ No, *skip to Criteria Questions*

CC. 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) OR Yesintek IV
- Avsola OR Inflectra

❒ Yes, *Continue to Criteria Questions*
❒ No, *Continue to Criteria Questions*

Criteria Questions:

What is the prescribed drug? ❑ Avsola ❑ Inflectra ❑ Remicade ❑ Renflexis
❑ unbranded infliximab ❑ Zymfentra

1. Will the requested drug be used in combination with any other biologic (e.g., Humira) 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 (e.g., Humira) or targeted synthetic drug (e.g., Olumiant, Xeljanz) associated with an increased risk of tuberculosis (TB)?
❒ Yes, *Continue to #9*
❒ No, *Continue to #3*

3. Has the patient had a tuberculosis (TB) test (e.g., tuberculosis skin test [TST] or 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 #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?
❒ Crohn's disease, *Continue to #100*
❒ Ulcerative colitis, *Continue to #200*
❒ Rheumatoid arthritis, *Continue to #300*
❒ Ankylosing spondylitis, *Continue to #400*
❒ Non-radiographic axial spondyloarthritis, *Continue to #400*
❒ Psoriatic arthritis, *Continue to #500*
❒ Psoriatic arthritis WITH co-existent plaque psoriasis, *Continue to #10*
❒ Plaque psoriasis, *Continue to #600*
❒ Behcet's disease, *Continue to #750*
❒ Hidradenitis suppurativa, *Continue to #800*
❒ Pyoderma gangrenosum, *Continue to #825*
❒ Sarcoidosis, *Continue to #850*
❒ Takayasu's arteritis, *Continue to #870*
❒ Uveitis, *Continue to #900*
❒ Reactive arthritis, *Continue to #925*
❒ Immune checkpoint inhibitor-related toxicity, *Continue to #950*
❒ Immune checkpoint inhibitor-related inflammatory arthritis, *Continue to #960*
❒ Acute graft versus host disease, *Continue to #975*

❒ Other, *No Further Questions*

10. What is the primary diagnosis being treated?
❒ Psoriatic arthritis, *Continue to #500*
❒ Plaque psoriasis, *Continue to #600*

Crohn's Disease

100. Has the patient been diagnosed with moderately to severely active Crohn's disease (CD)?
❒ Yes, *Continue to #101*
❒ No, *Continue to #101*

101. Is the patient 6 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 gastroenterologist?
❒ Yes, *Continue to #103*
❒ No, *Continue to #103*

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 #990*

Continuation of Therapy

104. Has the patient achieved or maintained remission?
❒ Yes, *Continue to #990*
❒ No, *Continue to #105*

105. 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 #106*
❒ No, *Continue to #106*

106. Which of the following has the patient experienced an improvement in from baseline?
❒ Abdominal pain or tenderness, *Continue to #990*
❒ Diarrhea, *Continue to #990*
❒ Body weight, *Continue to #990*
❒ Abdominal mass, *Continue to #990*
❒ Hematocrit, *Continue to #990*
❒ Appearance of the mucosa on endoscopy, computed tomography enterography (CTE), magnetic resonance enterography (MRE), or intestinal ultrasound, *Continue to #990*
❒ Improvement on a disease activity scoring tool (e.g., Crohn's Disease Activity Index [CDAI] score), *Continue to #990*
❒ None of the above, *Continue to #990*

Ulcerative Colitis

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

❒ Yes, *Continue to #201*
❒ No, *Continue to #201*

201. Is the patient 6 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 gastroenterologist?
❒ 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 #990*

204. Has the patient achieved or maintained remission?
❒ Yes, *Continue to #990*
❒ No, *Continue to #205*

205. 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 #206*
❒ No, *Continue to #206*

206. Which of the following has the patient experienced an improvement in from baseline?
❒ Stool frequency, *Continue to #990*
❒ Rectal bleeding, *Continue to #990*
❒ Urgency of defecation, *Continue to #990*
❒ C-reactive protein (CRP), *Continue to #990*
❒ Fecal calprotectin (FC), *Continue to #990*
❒ Appearance of the mucosa on endoscopy, computed tomography enterography (CTE), magnetic resonance enterography (MRE), or intestinal ultrasound, *Continue to #990*
❒ Improvement on a disease activity scoring tool (e.g., Ulcerative Colitis Endoscopic Index of Severity [UCEIS], Mayo Score]), *Continue to #990*
❒ None of the above, *Continue to #990*

Rheumatoid Arthritis

300. Has the patient been diagnosed with moderately to severely active rheumatoid arthritis (RA)?
❒ Yes, *Continue to #301*
❒ No, *Continue to #301*

301. Is the patient an adult?
❒ Yes, *Continue to #302*
❒ No, *Continue to #302*

302. Is the requested drug being prescribed by or in consultation with a rheumatologist?
❒ Yes, *Continue to #303*

❒ No, *Continue to #303*

Continuation of Therapy

303. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to #304*
❒ No, *Continue to #350*

304. 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 #350*
❒ No, *Continue to #305*
❒ Unknown, *Continue to #350*

305. Has the patient achieved or maintained a positive clinical response since starting treatment with the requested drug or biosimilar?
❒ Yes, *Continue to #306*
❒ No, *Continue to #306*

306. 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, *Continue to #990*
❒ No, *Continue to #990*

Initial Therapy

Prior treatment with another biologic or targeted synthetic drug

350. Has the patient ever received or is currently receiving a biologic (e.g., Humira) or targeted synthetic drug (e.g., Rinvoq, Xeljanz) indicated for moderately to severely active rheumatoid arthritis (excluding receiving the drug via samples or a manufacturer's patient assistance program)?
❒ Yes, *Continue to #351*
❒ No, *Continue to #353*

Combination with methotrexate or leflunomide

351. Is the requested medication being prescribed in combination with methotrexate or leflunomide?
❒ Yes, *Continue to #990*
❒ No, *Continue to #352*

352. Please indicate a clinical reason for the patient to not use methotrexate or leflunomide
❒ Clinical diagnosis of alcohol use disorder, alcoholic liver disease or other chronic liver disease, *Continue to #990*
❒ Drug interaction, *Continue to #990*
❒ Risk of treatment-related toxicity, *Continue to #990*
❒ Pregnancy or currently planning pregnancy, *Continue to #990*
❒ Breastfeeding, *Continue to #990*
❒ Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension), *Continue to #990*
❒ Hypersensitivity, *Continue to #990*
❒ History of intolerance or adverse event, *Continue to #990*
❒ Other, *Continue to #990*

❒ No clinical reason not to use methotrexate or leflunomide, *Continue to #990*

Biomarker testing and combination with methotrexate or leflunomide

353. 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 #355*
❒ No, *Continue to #354*

354. 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 #355*
❒ No, *Continue to #355*

355. Is the requested medication being prescribed in combination with methotrexate or leflunomide?
❒ Yes, *Continue to #357*
❒ No, *Continue to #356*

356. Please indicate a clinical reason for the patient to not use methotrexate or leflunomide
❒ Clinical diagnosis of alcohol use disorder, alcoholic liver disease or other chronic liver disease, *Continue to #357*
❒ Drug interaction, *Continue to #357*
❒ Risk of treatment-related toxicity, *Continue to #357*
❒ Pregnancy or currently planning pregnancy, *Continue to #357*
❒ Breastfeeding, *Continue to #357*
❒ Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension), *Continue to #357*
❒ Hypersensitivity, *Continue to #357*
❒ History of intolerance or adverse event, *Continue to #357*
❒ Other, *Continue to #357*
❒ No clinical reason not to use methotrexate or leflunomide, *Continue to #357*

Requirements regarding prior therapy

357. Has the patient experienced 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, *Continue to #990*
❒ No, *Continue to #358*

358. Has the patient experienced an intolerance to methotrexate?
❒ Yes, *Continue to #990*
❒ No, *Continue to #359*

359. Does the patient have a contraindication to methotrexate?
❒ Yes, *Continue to #360*
❒ No, *Continue to #360*

360. Please indicate the contraindication
❒ Clinical diagnosis of alcohol use disorder, alcoholic liver disease or other chronic liver disease, *Continue to #990*
❒ Drug interaction, *Continue to #990*
❒ Risk of treatment-related toxicity, *Continue to #990*

❒ Pregnancy or currently planning pregnancy, *Continue to #990*
❒ Breastfeeding, *Continue to #990*
❒ Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension), *Continue to #990*
❒ Hypersensitivity, *Continue to #990*
❒ History of intolerance or adverse event, *Continue to #990*
❒ Other, *Continue to #990*

Ankylosing spondylitis and non-radiographic axial spondyloarthritis

400. Is the patient an adult?
❒ 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 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, *Continue to #990*
❒ Total spinal pain, *Continue to #990*
❒ Inflammation (e.g., morning stiffness), *Continue to #990*
❒ Swollen joints, *Continue to #990*
❒ Tender joints, *Continue to #990*
❒ C-reactive protein (CRP), *Continue to #990*
❒ None of the above, *Continue to #990*

Initial Therapy

406. Has the patient been diagnosed with active ankylosing spondylitis (AS) or active non-radiographic axial spondyloarthritis (nr-axSpA)?
❒ Yes – Active ankylosing spondylitis, *Continue to #407*
❒ Yes – Active non-radiographic axial spondyloarthritis, *Continue to #407*

❒ No, *Continue to #407*

Prior treatment with another biologic or targeted synthetic drug

407. Has the patient ever received or is currently receiving a biologic (e.g., Humira) 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, *Continue to #990*
❒ No, *Continue to #408*

Requirements regarding prior therapy

408. Has the patient experienced an inadequate response with at least TWO nonsteroidal anti-inflammatory drugs (NSAIDs), or has an intolerance or contraindication to at least two NSAIDs?
❒ Yes, *Continue to #990*
❒ No, *Continue to #990*

Psoriatic Arthritis

500. Is the patient an adult?
❒ Yes, *Continue to #501*
❒ No, *Continue to #501*

501. Is the requested drug being prescribed by or in consultation with a rheumatologist or dermatologist?
❒ Yes, *Continue to #502*
❒ No, *Continue to #502*

Continuation of Therapy

502. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to #503*
❒ No, *Continue to #506*

503. 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 #506*
❒ No, *Continue to #504*
❒ Unknown, *Continue to #506*

504. 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?
❒ Yes, *Continue to #505*
❒ No, *Continue to #505*

505. Which of the following has the patient experienced an improvement in from baseline?
❒ Number of swollen joints, *Continue to #990*
❒ Number of tender joints, *Continue to #990*
❒ Dactylitis, *Continue to #990*
❒ Enthesitis, *Continue to #990*
❒ Axial disease, *Continue to #990*
❒ Skin and/or nail involvement, *Continue to #990*

❒ Functional status, *Continue to #990*
❒ C-reactive protein, *Continue to #990*
❒ None of the above, *Continue to #990*

Initial Therapy

506. Has the patient been diagnosed with active psoriatic arthritis (PsA)?
❒ Yes, *Continue to #507*
❒ No, *Continue to #507*

Prior treatment with another biologic or targeted synthetic drug

507. Has the patient ever received or is currently receiving a biologic (e.g., Humira) or targeted synthetic drug (e.g., Rinvoq, Otezla) that is indicated for active psoriatic arthritis (excluding receiving the drug via samples or a manufacturer's patient assistance program)?
❒ Yes, *Continue to #990*
❒ No, *Continue to #508*

New starts

508. What is the patient's disease severity?
❒ Mild to moderate, *Continue to #509*
❒ Severe, *Continue to #990*

509. Does the patient have enthesitis or predominantly axial disease?
❒ Yes, *Continue to #990*
❒ No, *Continue to #510*

510. 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, *Continue to #990*
❒ No, *Continue to #511*

511. Has the patient had an intolerance to methotrexate, leflunomide, or another conventional synthetic drug (e.g., sulfasalazine)?
❒ Yes, *Continue to #990*
❒ No, *Continue to #512*

512. Does the patient have a contraindication to methotrexate or leflunomide?
❒ Yes, *Continue to #513*
❒ No, *Continue to #514*

513. Please indicate the contraindication
❒ Clinical diagnosis of alcohol use disorder, alcoholic liver disease or other chronic liver disease, *Continue to #990*
❒ Drug interaction, *Continue to #990*
❒ Risk of treatment-related toxicity, *Continue to #990*
❒ Pregnancy or currently planning pregnancy, *Continue to #990*
❒ Breastfeeding, *Continue to #990*
❒ Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension), *Continue to #990*
❒ Hypersensitivity, *Continue to #990*

❒ History of intolerance or adverse event, *Continue to #990*
❒ Other, *Continue to #990*

514. Does the patient have a contraindication to another conventional synthetic drug (e.g., sulfasalazine)?
❒ Yes, *Continue to #990*
❒ No, *Continue to #990*

Moderate to Severe Plaque Psoriasis

600. Has the patient been diagnosed with moderate to severe plaque psoriasis?
❒ Yes, *Continue to #601*
❒ No, *Continue to #601*

601. Is the patient an adult?
❒ Yes, *Continue to #602*
❒ No, *Continue to #602*

602. Is the requested drug being prescribed by or in consultation with a dermatologist?
❒ 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, *Continue to #608*

604. 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 #608*
❒ No, *Continue to #605*
❒ Unknown, *Continue to #608*

605. 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 #606*
❒ No, *Continue to #606*

606. Has the patient experienced a reduction in body surface area (BSA) affected from baseline?
❒ Yes, *Continue to #990*
❒ No, *Continue to #607*

607. 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, *Continue to #990*
❒ No, *Continue to #990*

Initial Therapy

Prior treatment with another biologic or targeted synthetic drug

608. Has the patient ever received or is currently receiving a biologic (e.g., Humira) 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, *Continue to #990*
❒ No, *Continue to #609*

Requirements regarding prior therapy

609. Are crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) affected?
❒ Yes, *Continue to #990*
❒ No, *Continue to #610*

610. Is the percentage of body surface area (BSA) affected (prior to starting the requested medication) less than 3%?
❒ Yes, *Continue to #611*
❒ No, *Continue to #611*

611. 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 #612*
❒ Greater than or equal to 10% of BSA, *Continue to #990*

612. 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, *Continue to #990*
❒ No, *Continue to #613*

613. Does the patient have a clinical reason to avoid pharmacologic treatment with methotrexate, cyclosporine and acitretin?
❒ Yes, *Continue to #614*
❒ No, *Continue to #614*

614. Please indicate 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, *Continue to #990*
❒ Drug interaction, *Continue to #990*
❒ Risk of treatment-related toxicity, *Continue to #990*
❒ Pregnancy or currently planning pregnancy, *Continue to #990*
❒ Breastfeeding, *Continue to #990*
❒ Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension), *Continue to #990*
❒ Hypersensitivity, *Continue to #990*
❒ History of intolerance or adverse event, *Continue to #990*
❒ Other, *Continue to #990*

Behcet's disease

750. Is the requested drug being prescribed by or in consultation with a rheumatologist?
❒ Yes, *Continue to #751*
❒ No, *Continue to #751*

Continuation of Therapy

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

❒ Yes, *Continue to #752*
❒ No, *Continue to #754*

752. 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 #754*
❒ No, *Continue to #753*
❒ Unknown, *Continue to #754*

753. 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 #990*
❒ No, *Continue to #990*

Prior treatment with another biologic drug or Otezla

754. Has the patient ever received or is currently receiving Otezla or a biologic (e.g., Humira) indicated for the treatment of Behcet's disease?
❒ Yes, *Continue to #990*
❒ No, *Continue to #755*

New Starts

755. Has the patient had an inadequate response to at least one non-biologic medication for Behcet's disease (e.g., azathioprine, colchicine, cyclosporine, systemic corticosteroids)?
❒ Yes, *Continue to #990*
❒ No, *Continue to #990*

Hidradenitis suppurativa

800. Has the patient been diagnosed with severe, refractory hidradenitis suppurativa?
❒ Yes, *Continue to #801*
❒ No, *Continue to #801*

801. Is the requested drug being prescribed by or in consultation with a rheumatologist or dermatologist?
❒ Yes, *Continue to #802*
❒ No, *Continue to #802*

Continuation of Therapy

802. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to #803*
❒ No, *Continue to #806*

803. 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 #806*
❒ No, *Continue to #804*
❒ Unknown, *Continue to #806*

804. 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 #805*
❒ No, *Continue to #805*

805. Which of the following signs and symptoms has the patient experienced an improvement in from baseline?
❒ Reduction in abscess and inflammatory nodule count from baseline, *Continue to #990*
❒ Reduced formation of new sinus tracts and scarring, *Continue to #990*
❒ Decrease in frequency of inflammatory lesions from baseline, *Continue to #990*
❒ Reduction in pain from baseline, *Continue to #990*
❒ Reduction in suppuration from baseline, *Continue to #990*
❒ Improvement in frequency of relapses from baseline, *Continue to #990*
❒ Improvement in quality of life from baseline, *Continue to #990*
❒ Improvement on a disease severity assessment tool from baseline, *Continue to #990*
❒ None of the above, *Continue to #990*

Initial Therapy

Prior treatment with another biologic drug

806. Has the patient ever received or is currently receiving a biologic (e.g., Humira) indicated for the treatment of severe, refractory hidradenitis suppurativa (excluding receiving the drug via samples or a manufacturer's patient assistance program)?
❒ Yes, *Continue to #990*
❒ No, *Continue to #807*

Requirements regarding prior therapy

807. Has the patient experienced 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, *Continue to #990*
❒ No, *Continue to #808*

808. Has the patient had an intolerance to oral antibiotics used for the treatment of hidradenitis suppurativa?
❒ Yes, *Continue to #990*
❒ No, *Continue to #809*

809. Does the patient have a contraindication to oral antibiotics used for the treatment of hidradenitis suppurativa?
❒ Yes, *Continue to #990*
❒ No, *Continue to #990*

Pyoderma Gangrenosum

825. Is the requested drug being prescribed by or in consultation with a dermatologist?
❒ Yes, *Continue to #826*
❒ No, *Continue to #826*

Continuation of Therapy

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

❒ Yes, *Continue to #827*
❒ No, *Continue to #829*

827. 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 #829*
❒ No, *Continue to #828*
❒ Unknown, *Continue to #829*

828. 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 #990*
❒ No, *Continue to #990*

Initial Therapy

Prior treatment with another biologic drug

829. Has the patient ever received or is currently receiving a biologic (e.g., Humira) indicated for the treatment of pyoderma gangrenosum (excluding receiving the drug via samples or a manufacturer's patient assistance program)?
❒ Yes, *Continue to #990*
❒ No, *Continue to #830*

Requirements regarding prior therapy

830. Has the patient had an inadequate response to corticosteroids or immunosuppressive therapy (e.g., cyclosporine, mycophenolate mofetil)?
❒ Yes, *Continue to #990*
❒ No, *Continue to #831*

831. Does the patient have an intolerance or contraindication to corticosteroids and immunosuppressive therapy (e.g., cyclosporine, mycophenolate mofetil)?
❒ Yes, *Continue to #990*
❒ No, *Continue to #990*

Sarcoidosis

850. Is the requested drug being prescribed by or in consultation with a dermatologist, pulmonologist, rheumatologist, cardiologist, neurologist, or ophthalmologist?
❒ Yes, *Continue to #851*
❒ No, *Continue to #851*

Continuation of Therapy

851. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to #852*
❒ No, *Continue to #854*

852. 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 #854*
❒ No, *Continue to #853*
❒ Unknown, *Continue to #854*

853. 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 #990*
❒ No, *Continue to #990*

Initial Therapy

Requirements regarding prior therapy

854. Has the patient had an inadequate response to corticosteroids or immunosuppressive therapy (e.g., azathioprine, methotrexate)?
❒ Yes, *Continue to #990*
❒ No, *Continue to #855*

855. Does the patient have an intolerance or contraindication to corticosteroids and immunosuppressive therapy (e.g., azathioprine, methotrexate)?
❒ Yes, *Continue to #990*
❒ No, *Continue to #990*

Takayasu's arteritis

870. Has the patient been diagnosed with refractory Takayasu's arteritis?
❒ Yes, *Continue to #875*
❒ No, *Continue to #875*

875. Is the requested drug being prescribed by or in consultation with a rheumatologist?
❒ Yes, *Continue to #876*
❒ No, *Continue to #876*

Continuation of Therapy

876. Is this request for continuation of therapy with the requested drug or a biosimilar or the requested drug?
❒ Yes, *Continue to #877*
❒ No, *Continue to #879*

877. Is the patient currently receiving the requested drug or a biosimilar through samples or a manufacturer's patient assistance program?
❒ Yes, *Continue to #879*
❒ No, *Continue to #878*
❒ Unknown, *Continue to #879*

878. 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 #990*
❒ No, *Continue to #990*

Initial Therapy

Requirements regarding prior therapy

879. Has the patient had an inadequate response to corticosteroids or immunosuppressive therapy (e.g., methotrexate, azathioprine, mycophenolate mofetil)?
❒ Yes, *Continue to #990*
❒ No, *Continue to #880*

880. Does the patient have an intolerance or contraindication to corticosteroids and immunosuppressive therapy (e.g., methotrexate, azathioprine, mycophenolate mofetil)?
❒ Yes, *Continue to #990*
❒ No, *Continue to #990*

Uveitis

900. Is the requested drug being prescribed by or in consultation with an ophthalmologist or rheumatologist?
❒ 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 #905*

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 #905*
❒ No, *Continue to #903*
❒ Unknown, *Continue to #905*

903. 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 #904*
❒ No, *Continue to #904*

904. Which of the following signs and symptoms has the patient experienced an improvement in from baseline?
❒ Reduced frequency of recurrence compared to baseline, *Continue to #990*
❒ Zero anterior chamber inflammation or reduction in anterior chamber inflammation compared to baseline, *Continue to #990*
❒ Decreased reliance on topical corticosteroids, *Continue to #990*
❒ None of the above, *Continue to #990*

Initial Therapy

Prior treatment with another biologic drug

905. Has the patient ever received or is currently receiving a biologic (e.g., Humira) indicated for the treatment of uveitis (excluding receiving the drug via samples or a manufacturer's patient assistance program)?

❒ Yes, *Continue to #990*
❒ No, *Continue to #906*

Requirements regarding prior therapy

906. Has the patient had an inadequate response with corticosteroids or immunosuppressive therapy (e.g., azathioprine, cyclosporine, methotrexate, mycophenolate mofetil)?
❒ Yes, *Continue to #990*
❒ No, *Continue to #907*

907. Does the patient have an intolerance or contraindication to corticosteroids and immunosuppressive therapy (e.g., azathioprine, cyclosporine, methotrexate, mycophenolate mofetil)?
❒ Yes, *Continue to #990*
❒ No, *Continue to #990*

Reactive arthritis

Continuation of Therapy

925. Is the requested drug being prescribed by or in consultation with a rheumatologist?
❒ Yes, *Continue to #926*
❒ No, *Continue to #926*

926. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to #927*
❒ No, *Continue to #929*

927. 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 #929*
❒ No, *Continue to #928*
❒ Unknown, *Continue to #929*

928. Has the patient achieved or maintained positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition (e.g., tender joint count, swollen joint count, or pain) since starting treatment with the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to #990*
❒ No, *Continue to #990*

Initial Therapy

Prior treatment with another biologic drug

929. Has the patient ever received or is currently receiving a biologic (e.g., Enbrel) indicated for the treatment of reactive arthritis (excluding receiving the drug via samples or a manufacturer's patient assistance program)?
❒ Yes, *Continue to #990*
❒ No, *Continue to #930*

Requirements regarding prior therapy

930. Has the patient had an inadequate response to methotrexate or sulfasalazine?

❒ Yes, *Continue to #990*
❒ No, *Continue to #931*

931. Does the patient have an intolerance to methotrexate?
❒ Yes, *Continue to #934*
❒ No, *Continue to #932*

932. Does the patient have a contraindication to methotrexate?
❒ Yes, *Continue to #933*
❒ No, *Continue to #933*

933. Please indicate the contraindication to methotrexate
❒ Clinical diagnosis of alcohol use disorder, alcoholic liver disease or other chronic liver disease, *Continue to #934*
❒ Drug interaction, *Continue to #934*
❒ Risk of treatment-related toxicity, *Continue to #934*
❒ Pregnancy or currently planning pregnancy, *Continue to #934*
❒ Breastfeeding, *Continue to #934*
❒ Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension), *Continue to #934*
❒ Hypersensitivity, *Continue to #934*
❒ History of intolerance or adverse event, *Continue to #934*
❒ Other, *Continue to #934*

934. Does the patient have an intolerance to sulfasalazine?
❒ Yes, *Continue to #990*
❒ No, *Continue to #935*

935. Does the patient have a contraindication to sulfasalazine (e.g., porphyria, intestinal or urinary obstruction)?
❒ Yes, *Continue to #990*
❒ No, *Continue to #990*

Immune checkpoint inhibitor-related toxicity

950. Is the requested drug being prescribed by or in consultation with an oncologist gastroenterologist, or hematologist?
❒ Yes, *Continue to #951*
❒ No, *Continue to #951*

951. Has the patient experienced an inadequate response to systemic corticosteroids?
❒ Yes, *No Further Questions*
❒ No, *Continue to #952*

952. Has the patient experienced an intolerance to corticosteroids?
❒ Yes, *No Further Questions*
❒ No, *Continue to #953*

953. Does the patient have a contraindication to corticosteroids?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

Immune checkpoint inhibitor-related inflammatory arthritis

960. Is the requested drug being prescribed by or in consultation with an oncologist, hematologist, or rheumatologist?
❒ Yes, *Continue to #961*
❒ No, *Continue to #961*

961. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to #962*
❒ No, *Continue to #964*

962. Is the patient currently receiving the requested drug or a biosimilar of the requested drug through samples of a manufacturer's patient assistance program?
❒ Yes, *Continue to #964*
❒ No, *Continue to #963*
❒ Unknown, *Continue to #964*

963. 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 #990*
❒ No, *Continue to #990*

964. Does the patient have moderate or severe immunotherapy-related inflammatory arthritis?
❒ Yes, *Continue to #965*
❒ No, *Continue to #965*

965. Has the patient had an inadequate response to corticosteroids?
❒ Yes, *Continue to #990*
❒ No, *Continue to #966*

966. Has the patient had an inadequate response to a conventional synthetic drug (e.g., methotrexate, sulfasalazine, leflunomide, hydroxychloroquine)?
❒ Yes, *Continue to #990*
❒ No, *Continue to #967*

967. Does the patient have an intolerance or contraindication to corticosteroids?
❒ Yes, *Continue to #968*
❒ No, *Continue to #968*

968. Does the patient have an intolerance or contraindication to a conventional synthetic drug (e.g., methotrexate, sulfasalazine, leflunomide, hydroxychloroquine)?
❒ Yes, *Continue to #990*
❒ No, *Continue to #990*

Acute graft versus host disease

975. Is the requested drug being prescribed by or in consultation with an oncologist or hematologist?
❒ Yes, *Continue to #976*
❒ No, *Continue to #976*

976. Has the patient experienced an inadequate response to systemic corticosteroids?
❒ Yes, *Continue to #990*
❒ No, *Continue to #977*

977. Does the patient have an intolerance to corticosteroids?
❒ Yes, *Continue to #990*
❒ No, *Continue to #978*

978. Does the patient have a contraindication to corticosteroids?
❒ Yes, *Continue to #990*
❒ No, *Continue to #990*

Dosing

990. What is the diagnosis?
❒ Crohn's disease, *Continue to #991*
❒ Ulcerative colitis, *Continue to #991*
❒ Rheumatoid arthritis, *Continue to #993*
❒ Ankylosing spondylitis, *Continue to #993*
❒ Non-radiographic axial spondyloarthritis, *Continue to #993*
❒ Psoriatic arthritis, *Continue to #993*
❒ Plaque psoriasis, *Continue to #993*
❒ Behcet's disease, *Continue to #993*
❒ Hidradenitis suppurativa, *Continue to #993*
❒ Pyoderma gangrenosum, *Continue to #993*
❒ Sarcoidosis, *Continue to #993*
❒ Takayasu's arteritis, *Continue to #993*
❒ Uveitis, *Continue to #993*
❒ Reactive arthritis, *Continue to #993*
❒ Immune checkpoint inhibitor-related toxicity, *Continue to #993*
❒ Immune checkpoint inhibitor-related inflammatory arthritis, *Continue to #993*
❒ Acute graft versus host disease, *Continue to #993*

991. What is the prescribed product?
❒ Avsola, Inflectra, infliximab, Remicade, or Renflexis, *No Further Questions*
❒ Zymfentra, *Continue to #992*

992. What is the patient's age?
❒ Less than 18 years old, *No Further Questions*
❒ 18 years or older, *No Further Questions*

993. What is the prescribed product?
❒ Avsola, Inflectra, infliximab, Remicade, or Renflexis, *No Further Questions*
❒ Zymfentra, *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)**