



## Kevzara

### 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.

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**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? \_\_\_\_\_

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**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, *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 E*

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 E*  
 No, *skip to Criteria Questions*

E. What is the diagnosis?

- Ankylosing spondylitis, *Continue to Question F*  
 Crohn's disease, *Continue to Question I*  
 Plaque psoriasis, *Continue to Question L*  
 Psoriatic arthritis, *Continue to Question O*  
 Rheumatoid arthritis, *Continue to Question R*  
 Ulcerative colitis, *Continue to Question S*

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F. Is the requested product self-administered (oral or self-injected)?

Yes, *Continue to Question G*

No, *Continue to Question H*

G. Does the patient have a documented inadequate response, intolerable adverse event or contraindication to all of the following preferred products indicated for ankylosing spondylitis: Cosentyx SQ, Enbrel, Rinvoq, Taltz, and adalimumab-adaz, Hyrimoz (Cordavis brand) or Hadlima? **ACTION REQUIRED:** *Please submit supporting documentation*

Yes, *skip to Criteria Questions*

No, *skip to Criteria Questions*

H. Does the patient have a documented inadequate response, intolerable adverse event or contraindication to all of the following preferred products indicated for ankylosing spondylitis: Cosentyx IV, Avsola or Inflectra IV, and Simponi Aria? **ACTION REQUIRED:** *Please submit supporting documentation*

Yes, *skip to Criteria Questions*

No, *skip to Criteria Questions*

I. Is the requested product self-administered (oral or self-injected)?

Yes, *Continue to Question J*

No, *Continue to Question K*

J. Does the patient have a documented inadequate response, intolerable adverse event or contraindication to ALL of the following preferred products indicated for Crohn's disease? **ACTION REQUIRED:** *Please submit supporting documentation*

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

Yes, *skip to Criteria Questions*

No, *skip to Criteria Questions*

K. Does the patient have a documented inadequate response, intolerable adverse event, or contraindication to ALL of the following preferred products indicated for Crohn's disease? **ACTION REQUIRED:** *Please submit supporting documentation*

- Entyvio, Skyrizi IV, AND Tremfya IV
- Pyzchiva IV (Cordavis or Sandoz brand) OR Yesintek IV
- Avsola OR Inflectra

Yes, *skip to Criteria Questions*

No, *skip to Criteria Questions*

L. Is the requested product self-administered (oral or self-injected)?

Yes, *Continue to Question M*

No, *Continue to Question N*

M. Does the patient have a documented inadequate response, intolerable adverse event or contraindication to ALL of the

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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

N. 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

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 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

Q. 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

R. 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

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

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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

U. Does the patient have a documented inadequate response, intolerable adverse event, or contraindication to ALL of the following preferred products indicated for ulcerative colitis? **ACTION REQUIRED:** Please submit supporting documentation

- Entyvio, Skyrizi IV, AND Tremfya IV
- Pyzchiva IV (Cordavis or Sandoz brand) OR Yesintek IV
- Avsola OR Inflectra

Yes, Continue to Criteria Questions

No, Continue to Criteria Questions

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**Criteria Questions:**

1. Will the requested drug be used in combination with any other biologic (e.g., Humira) or targeted synthetic drug (e.g., Olumiant, 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?  
 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], chest x-ray) 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?  
 Rheumatoid arthritis, *Continue to #100*  
 Polymyalgia rheumatica, *Continue to #150*  
 Polyarticular juvenile idiopathic arthritis (pJIA), *Continue to #200*  
 Immune checkpoint inhibitor-related toxicity – inflammatory arthritis, *Continue to #250*  
 Giant cell arteritis, *Continue to #300*  
 Other, *No Further Questions*

**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?  
 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*

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Continuation of Therapy

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

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

104. Is the patient currently receiving 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 a positive clinical response since starting treatment with 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*

Initial Therapy

Prior treatment with another biologic or targeted synthetic drug

107. Has the patient received or is currently receiving a biologic or targeted synthetic drug (e.g., Rinvoq, Xeljanz) within the past 120 days 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*

Biomarker testing and 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 failed to achieve a low disease activity after a 3-month trial of methotrexate (MTX) monotherapy at a maximum titrated dose of at least 15 mg per week?

- Yes, *Continue to #111*  
 No, *Continue to #117*

111. Has the patient had an inadequate response to methotrexate in combination with at least one other conventional synthetic drug (i.e., hydroxychloroquine and/or sulfasalazine) after a 3-month trial at a maximum tolerated dose(s)?

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- Yes, *No Further Questions*
- No, *Continue to #112*

112. Has the patient experienced an intolerable adverse event to hydroxychloroquine or sulfasalazine?

- Yes, *No Further Questions*
- No, *Continue to #113*

113. Does the patient have a contraindication to sulfasalazine (e.g., porphyria, intestinal or urinary obstruction)?

- Yes, *Continue to #114*
- No, *Continue to #116*

114. Does the patient have a contraindication to hydroxychloroquine?

- Yes, *Continue to #115*
- No, *Continue to #116*

115. Please indicate the contraindication to hydroxychloroquine

- Clinical diagnosis of alcohol use disorder, alcoholic liver disease, or other chronic liver disease, *No Further Questions*
- Drug interaction, *No Further Questions*
- Risk of treatment-related toxicity, *No Further Questions*
- Pregnancy or currently planning pregnancy, *No Further Questions*
- Breastfeeding, *No Further Questions*
- Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension), *No Further Questions*
- Hypersensitivity, *No Further Questions*
- History of intolerance or adverse event, *No Further Questions*
- Other, please specify, *No Further Questions*

116. Does the patient have moderate to high disease activity?

- Yes, *No Further Questions*
- No, *No Further Questions*

117. Was the patient unable to tolerate a 3-month trial of methotrexate monotherapy at a maximum titrated dose of at least 15 mg per week?

- Yes, *Continue to #118*
- No, *Continue to #125*

118. Has the patient had an inadequate response to methotrexate in combination with at least one other conventional synthetic drug (i.e., hydroxychloroquine and/or sulfasalazine) after a 3-month trial at a maximum tolerated dose(s)?

- Yes, *No Further Questions*
- No, *Continue to #119*

119. Has the patient stopped taking methotrexate and has had a documented inadequate response to another conventional synthetic drug (i.e., leflunomide, hydroxychloroquine, and/or sulfasalazine) alone or in combination after a 3-month trial at a maximum tolerated dose(s)?

- Yes, *No Further Questions*
- No, *Continue to #120*

120. Has the patient experienced an intolerable adverse event to leflunomide, hydroxychloroquine, or sulfasalazine?

- Yes, *No Further Questions*
- No, *Continue to #121*

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121. Does the patient have a contraindication to sulfasalazine (e.g., porphyria, intestinal or urinary obstruction)?

Yes, *Continue to #122*

No, *Continue to #124*

122. Does the patient have a contraindication to leflunomide and hydroxychloroquine?

Yes, *Continue to #123*

No, *Continue to #124*

123. Please indicate the contraindication to leflunomide and hydroxychloroquine

Clinical diagnosis of alcohol use disorder, alcoholic liver disease, or other chronic liver disease, *No Further Questions*

Drug interaction, *No Further Questions*

Risk of treatment-related toxicity, *No Further Questions*

Pregnancy or currently planning pregnancy, *No Further Questions*

Breastfeeding, *No Further Questions*

Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension), *No Further Questions*

Hypersensitivity, *No Further Questions*

History of intolerance or adverse event, *No Further Questions*

Other, please specify, *No Further Questions*

124. Does the patient have moderate to high disease activity?

Yes, *No Further Questions*

No, *No Further Questions*

125. Has the patient experienced an intolerable adverse event to methotrexate and has discontinued methotrexate?

Yes, *Continue to #128*

No, *Continue to #126*

126. Does the patient have a contraindication to methotrexate?

Yes, *Continue to #127*

No, *Continue to #127*

127. Please indicate the contraindication to methotrexate

Clinical diagnosis of alcohol use disorder, alcoholic liver disease, or other chronic liver disease, *Continue to #128*

Drug interaction, *Continue to #128*

Risk of treatment-related toxicity, *Continue to #128*

Pregnancy or currently planning pregnancy, *Continue to #128*

Breastfeeding, *Continue to #128*

Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension), *Continue to #128*

Hypersensitivity, *Continue to #128*

History of intolerance or adverse event, *Continue to #128*

Other, please specify, *Continue to #128*

128. Has the patient had an inadequate response to another conventional synthetic drug (i.e., leflunomide, hydroxychloroquine, and/or sulfasalazine) alone or in combination after a 3-month trial at a maximum tolerated dose(s)?

Yes, *No Further Questions*

No, *Continue to #129*

129. Has the patient experienced an intolerable adverse event to leflunomide, hydroxychloroquine, or sulfasalazine?

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- Yes, *No Further Questions*
- No, *Continue to #130*

130. Does the patient have a contraindication to sulfasalazine (e.g., porphyria, intestinal or urinary obstruction)?

- Yes, *Continue to #131*
- No, *Continue to #133*

131. Does the patient have a contraindication to leflunomide and hydroxychloroquine?

- Yes, *Continue to #132*
- No, *Continue to #133*

132. Please indicate the contraindication to leflunomide and hydroxychloroquine

- 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*

133. Does the patient have moderate to high disease activity?

- Yes, *No Further Questions*
- No, *No Further Questions*

#### Polymyalgia Rheumatica

150. Is the patient an adult?

- Yes, *Continue to #151*
- No, *Continue to #151*

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

- Yes, *Continue to #152*
- No, *Continue to #152*

#### Continuation of Therapy

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

- Yes, *Continue to #153*
- No, *Continue to #156*

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

- Yes, *Continue to #156*
- No, *Continue to #154*
- Unknown, *Continue to #156*

154. 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?

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- Yes, *Continue to #155*
- No, *Continue to #155*

155. Which of the following has the patient experience an improvement in from baseline?

- Morning stiffness, *No Further Questions*
- Hip or shoulder pain, *No Further Questions*
- Hip or shoulder range of motion, *No Further Questions*
- C-reactive protein (CRP) and/or erythrocyte sedimentation rate (ESR), *No Further Questions*
- None of the above, *No Further Questions*

*Initial Therapy*

156. Has the patient experienced an inadequate response to systemic corticosteroids?

- Yes, *No Further Questions*
- No, *Continue to #157*

157. Has the patient experienced a disease flare during a taper with systemic corticosteroids?

- Yes, *No Further Questions*
- No, *Continue to #158*

158. Has the patient experienced an inadequate response to methotrexate

- Yes, *No Further Questions*
- No, *Continue to #159*

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

- Yes, *Continue to #160*
- No, *Continue to #160*

160. Does the patient have an intolerance or contraindication to methotrexate?

- Yes, *Continue to #161*
- No, *Continue to #161*

161. Please indicate the contraindication to methotrexate:

- 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*

*Polyarticular juvenile idiopathic arthritis*

200. Has the patient been diagnosed with active polyarticular juvenile idiopathic arthritis?

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

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201. Does the patient weigh 63 kilograms (kg) or greater?

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*

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

Yes, *Continue to #204*

No, *Continue to #207*

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

Yes, *Continue to #207*

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?

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*

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

Yes, *No Further Questions*

No, *Continue to #208*

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 one 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

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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*

*Immune checkpoint inhibitor-related toxicity – inflammatory arthritis*

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

Yes, *Continue to #251*

No, *Continue to #251*

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

Yes, *Continue to #252*

No, *Continue to #254*

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

Yes, *Continue to #254*

No, *Continue to #253*

Unknown, *Continue to #254*

253. 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, *No Further Questions*

254. Does the patient have moderate or severe immunotherapy-related inflammatory arthritis?

Yes, *Continue to #255*

No, *Continue to #255*

255. 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 #256*

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

Yes, *Continue to #257*

No, *Continue to #257*

257. 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*

*Giant Cell Arteritis*

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

Yes, *Continue to #301*

No, *Continue to #301*

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

Yes, *Continue to #302*

No, *Continue to #305*

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

Yes, *Continue to #305*

No, *Continue to #303*

Unknown, *Continue to #305*

303. 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 #304*

No, *Continue to #304*

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

Headaches, *No Further Questions*

Scalp tenderness, *No Further Questions*

Tenderness and/or thickening of superficial temporal arteries, *No Further Questions*

Constitutional symptoms (e.g., weight loss, fever, fatigue, night sweats), *No Further Questions*

Jaw and/or tongue claudication, *No Further Questions*

Acute visual symptoms (e.g., amaurosis fugax, acute visual loss, diplopia), *No Further Questions*

Symptoms of polymyalgia rheumatica (e.g., shoulder and/or hip girdle pain), *No Further Questions*

Limb claudication, *No Further Questions*

None of the above, *No Further Questions*

305. Has the diagnosis been confirmed by temporal artery biopsy or cross-sectional imaging?

Yes, *No Further Questions*

No, *Continue to #306*

306. Has the diagnosis been confirmed by acute-phase reactant elevation (i.e., high erythrocyte sedimentation rate [ESR] and/or high serum C-reactive protein [CRP])?

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)**

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