Siliq

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

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 M*
❒ Rheumatoid arthritis, *Continue to Question P*
❒ Ulcerative colitis, *Continue to Question S*

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. 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*

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

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

- Cosentyx SQ, Enbrel, Otezla, Rinvoq, Skyrizi SQ, Taltz, Tremfya SQ AND Xeljanz/Xeljanz XR
- adalimumab-adaz, Hyrimoz (Cordavis brand) OR Hadlima?
- Pyzchiva SQ (Cordavis or Sandoz brand) OR Yesintek SQ

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

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

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

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

R. Does the patient have a documented inadequate response, intolerable adverse event, or contraindication to both of the following preferred products indicated for rheumatoid arthritis: Avsola OR Inflectra and Simponi Aria? ***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 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*

Criteria Questions:

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

2. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic drug (e.g., Olumiant, Xeljanz) associated with an increased risk of tuberculosis?
❒ Yes, *Continue to #9*
❒ No, *Continue to #3*

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

4. What were the results of the tuberculosis (TB) test?
❒ Positive for TB, *Continue to #5*
❒ Negative for TB, *Continue to #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?
❒ Plaque psoriasis, *Continue to #100*
❒ Other, *No Further Questions*

Plaque Psoriasis

100. Has the patient been diagnosed with moderate to severe plaque psoriasis?
❒ 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 dermatologist?
❒ Yes, *Continue to #103*
❒ No, *Continue to #103*

Continuation of Therapy

103. Is this request for continuation of therapy with the requested drug?
❒ Yes, *Continue to #104*
❒ No, *Continue to #108*

104. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program?
❒ Yes, *Continue to #108*
❒ No, *Continue to #105*
❒ Unknown, *Continue to #108*

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?
❒ Yes, *Continue to #106*
❒ No, *Continue to #106*

106. Has the patient experienced a reduction in body surface area (BSA) affected from baseline?
❒ Yes, *No Further Questions*
❒ No, *Continue to #107*

107. 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 a targeted synthetic drug

108. Has the patient ever received or is currently receiving a biologic (e.g., Humira) or targeted synthetic drug (e.g., Sotyktu, Otezla) indicated for treatment of moderate to severe plaque psoriasis (excluding receiving the drug via samples or a manufacturer's patient assistance program)?
❒ Yes, *No Further Questions*
❒ No, *Continue to #109*

Requirements regarding prior therapy

109. Are crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) affected?
❒ Yes, *No Further Questions*
❒ No, *Continue to #110*

110. Is the percentage of body surface area (BSA) affected (prior to starting the requested medication) less than3%?
❒ Yes, *Continue to #111*
❒ No, *Continue to #111*

111. 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 #112*
❒ Greater than or equal to 10% of BSA, *No Further Questions*

112. 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 #113*

113. Does the patient have a clinical reason to avoid pharmacologic treatment with methotrexate, cyclosporine and acitretin?
❒ Yes, *Continue to #114*
❒ No, *Continue to #114*

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