Stelara, Steqeyma, Wezlana, Yesintek, Selarsdi, Otulfi

HMSA Medicare Advantage - 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

What product is being requested? ❑ Stelara IV ❑ Stelara SC ❑ Imuldosa IV ❑ Imuldosa SC
❑ Otulfi IV ❑ Otulfi SC ❑ Pyzchiva IV ❑ Pyzchiva SC ❑ Selarsdi IV ❑ Selarsdi SC ❑ Starjemza IV
❑ Starjemza SC ❑ Steqeyma IV ❑ Steqeyma SC ❑ Ustekinumab (unbranded Stelara) IV
❑ Ustekinumab (unbranded Stelara) SC ❑ Ustekinumab-aauz (unbranded Otulfi) IV
❑ Ustekinumab-aauz (unbranded Otulfi) SC ❑ Ustekinumab-aekn (unbranded Selarsdi) IV
❑ Ustekinumab-aekn (unbranded Selarsdi) SC ❑ Ustekinumab-stba (unbranded Steqeyma) IV
❑ Ustekinumab-stba (unbranded Steqeyma) SC ❑ Ustekinumab-ttwe (unbranded Pyzchiva) IV
❑ Ustekinumab ttwe (unbranded Pyzchiva) SC ❑ Wezlana IV ❑ Wezlana SC ❑ Yesintek IV ❑ Yesintek SC

Criteria Questions:

1. What is the diagnosis?
❒ Moderately to severely active Crohn's disease, *No Further Questions*
❒ Moderately to severely active ulcerative colitis, *No Further Questions*
❒ Immune checkpoint inhibitor-related diarrhea or colitis, *Continue to #2*
❒ Other, *No Further Questions*

2. Has the patient had an inadequate response or intolerance to infliximab or vedolizumab? ***If Yes, chart notes, medical record documentation, or claims history supporting previous medications tried and response to therapy must be submitted upon request***
❒ Yes, *No Further Questions*
❒ No, *Continue to #3*

3. Does the patient have a contraindication to infliximab or vedolizumab? (Please provide the clinical reason in the space provided.) ***If Yes, documentation of clinical reason to avoid therapy must be submitted upon request.***
❒ 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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