Taltz

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

 Taltz HMSACOM C19370-A - 02/2025.

Criteria Questions:

1. Will the requested drug be used in combination with any other biologic (e.g., Humira) or targeted synthetic drug (DMARD) (e.g., Olumiant, Otezla, Xeljanz) 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] oran interferon-release assay [IGRA]) within 6 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*

❒ Psoriatic arthritis WITH co-existent plaque psoriasis, *Continue to #10*

❒ Psoriatic arthritis, *Continue to #200*

❒ Ankylosing spondylitis, *Continue to #300*

❒ Non-radiographic axial spondyloarthritis, *Continue to #300*

❒ Other, *No Further Questions*

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

❒ Yes, *Continue to #11*

❒ No, *Continue to #11*

11. What is the primary diagnosis being treated?

❒ Psoriatic arthritis, *Continue to #201*

❒ Plaque psoriasis, *Continue to #101*

Moderate to Severe Plaque Psoriasis

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

❒ Yes, *Continue to #101*

❒ No, *Continue to #101*

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

❒ Yes, *Continue to #102*

❒ No, *Continue to #102*

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

❒ 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*

Initial Therapy

Prior treatment with Otezla or biologic medication

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 the treatment of moderate to severe plaque psoriasis (excluding receiving the drug via samples or a manufacturer's patient assistance program)?

❒ Yes, *No Further Questions*

❒ No, *Continue to #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 than 3%?

❒ Yes, *Continue to #112*

❒ 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 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*

❒ Breast feeding, *No Further Questions*

❒ Pregnancy or currently planning pregnancy, *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*

Psoriatic Arthritis

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

❒ Yes, *Continue to #201*

❒ No, *Continue to #201*

201. Is the patient an adult?

❒ Yes, *Continue to #202*

❒ No, *Continue to #202*

Continuation of Therapy

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

❒ Yes, *Continue to #203*

❒ No, *Continue to #210*

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

❒ Yes, *Continue to #210*

❒ No, *Continue to #204*

❒ Unknown, *Continue to #210*

204. 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 #205*

❒ No, *Continue to #205*

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

❒ Number of swollen joints, *No Further Questions*

❒ Number of tender joints, *No Further Questions*

❒ Dactylitis, *No Further Questions*

❒ Enthesitis, *No Further Questions*

❒ Axial disease, *No Further Questions*

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

❒ Functional status, *No Further Questions*

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

❒ None of the above, *No Further Questions*

Initial Therapy

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

❒ Yes, *Continue to #211*

❒ No, *Continue to #211*

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

❒ Yes, *No Further Questions*

❒ No, *Continue to #212*

212. What is the patient's disease severity?

❒ Mild to moderate, *Continue to #213*

❒ Severe, *No Further Questions*

213. Dose the patient have enthesitis or predominately axial disease?

❒ Yes, *No Further Questions*

❒ No, *Continue to #214*

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

❒ Yes, *No Further Questions*

❒ No, *Continue to #215*

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

❒ Yes, *No Further Questions*

❒ No, *Continue to #216*

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

❒ Yes, *Continue to #218*

❒ No, *Continue to #217*

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

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

218. Please indicated the contraindication to methotrexate or leflunomide:

❒ 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*

Active ankylosing spondylitis and non-radiographic active axial spondyloarthritis

300. Is the patient an adult?

❒ Yes, *Continue to #301*

❒ No, *Continue to #301*

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

❒ Yes, *Continue to #302*

❒ No, *Continue to #302*

Continuation of Therapy

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

❒ Yes, *Continue to #303*

❒ No, *Continue to #306*

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

❒ Yes, *Continue to #306*

❒ No, *Continue to #304*

❒ Unknown, *Continue to #306*

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

❒ Yes, *Continue to #305*

❒ No, *Continue to #305*

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

❒ Functional status, *No Further Questions*

❒ Total spinal pain, *No Further Questions*

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

❒ Swollen joints, *No Further Questions*

❒ Tender joints, *No Further Questions*

❒ C-reactive protein, *No Further Questions*

❒ None of the above, *No Further Questions*

Initial Therapy

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

❒ Yes – Active ankylosing spondylitis, *Continue to #307*

❒ Yes – Active non-radiographic axial spondyloarthritis, *Continue to #307*

❒ No, *Continue to #307*

Prior treatment with another biologic medication

307. 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, *No Further Questions*

❒ No, *Continue to #308*

Requirements regarding prior therapy

308. 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, *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)**

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