Taltz

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 1-866-249-6155**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506.** 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:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____
Request Initiated For: _____

1. What is the prescribed quantity and frequency?
   a) **Loading dose:**
   ❑ Taltz 80mg syringes/autoinjectors Quantity and Frequency: _____

   b) **Maintenance dose:**
   ❑ Taltz 80mg syringes/autoinjectors Quantity and Frequency: _____
   ❑ Other _____

2. What is the diagnosis?
   ❑ Moderate to severe plaque psoriasis ❑ Active axial spondyloarthritis
   ❑ Active ankylosing spondylitis (AS) ❑ Psoriatic arthritis WITH co-existent plaque psoriasis
   ❑ Active psoriatic arthritis WITHOUT co-existent plaque psoriasis
   ❑ Other _____

3. What is the ICD-10 code? _____

4. What is the patient's weight? _____ kg

5. Is the requested drug being prescribed by or in consultation with any of the following?
   ❑ Dermatologist ❑ Rheumatologist ❑ None of the above

Section A: Preferred Product

6. These are the preferred products for which coverage is provided for the treatment of the following indications:
   Question continues on next page.
   a) Ankylosing spondylitis: **Cosentyx, Enbrel, Humira, Remicade, Rinvoq, Simponi Aria, Cymzia syringe (secondary)***
   b) Non-radiographic axial spondyloarthritis: **Cimzia syringe, Cosentyx, Rinvoq**
   c) Psoriatic arthritis: **Cosentyx, Enbrel, Humira, Otezla, Remicade, Rinvoq, Simponi Aria, Skyrizi, Stelara (SC), Tremfya, Cymzia syringe (secondary)***
   Note: Secondary preferred product option only applies to members who have had a documented inadequate response or intolerable adverse event with two primary preferred products.
   Can the patient's treatment be switched to a preferred product?
   ❑ Yes - Please indicate: _____ ***If Yes, please call 1-866-814-5506 to have the updated form faxed to***

Send completed form to: Case Review Unit, CVS Caremark Prior Authorization Fax: 1-866-249-6155

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your office OR you may complete the PA electronically (ePA). You may sign up online via CoverMyMeds at: www.covermymeds.com/epa/caremark/ or call 1-866-452-5017.

❑ No ❑ Not applicable - Requested for condition not listed above, *skip to Section B: All Requests.*

7. Is this request for continuation of therapy with the requested product? ❑ Yes ❑ No *If No, skip to #9*

8. Is the patient currently receiving the requested product through samples or a manufacturer's patient assistance program? If unknown, answer Yes. ❑ Yes ❑ No *If No, skip to Section B: All Requests*

9. Does the patient have a documented inadequate response or intolerable adverse event with any of the following preferred products? ***ACTION REQUIRED: If Yes, attach supporting chart note(s).*** *Indicate ALL that apply.*

❑ Cimzia syringe:	❑ Inadequate response	❑ Intolerable adverse event
❑ Cosentyx:	❑ Inadequate response	❑ Intolerable adverse event
❑ Enbrel:	❑ Inadequate response	❑ Intolerable adverse event
❑ Humira:	❑ Inadequate response	❑ Intolerable adverse event
❑ Otezla:	❑ Inadequate response	❑ Intolerable adverse event
❑ Remicade:	❑ Inadequate response	❑ Intolerable adverse event
❑ Rinvoq:	❑ Inadequate response	❑ Intolerable adverse event
❑ Simponi Aria:	❑ Inadequate response	❑ Intolerable adverse event
❑ Skyrizi SC:	❑ Inadequate response	❑ Intolerable adverse event
❑ Stelara SC:	❑ Inadequate response	❑ Intolerable adverse event
❑ Tremfya:	❑ Inadequate response	❑ Intolerable adverse event

❑ No - None of the above

10. Does the patient have any of the following?
    - ❑ Documented clinical reason(s) to avoid TNF inhibitors
    - ❑ Documented clinical reason(s) to avoid JAK inhibitors, *skip to #12*
    - ❑ Documented clinical reason(s) to avoid TNF inhibitors and JAK inhibitors
    - ❑ None of the above

11. Does the patient have one of the following documented clinical reasons to avoid all of the preferred products that are TNF inhibitors (Cimzia syringe, Enbrel, and Humira)? ***ACTION REQUIRED: If Yes, attach supporting chart note(s).***
    - ❑ Yes – History of demyelinating disorder, *please specify product(s):* _____
    - ❑ Yes – History of congestive heart failure, *please specify product(s):* _____
    - ❑ Yes – History of hepatitis B virus infection, *please specify product(s):* _____
    - ❑ Yes – Autoantibody formation/lupus-like syndrome (attributed to TNF inhibitor), *please specify product(s):* _____
    - ❑ Yes – History or risk of lymphoma or other malignancy, *please specify product(s):* _____
    - ❑ Yes – History of being a primary non-responder to a TNF inhibitor (i.e., no clinical response with initial treatment), *please specify product(s):* _____
    - ❑ No – None of the above

12. Does the patient have one of the following documented clinical reasons to avoid the preferred product that is a JAK inhibitor (Rinvoq)? ***ACTION REQUIRED: If Yes, attach supporting chart note(s).***
    - ❑ Yes – History or risk of lymphoma, lung cancer, non-melanoma skin cancer, or other malignancy
    - ❑ Yes – History or risk of major adverse cardiovascular events (MI, stroke, etc.)
    - ❑ Yes – History or risk of thrombotic events (PE, DVT, arterial thrombosis, etc.)
    - ❑ Yes – History of hepatitis B or hepatitis C virus infection
    - ❑ Yes – History of being a primary non-responder to a JAK inhibitor (i.e., no clinical response with initial treatment)
    - ❑ No – None of the above

<u>Section B: All Requests</u>

13. 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 ❑ No

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14. 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? *If Yes, skip to #18* ❑ Yes ❑ No

15. Has the patient had a tuberculosis (TB) test (e.g., tuberculosis skin test [PPD], interferon-release assay [IGRA], chest x-ray) within 6 months of initiating therapy? ❑ Yes ❑ No

16. What were the results of the tuberculosis (TB) test?
❑ Positive for TB ❑ Negative for TB, *skip to #18* ❑ Unknown

17. Which of the following applies to the patient?
❑ Patient has latent TB and treatment for latent TB has been initiated
❑ Patient has latent TB and treatment for latent TB has been completed
❑ Patient has latent TB and treatment for latent TB has not been initiated
❑ Patient has active TB

18. Is this request for continuation of therapy with the requested drug?
❑ Yes ❑ No *If No, skip to diagnosis section*

19. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program? *If Yes or Unknown, skip to diagnosis section.* ❑ Yes ❑ No ❑ Unknown

20. 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?
❑ Yes ❑ No

Complete the following section based on the patient's <u>primary</u> diagnosis, if applicable.

<u>Section C: Plaque Psoriasis</u>

21. Has the patient been diagnosed with coexistent psoriatic arthritis as the primary diagnosis?
If Yes, skip to section D. ❑ Yes ❑ No

Initial Request

22. Are crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) affected?
ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation of body surface area affected. ❑ Yes ❑ No

23. What is the percentage of body surface area (BSA) affected (prior to starting the requested medication)? _____ %
ACTION REQUIRED: Please attach chart notes or medical record documentation of affected area.

24. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic drug (e.g., Sotyktu, Otezla) indicated for the treatment of moderate to severe plaque psoriasis?
ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried. ❑ Yes ❑ No

25. 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? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy.*** ❑ Yes ❑ No

26. Does the patient have a clinical reason to avoid pharmacologic treatment with methotrexate, cyclosporine or acitretin? ***ACTION REQUIRED: If Yes, please attach documentation of clinical reason to avoid therapy.***
❑ Yes ❑ No ***If Yes, indicate clinical reason:*** _____

Continuation of Therapy

27. Has the patient experienced a reduction in body surface area (BSA) affected from baseline?
ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation of decreased body surface area affected. ❑ Yes ❑ No

28. Has the patient experienced an improvement in signs and symptoms of the condition from baseline (e.g., itching, redness, flaking, scaling, burning, cracking, pain)? ***ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation of improvement in signs and symptoms.*** ❑ Yes ❑ No

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Section D: Psoriatic Arthritis

Continuation of Therapy

29. Which of the following has the patient experienced an improvement in from baseline? ***ACTION REQUIRED: Please attach chart notes or medical record documentation supporting positive clinical response.***
    ❑ Number of swollen joints ❑ Number of tender joints ❑ Dactylitis ❑ Axial disease
    ❑ Enthesitis ❑ Skin and/or nail involvement ❑ None of the above

Initial Request

30. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic drug (e.g., Rinvoq, Otezla) that is indicated for active psoriatic arthritis? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried and no further questions.*** ❑ Yes ❑ No

31. Does the patient have mild to moderate disease? ❑ Yes ❑ No *If No, skip to #37*

32. Does the patient have enthesitis or predominantly axial disease? *If Yes, no further questions* ❑ Yes ❑ No

33. 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? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy and no further questions.*** ❑ Yes ❑ No

34. Has the patient had an intolerance to methotrexate, leflunomide, or another conventional synthetic drug (e.g., sulfasalazine)? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy.*** ❑ Yes ❑ No

35. Does the patient have a contraindication to methotrexate or leflunomide? ***ACTION REQUIRED: If Yes, please attach documentation of clinical reason to avoid therapy.*** ❑ Yes ❑ No
    If Yes, indicate clinical reason: _____

36. Does the patient have a contraindication to another conventional synthetic drug (e.g., sulfasalazine)? ***ACTION REQUIRED: If Yes, please attach documentation of clinical reason to avoid therapy.*** ❑ Yes ❑ No

37. Does the patient have severe disease? ❑ Yes ❑ No

Section E: Ankylosing Spondylitis and Axial Spondyloarthritis

Continuation of Therapy

38. Which of the following has the patient experienced an improvement in from baseline? ***ACTION REQUIRED: Please attach chart notes or medical record documentation supporting positive clinical response.***
    ❑ Functional status ❑ Inflammation (e.g., morning stiffness) ❑ Total spinal pain ❑ None of the above

Initial Request

39. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic drug (e.g., Rinvoq, Xeljanz) indicated for the treatment of active ankylosing spondylitis or active axial spondyloarthritis? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried.*** ❑ Yes ❑ No

40. 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? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy. If therapy is not advisable, please attach documentation of clinical reason to avoid therapy.*** ❑ Yes ❑ No

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_____

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Prescriber or Authorized Signature **Date (mm/dd/yy)**

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