Skyrizi

HMSA - 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

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

Criteria Questions:

1. What is the diagnosis?
   - ❑ Moderate to Severe plaque psoriasis
   - ❑ Active psoriatic arthritis WITH co-existent plaque psoriasis
   - ❑ Active psoriatic arthritis WITHOUT co-existent plaque psoriasis
   - ❑ Moderately to severely active crohn's disease
   - ❑ Other _____
2. What is the ICD-10 code? _____
3. 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
4. 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 diagnosis section*
   ❑ Yes ❑ No
5. 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
6. What were the results of the tuberculosis (TB) test?
   ❑ Positive for TB ❑ Negative for TB, *skip to diagnosis section* ❑ Unknown
7. 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

   Complete the following section based on the patient's diagnosis, if applicable.

Section A: Moderate to Severe Plaque Psoriasis

8. Is this request for continuation of therapy with the requested drug? ❑ Yes ❑ No *If No, skip to #13*
9. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program? *If Yes or Unknown, skip to #13* ❑ Yes ❑ No ❑ Unknown
10. 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
11. Has the patient experienced a reduction in body surface area (BSA) affected from baseline?
    If Yes, no further questions. ❑ Yes ❑ No
12. Has the patient experienced an improvement in signs and symptoms from baseline (e.g., itching, redness, flaking, scaling, burning, cracking, pain)? *If Yes or No, no further questions.* ❑ Yes ❑ No
13. Has the patient previously received (including current utilizers) Otezla or any other biologic medication (e.g. Humira) indicated for the treatment of moderate to severe plaque psoriasis?
    If Yes, no further questions. ❑ Yes ❑ No
14. Are crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) affected?
    If Yes, no further questions. ❑ Yes ❑ No
15. What is the percentage of body surface area (BSA) affected (prior to starting the requested medication)?
    _____% *If greater than or equal to 10%, no further questions*
16. 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? *If Yes, no further questions.* ❑ Yes ❑ No

17. Does the patient have a clinical reason to avoid pharmacologic treatment with methotrexate, cyclosporine and acitretin?
    ❑ Yes ❑ No ***If Yes, indicate clinical reason:*** _____

Section B: Active Psoriatic Arthritis

18. Is this request for continuation of therapy with the requested drug? *If No, no further questions.* ❑ Yes ❑ No

19. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program? *If Yes or Unknown, no further questions.* ❑ 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

21. Which of the following has the patient experienced an improvement in from baseline?
    ❑ Number of swollen joints
    ❑ Number of tender joints
    ❑ Dactylitis
    ❑ Enthesitis
    ❑ Skin and/or nail involvement
    ❑ None of the above

Section C: Moderately to severely active Crohn's Disease

22. Is this request for initiation or continuation of treatment with Skyrizi?
    ❑ Initiation of the intravenous (IV) loading dose, *skip to #27*
    ❑ Initiation of the subcutaneous (SQ) maintenance dose, *skip to #27*
    ❑ Continuation of the subcutaneous (SQ) maintenance dose

23. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program? *If Yes or Unknown, skip to #27* ❑ Yes ❑ No ❑ Unknown

24. Has the patient achieved or maintained remission? *If Yes, no further questions.* ❑ Yes ❑ No

25. 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

26. Which of the following has the patient experienced an improvement in from baseline? *No further questions.*
    ❑ Abdominal pain or tenderness
    ❑ Diarrhea
    ❑ Body weight
    ❑ Abdominal mass
    ❑ Hematocrit
    ❑ Endoscopic appearance of the mucosa
    ❑ Improvement on a disease activity scoring tool (e.g., Crohn's Disease Activity Index (CDAI) score)
    ❑ None of the above

27. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) indicated for Crohn's disease? *If Yes, no further questions* ❑ Yes ❑ No

28. Has the patient tried and had an inadequate response to at least one conventional therapy option? *If Yes, no further questions.*
    ❑ Yes – Sulfasalazine (Azulfidine, Sulfazine)
    ❑ Yes – Metronidazole (Flagyl)
    ❑ Yes – Ciprofoxacin (Cipro)
    ❑ Yes – Prednisone
    ❑ Yes – Budesonide (Entocort EC)
    ❑ Yes – Azathioprine (Azasan, Imuran)
    ❑ Yes – Mercaptopurine (Purinethol)

- ❑ Yes – Methotrexate intramuscular (IM) or subcutaneous (SC)
- ❑ Yes – Methylprednisolone (Solu-Medrol)
- ❑ Yes – Rifaximin (Xifaxan)
- ❑ Yes – Tacrolimus
- ❑ No

29. Does the patient have a contraindication or intolerance to at least one conventional therapy option (e.g., azathioprine [Azasan, Imuran], budesonide [Entocort EC], ciprofloxacin [Cipro], mercaptopurine [Purinethol], methylprednisolone [Solu-Medrol], methotrexate, metronidazole [Flagyl], prednisone, sulfasalazine [Azulfidine, Sulfazine], rifaximin [Xifaxin], tacrolimus)? ❑ 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_____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

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