Actemra

Prior Authorization Request

CVS Caremark administers the medical drug prior authorization program on behalf of Harvard Pilgrim Health Care. Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form to CVS Caremark, toll-free at 1-844-851-0882** to initiate the review process. If you have questions regarding the prior authorization please contact CVS Caremark at **1-844-387-1435.**

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:** _____
Physician's Name: _____ **NPI#:** _____
Specialty: _____ **HPHC Provider ID**_____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Rendering Provider Info: ❑ **Same as Requesting Provider** **HPHC Provider ID:**_____
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____ **Provider Tax ID:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Additional Demographic Information:

Please indicate the place of service for the requested drug:
❑ Ambulatory Surgical ❑ Home ❑ Inpatient Hospital ❑ Off Campus Outpatient Hospital
❑ On Campus Outpatient Hospital ❑ Office ❑ Pharmacy

Drug Information:

*Strength/Measure*_____ *Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un

*Directions(sig)*_____ *Route of administration*_____

*Dosing frequency*_____

Criteria Questions:

1. What is the diagnosis?
   - ❑ Rheumatoid arthritis
   - ❑ Polyarticular juvenile idiopathic arthritis (pJIA)
   - ❑ Systemic juvenile idiopathic arthritis (sJIA)
   - ❑ Other _____
   - ❑ Unicentric Castleman's disease
   - ❑ Multicentric Castleman's disease
   - ❑ Giant cell arteritis

2. What is the ICD-10 code? _____

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

Section A: Rheumatoid Arthritis

3. Has the patient been diagnosed with moderately to severely active rheumatoid arthritis (RA)? ❑ Yes ❑ No

4. Has the patient received Actemra in a paid claim through a pharmacy or medical benefit in the previous 120 days?
   ❑ Yes ❑ No *If No, skip to #7*

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-844-851-0882

5. *If patient is continuing therapy,* how long has the patient been receiving the requested medication? _____ weeks / months ***(circle one)***

6. Has the patient achieved or maintained positive clinical response to treatment as evidenced by low disease activity or improvement in signs and symptoms of RA? ❑ Yes ❑ No *No Further Questions*

7. Has the patient received any of the following medications in a paid claim through a pharmacy or medical benefit in the previous 120 days? If yes, please indicate the most recent medication.

❑ Cimzia, *skip to #14*	❑ Kineret, *skip to #14*	❑ Simponi Aria, *skip to #14*
❑ Cosentyx, *skip to #9*	❑ Orencia, *skip to #14*	❑ Stelara, *skip to #9*
❑ Enbrel, *skip to #14*	❑ Remicade, *skip to #14*	❑ Taltz, *skip to #9*
❑ Humira, *skip to #14*	❑ Renflexis, *skip to #14*	❑ Tremfya, *skip to #9*
❑ Inflectra, *skip to #14*	❑ Rituxan, *skip to #14*	❑ Xeljanz, *skip to #14*
❑ Kevzara, *skip to #14*	❑ Siliq, *skip to #9*	❑ Xeljanz XR, *skip to #14*
❑ None of the above	❑ Simponi, *skip to #14*	

8. Has the patient undergone pretreatment screening for latent tuberculosis (TB) infection with either a TB skin test or an interferon gamma release assay (e.g., QFT-GIT, T-SPOT.TB)? ❑ Yes ❑ No

9. Has the patient experienced an inadequate response after at least 3 months of treatment with methotrexate? ❑ Yes ❑ No *If No, skip to #11*

10. What was the maximum titrated methotrexate dose? _____ mg per week

11. Has the patient experienced intolerance to methotrexate? *If Yes, skip to #14* ❑ Yes ❑ No

12. Does the patient have a contraindication to methotrexate? ❑ Yes ❑ No

13. Please indicate the contraindication:

❑History of intolerance or adverse event	❑Alcoholism, alcoholic liver disease or other chronic liver disease
❑Elevated liver transaminases	❑Interstitial pneumonitis or clinically significant pulmonary fibrosis
❑Renal impairment	❑Pregnancy or planning pregnancy (female)
❑Pregnancy or planning pregnancy (male)	❑Breastfeeding
❑Myelodysplasia	❑Hypersensitivity
❑Significant drug interaction	❑Other _____

14. Has the patient previously received treatment with Simponi Aria or Remicade for rheumatoid arthritis? ❑ Yes ❑ No *If No, skip to #16*

15. Has the patient experienced any of the following during treatment with Simponi Aria or Remicade? ***If yes, please attach supporting documentation.***
    ❑ Yes – Inadequate response
    ❑ Yes – Intolerable adverse event (e.g., hypersensitivity reaction)
    ❑ No

16. Does the patient have a contraindication to Simponi Aria or Remicade? ***If yes, please attach supporting documentation***.
    ❑ Yes ❑ No

Section B: Polyarticular juvenile idiopathic arthritis (pJIA)

17. Has the patient been diagnosed with active polyarticular juvenile idiopathic arthritis (pJIA)? ❑ Yes ❑ No

18. Has the patient received Actemra in a paid claim through a pharmacy or medical benefit in the previous 120 days? ❑ Yes ❑ No *If No, skip to #21*

19. How long has the patient been receiving the requested medication? _____ weeks / months ***(circle one)***

20. Has the patient achieved or maintained positive clinical response to treatment as evidenced by low disease activity or improvement in signs and symptoms? ❑ Yes ❑ No *No Further Questions*

21. Has the patient received Orencia in a paid claim through a pharmacy or medical benefit in the previous 120 days? *If Yes, No further questions* ❑ Yes ❑ No

22. Has the patient received any of the following medications in a paid claim through a pharmacy or medical benefit in the previous 120 days? *If yes, please indicate the most recent medication and skip to #24*
    ❑ Cimzia ❑ Cosentyx ❑ Enbrel ❑ Humira ❑ Inflectra ❑ Kevzara
    ❑ Remicade ❑ Renflexis ❑ Siliq ❑ Simponi ❑ Simponi Aria ❑ Stelara
    ❑ Taltz ❑ Tremfya ❑ Xeljanz ❑ Xeljanz XR
    ❑ None of the above, *proceed to #23*

23. Has the patient undergone pretreatment screening for latent tuberculosis (TB) infection with either a TB skin test or an interferon gamma release assay (e.g., QFT-GIT, T-SPOT.TB)? ❑ Yes ❑ No

24. Has the patient experienced an inadequate response to a tumor necrosis factor (TNF) inhibitor (e.g., Enbrel, Humira, or Remicade) after at least 3 months of treatment? *If Yes, skip to #27* ❑ Yes ❑ No

25. Has the patient experienced an intolerable adverse event to a tumor necrosis factor (TNF) inhibitor (e.g., Enbrel, Humira, or Remicade)? *If Yes, skip to #27* ❑ Yes ❑ No

26. Does the patient have contraindication to a tumor necrosis factor (TNF) inhibitor (e.g., Enbrel, Humira, or Remicade)? ❑ Yes ❑ No

27. What is the requested formulation?
    ❑ Prefilled syringes for subcutaneous injection ❑ Vials for intravenous infusion

<u>Section C: Systemic juvenile idiopathic arthritis (sJIA)</u>

28. Has the patient been diagnosed with active systemic juvenile idiopathic arthritis (sJIA)? ❑ Yes ❑ No

29. Has the patient received Actemra in a paid claim through a pharmacy or medical benefit in the previous 120 days? ❑ Yes ❑ No *If No, skip to #32*

30. How long has the patient been receiving the requested medication?
    _____ weeks / months ***(circle one)***

31. Has the patient achieved or maintained positive clinical response to treatment as evidenced by low disease activity or improvement in signs and symptoms? ❑ Yes ❑ No *No Further Questions*

32. Has the patient received Kineret in a paid claim through a pharmacy or medical benefit in the previous 120 days? *If Yes, No further question* ❑ Yes ❑ No

33. Has the patient received any of the following medications in a paid claim through a pharmacy or medical benefit in the previous 120 days? *If yes, please indicate the most recent medication and skip to #35*
    ❑ Cimzia ❑ Cosentyx ❑ Enbrel ❑ Humira ❑ Inflectra ❑ Kevzara
    ❑ Orencia ❑ Remicade ❑ Renflexis ❑ Siliq ❑ Simponi ❑ Simponi Aria
    ❑ Stelara ❑ Taltz ❑ Tremfya ❑ Xeljanz ❑ Xeljanz XR
    ❑ None of the above, *proceed to #34*

34. Has the patient undergone pretreatment screening for latent tuberculosis (TB) infection with either a TB skin test or an interferon gamma release assay (e.g., QFT-GIT, T-SPOT.TB)? ❑ Yes ❑ No

35. Has the patient experienced an inadequate response to ANY of the following? If yes, please indicate:
    ❑Yes - At least 2 weeks of treatment with corticosteroids (e.g. prednisone, methylprednisolone)
    ❑Yes - At least 3 months of treatment with methotrexate
    ❑Yes - At least 3 months of treatment with leflunomide
    ❑No – No history of an inadequate response to any of the above

36. What is the requested formulation?
❑ Prefilled syringes for subcutaneous injection ❑ Vials for intravenous infusion

Section D: Unicentric and Multicentric Castleman's disease

37. Has the patient received any of the following medications in a paid claim through a pharmacy or medical benefit in the previous 120 days? *If yes, please indicate the most recent medication and no further questions*

❑ Actemra	❑ Cimzia	❑ Cosentyx	❑ Enbrel	❑ Humira	❑ Inflectra
❑ Kevzara	❑ Orencia	❑ Remicade	❑ Renflexis	❑ Siliq	❑ Simponi
❑ Simponi Aria	❑ Stelara	❑ Taltz	❑ Tremfya	❑ Xeljanz	❑ Xeljanz XR

❑ None of the above

38. Has the patient undergone pretreatment screening for latent tuberculosis (TB) infection with either a TB skin test or an interferon gamma release assay (e.g., QFT-GIT, T-SPOT.TB)? ❑ 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: Case Review Unit CVS Caremark Specialty Programs Fax: 1-844-851-0882

CVS Caremark Specialty Pharmacy ● 2211 Sanders Road NBT-6 ● Northbrook, IL 60062
Phone: 1-844-387-1435 ● Fax: 1-844-851-0882 ● www.caremark.com