Ilumya

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.**

e 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:** ____________________

<u>Rendering</u> 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.

<u>Additional Demographic Information:</u>

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*

<u>Drug Information:</u>

*Strength/Measure*______________________________ *Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un
*Directions(sig)*_________________________________ *Route of administration*________________________
*Dosing frequency*_______________________________

<u>Criteria Questions:</u>

1. What is the diagnosis?
   ❑ Plaque psoriasis ❑ Other ______________________________________
2. What is the ICD-10 code? _______________
3. Has the patient been diagnosed with moderate to severe plaque psoriasis? ❑ Yes ❑ No
4. Is this request for continuation of therapy? ❑ Yes ❑ No *If No, skip to #8*
5. Is the patient receiving Ilumya through samples or a manufacturer's patient assistance program?
   ❑ Yes ❑ No ❑ Unknown *If Yes or Unknown, skip to #8*
6. How long has the patient been receiving the requested medication?
   _______________ weeks / months ***(circle one)***
7. 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*

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8. Has the patient received any of the following medications? *If yes, please specify the most recent medication and skip to #10*
   ❑ Actemra ❑ Cimzia ❑ Cosentyx ❑ Enbrel ❑ Humira ❑ Inflectra ❑ Kevzara ❑ Orencia
   ❑ Otezla ❑ Remicade ❑ Renflexis ❑ Siliq ❑ Simponi ❑ Simponi Aria ❑ Stelara ❑ Taltz
   ❑ Tremfya ❑ Xeljanz ❑ Xeljanz XR ❑ None of the above,

9. 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

10. Did the patient fail treatment with Remicade? ***If yes, please attach supporting documentation.***
    ❑ Yes *If Yes, skip to #12* ❑ No

11. Does the patient have a contraindication to therapy with Remicade? ***If yes, please attach supporting documentation***. ❑ Yes ❑ No

12. What is the percentage of body surface area (BSA) affected (prior to starting the requested medication)?
    _______________ %

13. Are crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) affected?
    ❑ Yes ❑ No

14. 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

15. Does the patient have a clinical reason to avoid pharmacologic treatment with methotrexate, cyclosporine or acitretin? ❑ Yes ❑ No *If No, skip to #17*

16. Please indicate clinical reason to avoid pharmacologic treatment: _____________________________________

17. Does the patient have severe psoriasis that warrants a biologic disease-modifying antirheumatic drug (DMARD) as first line 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____

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

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

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