Stelara

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
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____ **HPHC Provider 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?
   - ❑ Plaque psoriasis
   - ❑ Psoriatic arthritis
   - ❑ Crohn's disease
   - ❑ Other_____
2. What is the ICD-10 code? _____

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

Section A: Plaque psoriasis
3. Has the patient been diagnosed with moderate to severe plaque psoriasis? ❑ Yes ❑ No
4. Has the patient received Stelara 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. 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? *If Yes, skip to #16* ❑ Yes ❑ No

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 specify the most recent medication:

❑ Cimzia, *skip to #9*	❑ Otezla, *skip to #8*	❑ Simponi Aria, *skip to #9*
❑ Cosentyx, *skip to #16*	❑ Orencia, *skip to #9*	❑ Actemra, *skip to #9*
❑ Enbrel, *skip to #16*	❑ Remicade, *skip to #16*	❑ Taltz, *skip to #16*
❑ Humira, *skip to #16*	❑ Simponi, *skip to #9*	❑ Xeljanz, *skip to #9*
❑ Inflectra, *skip to #16*	❑ Kevzara, *skip to #9*	❑ Xeljanz XR, *skip to #9*
❑ Renflexis, *skip to #16*	❑ Siliq, *skip to #16*	❑ Tremfya, *skip to #16*
❑ None of the above		

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. What is the percentage of body surface area (BSA) affected? _____% of BSA

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

11. Has the patient experienced an inadequate response to phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine or acitretin? *If Yes, skip to #16* ❑ Yes ❑ No

12. Has the patient had an intolerance or adverse event to a trial of phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine or acitretin? *If Yes, skip to #16* ❑ Yes ❑ No

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

14. Please indicate clinical reason to avoid pharmacologic treatment and *skip to #16.*

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15. Does the patient have severe psoriasis that warrants a biologic DMARD as first-line therapy? ❑ Yes ❑ No

16. What is the requested formulation?
    ❑ Stelara for subcutaneous injection ❑ Stelara for intravenous infusion

<u>Section B: Psoriatic Arthritis</u>

17. Has the patient been diagnosed with active psoriatic arthritis (PsA)? ❑ Yes ❑ No

18. Has the patient received Stelara 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? *If Yes, skip to #23* ❑ Yes ❑ No

21. 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 specify the most recent medication and skip to #23.

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

❑ None of the above

22. 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

23. What is the requested formulation?
❑ Stelara for subcutaneous injection
❑ Stelara for intravenous infusion

Section C: Crohn's Disease:

24. Has the patient been diagnosed with moderately to severely active Crohn's disease (CD)?
❑ Yes ❑ No

25. Has the patient received Stelara in a paid claim through a pharmacy or medical benefit in the previous 120 days?
❑ Yes ❑ No *If No, skip to #33*

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

27. Has the patient achieved or maintained positive clinical response to treatment as evidenced by low disease activity or improvement in signs and symptoms? *If Yes, skip to #39* ❑ Yes ❑ No

28. 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 specify the most recent medication

❑ Cimzia, *skip to #34*	❑ Tysabri, *skip to #34*	❑ Simponi Aria, *skip to #30*
❑ Cosentyx, *skip to #30*	❑ Orencia, *skip to #30*	❑ Actemra, *skip to #30*
❑ Enbrel, *skip to #30*	❑ Remicade, *skip to #34*	❑ Taltz, *skip to #30*
❑ Humira, *skip to #34*	❑ Simponi, *skip to #30*	❑ Xeljanz, *skip to #30*
❑ Inflectra, *skip to #34*	❑ Entyvio, *skip to #34*	❑ Xeljanz XR, *skip to #30*
❑ Kevzara, *skip to #30*	❑ Renflexis, *skip to #34*	❑ Siliq, *skip to #30*
❑ Tremfya, *skip to #30*	❑ None of the above	

29. 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

30. Has the patient tried and had an inadequate response to at least one conventional therapy option (e.g., azathioprine [Azasan, Imuran], budesonide [Entocort EC], ciprofloxacin [Cipro], mesalamine [Asacol, Delzicol, Pentasa, Lialda], mercaptopurine [Purinethol], methylprednisolone [Solu-Medrol], methotrexate, metronidazole [Flagyl], prednisone, sulfasalazine [Azulfidine], rifaximin [Xifaxan])? ❑ Yes ❑ No *If No, skip to #32*

31. Please indicate the previous treatment regimen:

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32. 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], mesalamine [Asacol, Delzicol, Pentasa, Lialda], mercaptopurine [Purinethol], methylprednisolone [Solu-Medrol], methotrexate, metronidazole [Flagyl], prednisone, sulfasalazine [Azulfidine], rifaximin [Xifaxan])? ❑ Yes ❑ No *If No, skip to #34*

33. Please indicate the contraindication or intolerance:
_____

34. What is the requested formulation? ❑ Stelara for subcutaneous injection ❑ Stelara for intravenous infusion

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