Cosentyx

CareFirst 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 1-855-330-1720**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-888-877-0518.** 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:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ❑ Same as Requesting Provider
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ Same as Referring Provider ❑ Same as Requesting Provider
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

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

Required Demographic Information:

Patient Weight: _____kg

Patient Height: _____cm

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

What is the ICD-10 code? _____

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

 CareFirst MR C26742-A, Psoriasis Enhanced SGM 4179-A, Cosentyx SGM 2017-A – 04/2025.

Exception Criteria Questions:

A. The preferred products for your patient's health plan are Simponi Aria and Stelara. Can the patient's treatment be switched to one of the preferred products?

❒ Yes, Simponi Aria, *Please obtain Form for preferred product and submit for corresponding PA.*

❒ Yes, Stelara, *Please obtain Form for preferred product and submit for corresponding PA.*

❒ No, *Continue to Question B*

B. Is this request for continuation of therapy with the requested product?

❒ Yes, *Continue to Question C*

❒ No, *Continue to Question D*

C. Is the patient currently receiving the requested product through samples or a manufacturer's patient assistance program?

❒ Yes, *Continue to Question D*

❒ No, *Skip to Psoriasis Enhanced SGM 4179-A Criteria Questions*

❒ Unknown, *Continue to Question D*

D. What is the diagnosis?

❒ Psoriatic Arthritis, *Continue to Question E*
❒ Rheumatoid arthritis, Ankylosing spondylitis, Polyarticular juvenile idiopathic arthritis, *Skip to Question F*
❒ Crohn's disease, Ulcerative colitis, Plaque psoriasis, *Skip to Question G*
❒ Other, *Skip to Psoriasis Enhanced SGM 4179-A Criteria Questions*

E. Did the patient have a documented inadequate response, intolerable adverse event, or contraindication to BOTH preferred products (Simponi aria and Stelara)? ***Action Required: If 'Yes', attach supporting chart note(s)***

❒ Yes, *Skip to Cosentyx 2017-A SGM Criteria Question 1*
❒ No, *Skip to Cosentyx 2017-A SGM Criteria Question 1*

F. Did the patient have a documented inadequate response, intolerable adverse event or contraindication to Simponi Aria*?* ***Action Required***: ***If 'Yes', attach supporting chart note(s)***

❒ Yes, *Skip to Cosentyx 2017-A SGM Criteria Question 1*
❒ No, *Skip to Cosentyx 2017-A SGM Criteria Question 1*

G. Did the patient have a documented inadequate response, intolerable adverse event, or contraindication to Stelara? ***Action Required***: ***If 'Yes', attach supporting chart note(s)***

❒ Yes, *Continue to Psoriasis Enhanced SGM 4179-A Criteria Questions*
❒ No *Continue to Psoriasis Enhanced SGM 4179-A Criteria Questions*

Psoriasis Enhanced SGM 4179-A Criteria Questions:

Is the diagnosis moderate or severe plaque psoriasis?
❒ Yes, *Continue to Question 1*
❒ No, *Skip to Cosentyx SGM 2017-A Criteria Question 1*

1. What is the patient's age? Indicate in years.

❒ 18 years of age or older _____, *Continue to 2*

❒ Less than 18 years of age _____, *Skip to Cosentyx 2017-A SGM Criteria Question 1.*

2. What is the diagnosis?

❒ Plaque psoriasis, *Continue to 3*

❒ Plaque psoriasis with co-existing psoriatic arthritis, *Skip to Cosentyx 2017-A SGM Criteria Question 1.*

❒ Other, please specify: _____, *Skip to Cosentyx 2017-A SGM Criteria Question 1*

3. Is the request for Sotyktu?
❒ Yes, *Continue to 4*
❒ No, *Continue to 5*

4. Will the requested drug be used in combination with any other biologic (e.g., Humira) or targeted synthetic drug (e.g., Otezla)?
❒ Yes, *Continue to 7*
❒ No, *Continue to 7*

5. Will the requested drug be used in combination with any other biologic (e.g., Humira) or targeted synthetic drug (e.g., Otezla, Sotyktu) for the same indication?
❒ Yes, *Continue to 6*
❒ No, *Continue to 6*

6. What is the requested medication?

❒ Otezla, *Continue to 11*

❒ Other, please specify: _____, *Continue to 7*

7. 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?
❒ Yes, *Continue to 12*
❒ No, *Continue to 8*

8. Has the patient had a tuberculosis (TB) test (e.g., tuberculosis skin test [TST], interferon-release assay [IGRA]) within 12 months of initiating therapy?
❒ Yes, *Continue to 9*
❒ No, *Continue to 11*

9. What were the results of the TB test?

❒ Positive for TB, *Continue to 10*

❒ Negative for TB, *Continue to 12*

❒ Unknown, *No further questions*

10. Which of the following applies to the patient?

❒ Patient has latent TB and treatment for latent TB has been initiated, *Continue to 12*

❒ Patient has latent TB and treatment for latent TB has been completed, *Continue to 12*

❒ Patient has latent TB and treatment for latent TB has not been initiated, *Continue to 12*

❒ Patient has active TB, *Continue to 12*

11. What is the severity of the disease?

❒ Mild plaque psoriasis, *Skip to Cosentyx 2017-A SGM Criteria Question 1*

❒ Moderate plaque psoriasis, *Continue to 13*

❒ Severe plaque psoriasis, *Continue to 13*

12. Has the patient been diagnosed with moderate to severe plaque psoriasis?

❒ Yes, *Continue to 13*

❒ No, *Continue to 13*

13. Is the requested drug prescribed by or in consultation with a dermatologist?

❒ Yes, *Continue to 14*

❒ No, *Continue to 14*

14. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug (if applicable)?

❒ Yes, *Continue to 15*

❒ No, *Continue to 21*

15. Is the patient currently receiving the requested drug or a biosimilar of the requested drug (if applicable) through samples or a manufacturer's patient assistance program?

❒ Yes, *Continue to 21*

❒ No, *Continue to 16*

❒ Unknown, *Continue to 21*

16. Has the patient achieved or maintained a 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 or a biosimilar of the requested drug?

❒ Yes, *Continue to 17*

❒ No, *Continue to 17*

17. What is the patient's current psoriasis involvement in body surface area (BSA) percent? Indicate in percentage. ***ACTION REQUIRED***: Attach supporting chart note(s) or medical record documentation for current psoriasis involvement of BSA percent.

❒ Less than or equal to 3% _____% ***ACTION REQUIRED***: Submit supporting documentation, *Skip to Cosentyx 2017-A SGM Criteria Question 77*

❒ Greater than 3% _____% ***ACTION REQUIRED***: Submit supporting documentation. *Continue to 18*

18. What is the patient's percent improvement in body surface area (BSA) from baseline? Indicate in percentage. ***ACTION REQUIRED***: Attach supporting chart note(s) or medical record documentation for percent improvement of BSA from baseline.

❒ Less than 75% BSA improvement _____% ***ACTION REQUIRED***: Submit supporting documentation, *Continue to 19*
❒ Greater than or equal to 75% BSA improvement _____% ***ACTION REQUIRED***: Submit supporting documentation, *Skip to Cosentyx 2017-A SGM Criteria Question 77*
19. What is the patient's percent reduction in the Psoriasis Area Severity Index (PASI) score from baseline? Indicate score reduction in percentage. ***ACTION REQUIRED***: Attach supporting chart note(s) or medical record documentation for percent reduction of PASI score from baseline.
❒ Greater than or equal to 75% reduction _____% ***ACTION REQUIRED***: Submit supporting documentation, *Skip to Cosentyx 2017-A SGM Criteria Question 77*
❒ Greater than or equal to 50% and less than 75% reduction _____% ***ACTION REQUIRED***: Submit supporting documentation, *Continue to 20*
❒ Less than 50% reduction _____%, *Continue to 20*
20. What is the patient's Dermatology Life Quality Index (DLQI) score? Indicate patient's DLQI score. ***ACTION REQUIRED***: Attach supporting chart note(s) or medical record documentation for Dermatology Life Quality Index (DLQI) score.
❒ Less than or equal to 5 _____ ***ACTION REQUIRED***: Submit supporting documentation, *Skip to Cosentyx 2017-A SGM Criteria Question 77*
❒ Greater than 5 _____, *No further questions*
21. Has the patient received or is currently receiving a biologic (e.g., Humira) or targeted synthetic drug (e.g., Sotyktu, Otezla) within the past 120 days indicated for the treatment of moderate to severe plaque psoriasis (excluding receiving the drug via samples or a manufacturer's patient assistance program)? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried.
❒ Yes, *Skip to Cosentyx 2017-A SGM Criteria Question 77*
❒ No, *Continue to 22*

22. Is the percentage of body surface area (BSA) affected (prior to starting the requested medication) less than 3%?
❒ Yes, *Continue to 23*
❒ No, *Continue to 23*

23. What is the percentage of body surface area (BSA) affected (prior to starting the requested medication)? Indicate in percentage. ***ACTION REQUIRED***: Attach supporting chart notes or medical record documentation of body surface area (BSA) affected.
❒ Greater than or equal to 3% but less than 10% _____% ***ACTION REQUIRED***: Submit supporting documentation, *Continue to 24*
❒ Greater than or equal to 10% _____% ***ACTION REQUIRED***: Submit supporting documentation, *Continue to 33*

24. What is the patient's Psoriasis Area Severity Index (PASI) score? Indicate patient's PASI score. ***ACTION REQUIRED***: Attach supporting chart note(s) or medical record documentation of Psoriasis Area Severity Index (PASI) score.
❒ Greater than or equal to 10 _____ ***ACTION REQUIRED***: Submit supporting documentation, *Continue to 26*
❒ Less than 10 _____ ***ACTION REQUIRED***: Submit supporting documentation, *Continue to 25*

25. Is the affected area severe at localized sites and associated with significant functional impairment and/or high levels of distress (e.g., nail disease or involvement of high-impact and difficult-to-treat sites such as face, scalp, palms, soles, flexures and genitals)? ***ACTION REQUIRED***: If Yes, please attach supporting chart notes or medical record documentation of affected area(s) with significant functional impairment and/or high levels of distress.
❒ Yes, *Continue to 33*
❒ No, *Continue to 33*

26. Has the patient had an inadequate response at the maximum tolerated dose to a medium to super-high potency topical corticosteroid therapy for a duration of at least 4 weeks? ***ACTION REQUIRED***: If Yes, please attach supporting chart notes, medical record documentation, or claims history of all prior and current use of treatment regimens for topical corticosteroid therapy, including dosage, duration, and response to therapy.
❒ Yes, *Continue to 33*
❒ No, *Continue to 27*

27. Has the patient had an inadequate response at the maximum tolerated dose to a topical calcineurin inhibitor therapy for a duration of at least 8 weeks? ***ACTION REQUIRED***: If Yes, please attach supporting chart note(s), medical record documentation, or claims history of all prior and current use of treatment regimens for topical calcineurin inhibitor therapy, including dosage, duration, and response to therapy.
❒ Yes, *Continue to 33*
❒ No, *Continue to 28*

28. Has the patient had an inadequate response at the maximum tolerated dose to a topical vitamin D analog therapy for a duration of at least 12 weeks? ***ACTION REQUIRED***: If Yes, please attach supporting chart note(s), medical record documentation, or claims history of all prior and current use of treatment regimens for topical vitamin D analog therapy, including dosage, duration, and response to therapy.
❒ Yes, *Continue to 33*
❒ No, *Continue to 29*

29. Has the patient had an inadequate response at the maximum tolerated dose to a topical retinoid therapy for a duration of at least 12 weeks? ***ACTION REQUIRED***: If Yes, please attach supporting chart note(s), medical record documentation, or claims history of all prior and current use of treatment regimens for topical retinoid therapy, including dosage, duration, and response to therapy.
❒ Yes, *Continue to 33*
❒ No, *Continue to 30*

30. Has the patient had an inadequate response at the maximum tolerated dose to a topical aryl hydrocarbon receptor agonist therapy for a duration of at least 12 weeks? ***ACTION REQUIRED***: If Yes, please attach supporting chart note(s), medical record documentation, or claims history of all prior and current use of treatment regimens for topical aryl hydrocarbon receptor agonist therapy, including dosage, duration, and response to therapy.
❒ Yes, *Continue to 33*
❒ No, *Continue to 31*

31. Has the patient had an inadequate response at the maximum tolerated dose to a topical phosphodiesterase 4 inhibitor therapy for a duration of at least 8 weeks? ***ACTION REQUIRED***: If Yes, please attach supporting chart note(s), medical record documentation, or claims history of all prior and current use of treatment regimens for topical phosphodiesterase 4 inhibitor therapy, including dosage, duration, and response to therapy.
❒ Yes, *Continue to 33*
❒ No, *Continue to 32*

32. 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 affected areas.
❒ Yes, *Continue to 33*
❒ No, *Continue to 33*

33. Has the patient had a trial of phototherapy (e.g., UVB, PUVA) for a duration of at least 3 months? ***ACTION REQUIRED***: If Yes, please attach supporting chart note(s) or medical record documentation for phototherapy, including dosage, duration, and response to therapy.
❒ Yes, *Continue to 35*
❒ No, *Continue to 34*

34. Does the patient meet any of the following criteria: a) the patient has experienced an intolerable adverse event with phototherapy, b) the patient has a clinical reason to avoid phototherapy, or c) the patient does not have access to phototherapy? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous treatments tried (if applicable), including duration and response to therapy. If therapy is not advisable, please attach documentation of clinical reason to avoid therapy.
❒ Yes, intolerable adverse event to phototherapy ***ACTION REQUIRED***: Submit supporting documentation, *Continue to 35*
❒ Yes, clinical reason to avoid phototherapy ***ACTION REQUIRED***: Submit supporting documentation, *Continue to 35*
❒ Yes, does not have access to phototherapy ***ACTION REQUIRED***: Submit supporting documentation, *Continue to 35*
❒ None of the above, *Continue to 35*

35. Has the patient had a trial of methotrexate at a dose of at least 25 mg/week or at the maximum tolerated dose for a duration of at least 3 months? ***ACTION REQUIRED***: If Yes, please attach supporting chart note(s), medical record documentation, or claims history of all prior and current use of treatment regimens for methotrexate, including dosage, duration, and response to therapy.
❒ Yes, *Skip to Cosentyx 2017-A SGM Criteria Question 77*
❒ No, *Continue to 36*

36. Has the patient had a trial of cyclosporine at a dose of at least 5 mg/kg/day or at the maximum tolerated dose for a duration of at least 6 weeks? ***ACTION REQUIRED***: If Yes, please attach supporting chart note(s), medical record documentation, or claims history of all prior and current use of treatment regimens for cyclosporine, including dosage, duration, and response to therapy.
❒ Yes, *Skip to Cosentyx 2017-A SGM Criteria Question 77*
❒ No, *Continue to 37*

37. Has the patient had a trial of acitretin at a dose of at least 50 mg/day or at the maximum tolerated dose for a duration of at least 3 months? ***ACTION REQUIRED***: If Yes, please attach supporting chart note(s), medical record documentation, or claims history of all prior and current use of treatment regimens for acitretin, including dosage, duration, and response to therapy.
❒ Yes, *Skip to Cosentyx 2017-A SGM Criteria Question 77*
❒ No, *Continue to 38*

38. Does the patient have a clinical reason to avoid systemic pharmacologic treatment with methotrexate, cyclosporine, and acitretin? ***ACTION REQUIRED***: Please attach documentation of clinical reason to avoid therapy.
❒ Yes, *Continue to 39*
❒ No, *Continue to 39*

39. Please indicate the clinical reason to avoid pharmacologic treatment with methotrexate, cyclosporine, and acitretin.

❒ Clinical diagnosis of alcohol use disorder, alcoholic liver disease, or other chronic liver disease, *Skip to Cosentyx 2017-A SGM Criteria Question 77*

❒ Drug interaction, *Skip to Cosentyx 2017-A SGM Criteria Question 77*

❒ Risk of treatment-related toxicity, *Skip to Cosentyx 2017-A SGM Criteria Question 77*

❒ Pregnancy or currently planning pregnancy, *Skip to Cosentyx 2017-A SGM Criteria Question 77*

❒ Breastfeeding, *Skip to Cosentyx 2017-A SGM Criteria Question 77*

❒ Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension), *Skip to Cosentyx 2017-A SGM Criteria Question 77*

❒ Hypersensitivity, *Skip to Cosentyx 2017-A SGM Criteria Question 77*

❒ History of intolerance or adverse event, *Skip to Cosentyx 2017-A SGM Criteria Question 77*

❒ Other, please specify. _____, *No Further Questions*

Cosentyx 2017-A SGM Criteria Questions:

1. Will the requested drug be used in combination with any other biologic (e.g., Humira) or targeted synthetic drug (e.g., Olumiant, Otezla, Xeljanz) for the same indication?
❒ Yes, *Continue to 2*
❒ No, *Continue to 2*

2. 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?
❒ Yes, *Continue to 6*
❒ No, *Continue to 3*

3. Has the patient had a tuberculosis (TB) test (e.g., tuberculosis skin test [TST], interferon-release assay [IGRA]) within 6 months of initiating therapy?
❒ Yes, *Continue to 4*
❒ No, *Continue to 4*

4. What were the results of the tuberculosis (TB) test?
❒ Positive for TB, *Continue to 5*
❒ Negative for TB, *Continue to 6*
❒ Unknown, *No Further Questions*

5. Which of the following applies to the patient?
❒ Patient has latent TB and treatment for latent TB has been initiated, *Continue to 6*
❒ Patient has latent TB and treatment for latent TB has been completed, *Continue to 6*
❒ Patient has latent TB and treatment for latent TB has not been initiated, *Continue to 6*
❒ Patient has active TB, *Continue to 6*

6. What is the diagnosis?
❒ Plaque psoriasis, *Continue to 9*
❒ Ankylosing spondylitis, *Continue to 24*
❒ Non-radiographic axial spondyloarthritis, *Continue to 24*
❒ Psoriatic arthritis WITH co-existent plaque psoriasis, *Continue to 7*
❒ Psoriatic arthritis, *Continue to 34*
❒ Enthesitis-related arthritis (ERA), *Continue to 50*
❒ Hidradenitis suppurativa, *Continue to 64*
❒ Other, please specify. _____, *No Further Questions*

7. Is the requested drug being prescribed by or in consultation with a rheumatologist or dermatologist?
❒ Yes, *Continue to 8*
❒ No, *Continue to 8*

8. What is the primary diagnosis being treated?
❒ Psoriatic arthritis, *Continue to 35*
❒ Plaque psoriasis, *Continue to 10*

9. Is the requested drug being prescribed by or in consultation with a dermatologist?
❒ Yes, *Continue to 10*
❒ No, *Continue to 10*

10. Has the patient been diagnosed with moderate to severe plaque psoriasis?
❒ Yes, *Continue to 11*
❒ No, *Continue to 11*

11. Is the patient 6 years of age or older?
❒ Yes, *Continue to 12*
❒ No, *Continue to 12*

12. Is this request for continuation of therapy with the requested drug?
❒ Yes, *Continue to 13*
❒ No, *Continue to 17*

13. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program?
❒ Yes, *Continue to 17*
❒ No, *Continue to 14*
❒ Unknown, *Continue to 17*

14. Has the patient achieved or maintained a 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, *Continue to 15*
❒ No, *Continue to 15*

15. 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, *Continue to 76*
❒ No, *Continue to 16*

16. 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, *Continue to 76*
❒ No, *Continue to 76*

17. Has the patient ever received or is currently receiving a biologic (e.g., Humira) or targeted synthetic drug (e.g., Sotyktu, Otezla) indicated for the treatment of moderate to severe plaque psoriasis (excluding receiving the drug via samples or a manufacturer's patient assistance program)? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried.
❒ Yes, *Continue to 76*
❒ No, *Continue to 18*

18. 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 affected areas.

❒ Yes, *Continue to 76*
❒ No, *Continue to 19*

19. Is the percentage of body surface area (BSA) affected (prior to starting the requested medication) less than 3%?
❒ Yes, *Continue to 20*
❒ No, *Continue to 20*

20. What is the percentage of body surface area (BSA) affected (prior to starting the requested medication)? Indicate percentage. ***ACTION REQUIRED***: Please attach chart notes or medical record documentation of body surface area affected.
❒ Greater than or equal to 3% to less than 10% of BSA _____ ***ACTION REQUIRED***: Submit supporting documentation, *Continue to 21*
❒ Greater than or equal to 10% of BSA _____ ***ACTION REQUIRED***: Submit supporting documentation, *Continue to 76*

21. 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, *Continue to 76*
❒ No, *Continue to 22*

22. Does the patient have a clinical reason to avoid pharmacologic treatment with methotrexate, cyclosporine, and acitretin? ***ACTION REQUIRED***: If Yes, please attach documentation of clinical reason to avoid therapy.
❒ Yes, *Continue to 23*
❒ No, *Continue to 23*

23. Please indicate the clinical reason to avoid pharmacologic treatment with methotrexate, cyclosporine, and acitretin.

❒ Clinical diagnosis of alcohol use disorder, alcoholic liver disease, or other chronic liver disease, *Continue to 76*

❒ Drug interaction, *Continue to 76*

❒ Risk of treatment-related toxicity, *Continue to 76*

❒ Pregnancy or currently planning pregnancy, *Continue to 76*

❒ Breastfeeding, *Continue to 76*

❒ Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension), *Continue to 76*

❒ Hypersensitivity, *Continue to 76*

❒ History of intolerance or adverse event, *Continue to 76*

❒ Other, please specify. _____, *Continue to 76*

24. Is the patient an adult (18 years of age or older)?
❒ Yes, *Continue to 25*
❒ No, *Continue to 25*

25. Is the requested drug being prescribed by or in consultation with a rheumatologist?
❒ Yes, *Continue to 26*
❒ No, *Continue to 26*

26. Is this request for continuation of therapy with the requested drug?
❒ Yes, *Continue to 27*
❒ No, *Continue to 31*

27. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program?

❒ Yes, *Continue to 31*

❒ No, *Continue to 28*

❒ Unknown, *Continue to 31*

28. Has the patient achieved or maintained a 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, *Continue to 29*
❒ No, *Continue to 30*

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.

❒ Functional status ***ACTION REQUIRED***: Submit supporting documentation, *Continue to 76*

❒ Total spinal pain ***ACTION REQUIRED***: Submit supporting documentation, *Continue to 76*

❒ Inflammation (e.g., morning stiffness) ***ACTION REQUIRED***: Submit supporting documentation, *Continue to 76*

❒ Swollen joints ***ACTION REQUIRED***: Submit supporting documentation, *Continue to 76*

❒ Tender joints ***ACTION REQUIRED***: Submit supporting documentation, *Continue to 76*

❒ C-reactive protein (CRP) ***ACTION REQUIRED***: Submit supporting documentation, *Continue to 76*

❒ None of the above, *Continue to 30*

30. Is this a request for an increase in dosing regimen due to the patient not achieving an adequate clinical response at the current dose?
❒ Yes, *Continue to 76*
❒ No, *Continue to 76*

31. Has the patient been diagnosed with active ankylosing spondylitis (AS) or active non-radiographic axial spondyloarthritis (nr-axSpA)?

❒ Yes - active ankylosing spondylitis, *Continue to 32*

❒ Yes - active non-radiographic axial spondyloarthritis, *Continue to 32*

❒ No, *Continue to 32*

32. Has the patient ever received or is currently receiving a biologic (e.g., Humira) or targeted synthetic drug (e.g., Rinvoq, Xeljanz) indicated for the treatment of active ankylosing spondylitis or active non-radiographic axial spondyloarthritis (excluding receiving the drug via samples or a manufacturer's patient assistance program)? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried.
❒ Yes, *Continue to 76*
❒ No, *Continue to 33*

33. Has the patient had 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, *Continue to 76*
❒ No, *Continue to 76*

34. Is the requested drug being prescribed by or in consultation with a rheumatologist or dermatologist?
❒ Yes, *Continue to 35*
❒ No, *Continue to 35*

35. Is the patient 2 years of age or older?
❒ Yes, *Continue to 36*
❒ No, *Continue to 36*

36. Is this request for continuation of therapy with the requested drug?
❒ Yes, *Continue to 37*
❒ No, *Continue to 41*

37. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program?
❒ Yes, *Continue to 41*
❒ No, *Continue to 38*
❒ Unknown, *Continue to 41*

38. Has the patient achieved or maintained a 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, *Continue to 39*
❒ No, *Continue to 40*

39. 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 ***ACTION REQUIRED***: Submit supporting documentation, *Continue to 76*
❒ Number of tender joints ***ACTION REQUIRED***: Submit supporting documentation, *Continue to 76*
❒ Dactylitis ***ACTION REQUIRED***: Submit supporting documentation, *Continue to 76*
❒ Enthesitis ***ACTION REQUIRED***: Submit supporting documentation, *Continue to 76*
❒ Axial disease ***ACTION REQUIRED***: Submit supporting documentation, *Continue to 76*
❒ Skin and/or nail involvement ***ACTION REQUIRED***: Submit supporting documentation, *Continue to 76*
❒ Functional status ***ACTION REQUIRED***: Submit supporting documentation, *Continue to 76*
❒ C-reactive protein (CRP) ***ACTION REQUIRED***: Submit supporting documentation, *Continue to 76*
❒ None of the above, *Continue to 40*

40. Is this a request for an increase in dosing regimen due to the patient not achieving an adequate clinical response at the current dose?
❒ Yes, *Continue to 76*
❒ No, *Continue to 76*

41. Has the patient been diagnosed with active psoriatic arthritis (PsA)?
❒ Yes, *Continue to 42*
❒ No, *Continue to 42*

42. Has the patient ever received or is currently receiving a biologic (e.g., Humira) or targeted synthetic drug (e.g., Rinvoq, Otezla) indicated for the treatment of active psoriatic arthritis (excluding receiving the drug via samples or a manufacturer's patient assistance program)? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried.
❒ Yes, *Continue to 76*
❒ No, *Continue to 43*

43. What is the patient's disease severity?
❒ Mild to moderate disease, *Continue to 44*
❒ Severe disease, *Continue to 76*

44. Does the patient have enthesitis or predominantly axial disease?
❒ Yes, *Continue to 76*
❒ No, *Continue to 45*

45. 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.
❒ Yes, *Continue to 76*
❒ No, *Continue to 46*

46. 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, *Continue to 76*
❒ No, *Continue to 47*

47. Does the patient have a contraindication to methotrexate or leflunomide? ***ACTION REQUIRED***: If Yes, please attach documentation of clinical reason to avoid therapy.
❒ Yes, *Continue to 49*
❒ No, *Continue to 48*

48. 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, *Continue to 76*
❒ No, *Continue to 76*

49. Please indicate the contraindication to methotrexate or leflunomide.
❒ Clinical diagnosis of alcohol use disorder, alcoholic liver disease, or other chronic liver disease, *Continue to 76*
❒ Drug interaction, *Continue to 76*
❒ Risk of treatment-related toxicity, *Continue to 76*
❒ Pregnancy or currently planning pregnancy, *Continue to 76*
❒ Breastfeeding, *Continue to 76*

❒ Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension), *Continue to 76*

❒ Hypersensitivity, *Continue to 76*

❒ History of intolerance or adverse event, *Continue to 76*

❒ Other, please specify. _____, *Continue to 76*

50. Has the patient been diagnosed with active enthesitis-related arthritis?
❒ Yes, *Continue to 51*
❒ No, *Continue to 51*

51. Is the patient 4 years of age or older?
❒ Yes, *Continue to 52*
❒ No, *Continue to 52*

52. Is the requested drug being prescribed by or in consultation with a rheumatologist?
❒ Yes, *Continue to 53*
❒ No, *Continue to 53*

53. Is this request for continuation of therapy with the requested drug?
❒ Yes, *Continue to 54*
❒ No, *Continue to 57*

54. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program?

❒ Yes, *Continue to 57*

❒ No, *Continue to 55*

❒ Unknown, *Continue to 57*

55. Has the patient achieved or maintained a 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, *Continue to 56*
❒ No, *Continue to 56*

56. 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 flares ***ACTION REQUIRED***: Submit supporting documentation, *Continue to 76*
❒ Number of joints with active arthritis (e.g., swelling, pain) ***ACTION REQUIRED***: Submit supporting documentation, *Continue to 76*
❒ Number of joints with limited movement ***ACTION REQUIRED***: Submit supporting documentation, *Continue to 76*

❒ Dactylitis ***ACTION REQUIRED***: Submit supporting documentation, *Continue to 76*

❒ Enthesitis ***ACTION REQUIRED***: Submit supporting documentation, *Continue to 76*

❒ None of the above, *Continue to 76*

57. Has the patient ever received or is currently receiving a biologic indicated for the treatment of active enthesitis-related arthritis (excluding receiving the drug via samples or a manufacturer's patient assistance program)? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried.

❒ Yes, *Continue to 76*
❒ No, *Continue to 58*

58. Does the patient's disease demonstrate at least three active joints involved and at least one site of active enthesitis at baseline or documented by history?
❒ Yes, *Continue to 59*
❒ No, *Continue to 59*

59. Has the patient experienced an inadequate response to nonsteroidal anti-inflammatory drugs (NSAIDs), sulfasalazine, or methotrexate? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy.
❒ Yes, *Continue to 76*
❒ No, *Continue to 60*

60. Has the patient experienced an intolerance or contraindication to nonsteroidal anti-inflammatory drugs (NSAIDs) AND sulfasalazine (e.g., porphyria, intestinal or urinary obstruction)? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy. If therapy is not advisable, please attach documentation of clinical reason to avoid therapy.
❒ Yes, *Continue to 61*
❒ No, *Continue to 61*

61. Has the patient experienced an intolerance to methotrexate? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy.
❒ Yes, *Continue to 76*
❒ No, *Continue to 62*

62. Does the patient have a contraindication to methotrexate? ***ACTION REQUIRED***: If Yes, please attach documentation of clinical reason to avoid therapy.
❒ Yes, *Continue to 63*
❒ No, *Continue to 63*

63. Please indicate the contraindication to methotrexate.

❒ Clinical diagnosis of alcohol use disorder, alcoholic liver disease, or other chronic liver disease, *Continue to 76*

❒ Drug interaction, *Continue to 76*

❒ Risk of treatment-related toxicity, *Continue to 76*

❒ Pregnancy or currently planning pregnancy, *Continue to 76*

❒ Breastfeeding, *Continue to 76*

❒ Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension), *Continue to 76*

❒ Hypersensitivity, *Continue to 76*

❒ History of intolerance or adverse event, *Continue to 76*

❒ Other, please specify. _____, *Continue to 76*

64. Has the patient been diagnosed with moderate to severe hidradenitis suppurativa?
❒ Yes, *Continue to 65*
❒ No, *Continue to 65*

65. Is the patient an adult (18 years of age or older)?
❒ Yes, *Continue to 66*
❒ No, *Continue to 66*

66. Is the requested drug being prescribed by or in consultation with a rheumatologist or dermatologist?
❒ Yes, *Continue to 67*
❒ No, *Continue to 67*

67. Is this request for continuation of therapy with the requested drug?
❒ Yes, *Continue to 68*
❒ No, *Continue to 72*

68. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program?

❒ Yes, *Continue to 72*

❒ No, *Continue to 69*

❒ Unknown, *Continue to 72*

69. Has the patient achieved or maintained a 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, *Continue to 70*
❒ No, *Continue to 71*

70. Which of the following has the patient experienced an improvement in since starting treatment with the requested drug? ***ACTION REQUIRED***: Please attach chart notes or medical records supporting positive clinical response.
❒ Reduction in abscess and inflammatory nodule count from baseline ***ACTION REQUIRED***: Submit supporting documentation, *Continue to 76*
❒ Reduced formation of new sinus tracts and scarring ***ACTION REQUIRED***: Submit supporting documentation, *Continue to 76*
❒ Decrease in frequency of inflammatory lesions from baseline ***ACTION REQUIRED***: Submit supporting documentation, *Continue to 76*

❒ Reduction in pain from baseline ***ACTION REQUIRED***: Submit supporting documentation, *Continue to 76*
❒ Reduction in suppuration from baseline ***ACTION REQUIRED***: Submit supporting documentation, *Continue to 76*
❒ Improvement in frequency of relapses from baseline ***ACTION REQUIRED***: Submit supporting documentation, *Continue to 76*
❒ Improvement in quality of life from baseline ***ACTION REQUIRED***: Submit supporting documentation, *Continue to 76*
❒ Improvement on a disease severity assessment tool from baseline ***ACTION REQUIRED***: Submit supporting documentation, *Continue to 76*

❒ None of the above, *Continue to 71*

71. Is this a request for an increase in dosing regimen due to the patient not achieving an adequate clinical response at the current dose or frequency?
❒ Yes, *Continue to 76*
❒ No, *Continue to 76*

72. Has the patient ever received or is currently receiving a biologic indicated for the treatment of moderate to severe hidradenitis suppurativa (excluding receiving the drug via samples or a manufacturer's patient assistance program)? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medication tried.
❒ Yes, *Continue to 76*
❒ No, *Continue to 73*

73. Has the patient experienced an inadequate response after at least 90 days of treatment with an oral antibiotic used for the treatment of hidradenitis suppurativa (e.g., clindamycin, metronidazole, moxifloxacin, rifampin, tetracyclines)? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy.
❒ Yes, *Continue to 76*
❒ No, *Continue to 74*

74. Has the patient experienced an intolerance to oral antibiotics used for the treatment of hidradenitis suppurativa? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy.
❒ Yes, *Continue to 76*
❒ No, *Continue to 75*

75. Does the patient have a contraindication to oral antibiotics used for the treatment of hidradenitis suppurativa? ***ACTION REQUIRED***: If Yes, please attach documentation of clinical reason to avoid therapy.
❒ Yes, *Continue to 76*
❒ No, *Continue to 76*

76. What is the diagnosis?
❒ Plaque psoriasis, *Continue to 77*
❒ Ankylosing spondylitis, *Continue to 89*
❒ Non-radiographic axial spondyloarthritis, *Continue to 107*
❒ Psoriatic arthritis WITH co-existent plaque psoriasis, *Continue to 121*
❒ Psoriatic arthritis, *Continue to 135*
❒ Enthesitis-related arthritis (ERA), *Continue to 160*
❒ Hidradenitis suppurativa, *Continue to 168*

77. What is the route of administration?
❒ Intravenous, *Continue to 78*
❒ Subcutaneous, *Continue to 78*

78. Is the patient currently receiving Cosentyx?
❒ Yes, *Continue to 79*
❒ No, *Continue to 84*

79. What is the patient's age? Indicate in years.
❒ 6 years to less than 18 years of age _____ years, *Continue to 82*
❒ 18 years of age or older _____ years, *Continue to 80*

80. Does the prescribed dose exceed 300 mg?
❒ Yes, *Continue to 81*
❒ No, *Continue to 81*

81. Is the prescribed frequency for the maintenance dose more frequent than one dose every 4 weeks?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

82. Does the prescribed dose exceed 150 mg?
❒ Yes, *Continue to 83*
❒ No, *Continue to 83*

83. Is the prescribed frequency for the maintenance dose more frequent than one dose every 4 weeks?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

84. What is the patient's age? Indicate in years.

❒ 6 years to less than 18 years of age _____ years, *Continue to 87*

❒ 18 years of age or older _____ years, *Continue to 85*

85. Does the prescribed dose exceed a loading dose of 300 mg at weeks 0, 1, 2, 3, and 4, and a maintenance dose of 300 mg thereafter?
❒ Yes, *Continue to 86*
❒ No, *Continue to 86*

86. Is the prescribed frequency for the maintenance dose more frequent than one dose every 4 weeks?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

87. Does the prescribed dose exceed a loading dose of 150 mg at weeks 0, 1, 2, 3, and 4, and a maintenance dose of 150 mg thereafter?
❒ Yes, *Continue to 88*
❒ No, *Continue to 88*

88. Is the prescribed frequency for the maintenance dose more frequent than one dose every 4 weeks?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

89. What is the route of administration?

❒ Intravenous, *Continue to 100*

❒ Subcutaneous, *Continue to 90*

90. Is the patient currently receiving Cosentyx?
❒ Yes, *Continue to 92*
❒ No, *Continue to 91*

91. Is a loading dose prescribed?
❒ Yes, *Continue to 98*
❒ No, *Continue to 92*

92. Does the prescribed dose exceed 150 mg?
❒ Yes, *Continue to 94*
❒ No, *Continue to 93*

93. Is the prescribed frequency for the maintenance dose more frequent than one dose every 4 weeks?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

94. Please select the situation that applies to the patient.
❒ Patient is continuing therapy at current dose, *Continue to 96*
❒ Prescriber is increasing dose, *Continue to 95*
❒ Prescriber is decreasing dose, *Continue to 96*

95. Did the patient continue to have active ankylosing spondylitis at the 150 mg dose?
❒ Yes, *Continue to 96*
❒ No, *Continue to 96*

96. Does the prescribed dose exceed 300 mg?
❒ Yes, *Continue to 97*
❒ No, *Continue to 97*

97. Is the prescribed frequency for the maintenance dose more frequent than one dose every 4 weeks?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

98. Does the prescribed dose exceed a loading dose of 150 mg at weeks 0, 1, 2, 3, and 4, and a maintenance dose of 150 mg thereafter?
❒ Yes, *Continue to 99*
❒ No, *Continue to 99*

99. Is the prescribed frequency for the maintenance dose more frequent than one dose every 4 weeks?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

100. Is the patient currently receiving Cosentyx?
❒ Yes, *Continue to 105*
❒ No, *Continue to 101*

101. Is a loading dose prescribed?
❒ Yes, *Continue to 102*
❒ No, *Continue to 105*

102. Does the prescribed dose exceed a loading dose of 6 mg/kg at week 0, and a maintenance dose of 1.75 mg/kg thereafter?
❒ Yes, *Continue to 103*
❒ No, *Continue to 103*

103. Is the prescribed frequency for the maintenance dose more frequent than one dose every 4 weeks?
❒ Yes, *Continue to 104*
❒ No, *Continue to 104*

104. What is the patient's weight? Indicate units.
❒ 100 kg (220.5 lbs) or less _____ *No Further Questions*
❒ Greater than 100 kg (220.5 lbs) _____ *No Further Questions*

105. Does the prescribed dose exceed 1.75 mg/kg?
❒ Yes, *Continue to 106*
❒ No, *Continue to 106*

106. Is the prescribed frequency for the maintenance dose more frequent than one dose every 4 weeks?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

107. What is the route of administration?
❒ Intravenous, *Continue to 114*
❒ Subcutaneous, *Continue to 108*

108. Is the patient currently receiving Cosentyx?
❒ Yes, *Continue to 110*
❒ No, *Continue to 109*

109. Is a loading dose prescribed?
❒ Yes, *Continue to 112*
❒ No, *Continue to 110*

110. Does the prescribed dose exceed 150 mg?
❒ Yes, *Continue to 111*
❒ No, *Continue to 111*

111. Is the prescribed frequency for the maintenance dose more frequent than one dose every 4 weeks?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

112. Does the prescribed dose exceed a loading dose of 150 mg at weeks 0, 1, 2, 3, and 4, and a maintenance dose of 150 mg thereafter?
❒ Yes, *Continue to 113*
❒ No, *Continue to 113*

113. Is the prescribed frequency for the maintenance dose more frequent than one dose every 4 weeks?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

114. Is the patient currently receiving Cosentyx?
❒ Yes, *Continue to 119*
❒ No, *Continue to 115*

115. Is a loading dose prescribed?
❒ Yes, *Continue to 116*
❒ No, *Continue to 119*

116. Does the prescribed dose exceed a loading dose of 6 mg/kg at week 0, and a maintenance dose of 1.75 mg/kg thereafter?
❒ Yes, *Continue to 117*
❒ No, *Continue to 117*

117. Is the prescribed frequency for the maintenance dose more frequent than one dose every 4 weeks?
❒ Yes, *Continue to 118*
❒ No, *Continue to 118*

118. What is the patient's weight? Indicate units.
❒ 100 kg (220.5 lbs) or less _____, *No Further Questions*
❒ Greater than 100 kg (220.5 lbs) _____, *No Further Questions*

119. Does the prescribed dose exceed 1.75 mg/kg?
❒ Yes, *Continue to 120*
❒ No, *Continue to 120*

120. Is the prescribed frequency for the maintenance dose more frequent than one dose every 4 weeks?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

121. What is the route of administration?
❒ Intravenous, *Continue to 122*
❒ Subcutaneous, *Continue to 122*

122. Is the patient currently receiving Cosentyx?
❒ Yes, *Continue to 124*
❒ No, *Continue to 123*

123. Is a loading dose prescribed?
❒ Yes, *Continue to 130*
❒ No, *Continue to 124*

124. What is the patient's age? Indicate in years.

❒ 2 years to less than 18 years of age _____ years, *Continue to 127*

❒ 18 years of age or older _____ years, *Continue to 125*

125. Does the prescribed dose exceed 300 mg?
❒ Yes, *Continue to 126*
❒ No, *Continue to 126*

126. Is the prescribed frequency for the maintenance dose more frequent than one dose every 4 weeks?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

127. What is the patient's weight? Indicate in kilograms (kg).

❒ Less than 15 kg _____ kg, *No Further Questions*

❒ Greater than or equal to 15 kg _____ kg, *Continue to 128*

128. Does the prescribed dose exceed 150 mg?
❒ Yes, *Continue to 129*
❒ No, *Continue to 129*

129. Is the prescribed frequency for the maintenance dose more frequent than one dose every 4 weeks?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

130. What is the patient's age? Indicate in years.

❒ 2 years to less than 18 years of age _____, years, *Continue to 133*

❒ 18 years of age or older _____, years, *Continue to 131*

131. Does the prescribed dose exceed a loading dose of 300 mg at weeks 0, 1, 2, 3, and 4, and a maintenance dose of 300 mg thereafter?
❒ Yes, *Continue to 132*
❒ No, *Continue to 132*

132. Is the prescribed frequency for the maintenance dose more frequent than one dose every 4 weeks?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

133. Does the prescribed dose exceed a loading dose of 150 mg at weeks 0, 1, 2, 3, and 4, and a maintenance dose of 150 mg thereafter?
❒ Yes, *Continue to 134*
❒ No, *Continue to 134*

134. Is the prescribed frequency for the maintenance dose more frequent than one dose every 4 weeks?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

135. What is the route of administration?

❒ Intravenous, *Continue to 152*

❒ Subcutaneous, *Continue to 136*

136. Is the patient currently receiving Cosentyx?
❒ Yes, *Continue to 138*
❒ No, *Continue to 137*

137. Is a loading dose prescribed?
❒ Yes, *Continue to 148*
❒ No, *Continue to 138*

138. What is the patient's age? Indicate in years.

❒ 2 years to less than 18 years of age _____ years, *Continue to 145*

❒ 18 years of age or older _____ years, *Continue to 139*

139. Does the prescribed dose exceed 150 mg?
❒ Yes, *Continue to 141*
❒ No, *Continue to 140*

140. Is the prescribed frequency of the maintenance dose more frequent than one dose every 4 weeks?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

141. Please select the situation that applies to the patient.

❒ Patient is continuing therapy at current dose, *Continue to 143*

❒ Prescriber is increasing dose, *Continue to 142*

❒ Prescriber is decreasing dose, *Continue to 143*

❒ None of the above, *No Further Questions*

142. Did the patient continue to have active psoriatic arthritis at the 150 mg dose?
❒ Yes, *Continue to 143*
❒ No, *Continue to 143*

143. Does the prescribed dose exceed 300 mg?
❒ Yes, *Continue to 144*
❒ No, *Continue to 144*

144. Is the prescribed frequency for the maintenance dose more frequent than one dose every 4 weeks?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

145. What is the patient's weight? Indicate in kilograms (kg).

❒ Less than 15 kg _____kg, *No Further Questions*

❒ Greater than or equal to 15 kg _____kg, *Continue to 146*

146. Does the prescribed dose exceed 150 mg?
❒ Yes, *Continue to 147*
❒ No, *Continue to 147*

147. Is the prescribed frequency for the maintenance dose more frequent than one dose every 4 weeks?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

148. What is the patient's age? Indicate in years.

❒ 2 years to less than 18 years of age _____ years, *Continue to 149*

❒ 18 years of age or older _____ years, *Continue to 150*

149. What is the patient's weight? Indicate in kilograms (kg).

❒ Less than 15 kg _____kg, *No Further Questions*

❒ Greater than or equal to 15 kg _____kg, *Continue to 150*

150. Does the prescribed dose exceed a loading dose of 150 mg at weeks 0, 1, 2, 3, and 4, and a maintenance dose of 150 mg thereafter?
❒ Yes, *Continue to 151*
❒ No, *Continue to 151*

151. Is the prescribed frequency for the maintenance dose more frequent than one dose every 4 weeks?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

152. What is the patient's age? Indicate in years.

❒ 2 years to less than 18 years of age _____ years, *No Further Questions*

❒ 18 years of age or older _____ years, *Continue to 153*

153. Is the patient currently receiving Cosentyx?
❒ Yes, *Continue to 158*
❒ No, *Continue to 154*

154. Is a loading dose prescribed?
❒ Yes, *Continue to 155*
❒ No, *Continue to 158*

155. Does the prescribed dose exceed a loading dose of 6 mg/kg at week 0, and a maintenance dose of 1.75 mg/kg thereafter?
❒ Yes, *Continue to 156*
❒ No, *Continue to 156*

156. Is the prescribed frequency for the maintenance dose more frequent than one dose every 4 weeks?
❒ Yes, *Continue to 157*
❒ No, *Continue to 157*

157. What is the patient's weight? Indicate units.

❒ 100 kg (220.5 lbs) or less _____, *No Further Questions*

❒ Greater than 100 kg (220.5 lbs) _____, *No Further Questions*

158. Does the prescribed dose exceed 1.75 mg/kg?
❒ Yes, *Continue to 159*
❒ No, *Continue to 159*

159. Is the prescribed frequency for the maintenance dose more frequent than one dose every 4 weeks?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

160. What is the route of administration?

❒ Intravenous, *Continue to 161*

❒ Subcutaneous, *Continue to 161*

161. Is the patient currently receiving Cosentyx?
❒ Yes, *Continue to 162*
❒ No, *Continue to 165*

162. What is the patient's weight? Indicate in kilograms (kg).

❒ Less than 15 kg _____kg, *Continue to 163*

❒ Greater than or equal to 15 kg _____kg, *Continue to 163*

163. Does the prescribed dose exceed 150 mg?
❒ Yes, *Continue to 164*
❒ No, *Continue to 164*

164. Is the prescribed frequency for the maintenance dose more frequent than one dose every 4 weeks?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

165. What is the patient's weight? Indicate in kilograms (kg).

❒ Less than 15 kg _____kg, *Continue to 166*

❒ Greater than or equal to 15 kg _____kg, *Continue to 166*

166. Does the prescribed dose exceed a loading dose of 150 mg at weeks 0, 1, 2, 3, and 4, and a maintenance dose of 150 mg thereafter?
❒ Yes, *Continue to 167*
❒ No, *Continue to 167*

167. Is the prescribed frequency for the maintenance dose more frequent than one dose every 4 weeks?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

168. What is the route of administration?

❒ Intravenous, *Continue to 169*

❒ Subcutaneous, *Continue to 169*

169. Is the patient currently receiving Cosentyx?
❒ Yes, *Continue to 170*
❒ No, *Continue to 175*

170. Does the prescribed dose exceed 300 mg?
❒ Yes, *Continue to 171*
❒ No, *Continue to 171*

171. Is the prescribed frequency for the maintenance dose more frequent than one dose every 4 weeks?
❒ Yes, *Continue to 172*
❒ No, *No Further Questions*

172. Please select the situation that applies to the patient.

❒ Patient is continuing therapy at current dose, *Continue to 174*

❒ Prescriber is increasing dose, *Continue to 173*

❒ Prescriber is decreasing dose, *Continue to 174*

173. Does the patient require an increased frequency of administration due to an inadequate response at the current dose?
❒ Yes, *Continue to 174*
❒ No, *Continue to 174*

174. Is the prescribed frequency for the maintenance dose more frequent than one dose every 2 weeks?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

175. Does the prescribed dose exceed a loading dose of 300 mg at weeks 0, 1, 2, 3, and 4, and a maintenance dose of 300 mg thereafter?
❒ Yes, *Continue to 176*
❒ No, *Continue to 176*

176. Is the prescribed frequency for the maintenance dose more frequent than one dose every 4 weeks?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

Step Therapy Override: Complete if Applicable for the state of Maryland.	Please Circle	
Is the requested drug being used to treat stage four advanced metastatic cancer?	Yes	No
Is the requested drug's use consistent with the FDA-approved indication or the National Comprehensive Cancer Network Drugs & Biologics Compendium indication for the treatment of stage four advanced metastatic cancer and is supported by peer-reviewed medical literature?	Yes	No
Is the requested drug being used for an FDA-approved indication OR an indication supported in the compendia of current literature (examples: AHFS, Lexicomp, Clinical Pharmacology, Micromedex, current accepted guidelines)?	Yes	No
Does the prescribed quantity fall within the manufacturer's published dosing guidelines or within dosing guidelines found in the compendia of current literature (examples: package insert, AHFS, Lexicomp, Clinical Pharmacology, Micromedex, current accepted guidelines)?	Yes	No
Do patient chart notes document the requested drug was ordered with a paid claim at the pharmacy, the pharmacy filled the prescription and delivered to the patient or other documentation that the requested drug was prescribed for the patient in the last 180 days?	Yes	No
Has the prescriber provided proof documented in the patient chart notes that in their opinion the requested drug is effective for the patient's condition?	Yes	No

Step Therapy Override: Complete if Applicable for the state of Virginia.	Please Circle	
Is the requested drug being used for an FDA-approved indication or an indication supported in the compendia of current literature (examples: AHFS, Micromedex, current accepted guidelines)?	Yes	No
Does the prescribed dose and quantity fall within the FDA-approved labeling or within dosing guidelines found in the compendia of current literature?	Yes	No
Is the request for a brand drug that has an AB-rated generic equivalent or interchangeable biological product available?	Yes	No
Has the patient had a trial and failure of the AB-rated generic equivalent or interchangeable biological product due to an adverse event (examples: rash, nausea, vomiting, anaphylaxis) that is thought to be due to an inactive ingredient?	Yes	No
Is the preferred drug contraindicated?	Yes	No
Is the preferred drug expected to be ineffective based on the known clinical characteristics of the patient and the prescription drug regimen?	Yes	No
Has the patient tried the preferred drug while on their current or previous health benefit plan and it was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event?	Yes	No
Is the patient currently receiving a positive therapeutic outcome with the requested drug for their medical condition?	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: 1-855-330-1720

 CareFirst MR C26742-A, Psoriasis Enhanced SGM 4179-A, Cosentyx SGM 2017-A – 04/2025.