Dupixent

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

 MR CareFirst C26694-A Dupixent SGM 1690-A 3/2026.

CVS Caremark Specialty Pharmacy ● 2211 Sanders Road NBT-6 ● Northbrook, IL 60062
Phone: 1-888-877-0518 ● Fax: 1-855-330-1720 ● www.caremark.com

Exception Criteria Questions:

1. Is the requested product for the treatment of atopic dermatitis, eosinophilic esophagitis (EoE), or prurigo nodularis (PN)?
❒ Yes, *Skip to Clinical Criteria Questions*
❒ No, *Continue to Question 2*

2. Does the patient meet any of the following? ***Action Required***: If 'Yes', attach supporting chart note(s)
❒ Patient has a documented inadequate response, contraindication, or intolerable adverse event to Xolair for moderate asthma, *Skip to Clinical Criteria Questions*
❒ Patient is less than 12 years of age and has a documented inadequate response, contraindication, or intolerable adverse event to Fasenra, Nucala, and Xolair for severe asthma, *Skip to Clinical Criteria Questions*
❒ Patient is 12 years or older and has a documented inadequate response, contraindication, or intolerable adverse event to all preferred products for severe asthma, *Skip to Clinical Criteria Questions*
❒ None of the above, *Continue to Question 3*

3. Is the patient less than 18 years of age with a documented inadequate response, contraindication, or intolerable adverse event to Tezspire for chronic rhinosinusitis with nasal polyps (CRSwNP)? ***Action Required***: If 'Yes', attach supporting chart note(s)
❒ Yes, *Skip to Clinical Criteria Questions*
❒ No, *Continue to Question 4*

4. Is the patient an adult with a documented inadequate response, contraindication, or intolerable adverse event to Nucala and Tezspire for chronic rhinosinusitis with nasal polyps (CRSwNP)? ***Action Required***: If 'Yes', attach supporting chart note(s)
❒ Yes, *Skip to Clinical Criteria Questions*
❒ No, *Continue to Question 5*

5. Does the patient meet any of the following? ***Action Required***: If 'Yes', attach supporting chart note(s)
❒ Patient has a documented inadequate response, contraindication, or intolerable adverse event to Nucala for Chronic Obstructive Pulmonary Disease (COPD), *Continue to Clinical Criteria Questions*
❒ Patient has a documented inadequate response, contraindication, or intolerable adverse event to Xolair for Chronic Spontaneous Urticaria (CSU)., *Continue to Clinical Criteria Questions*
❒ None of the above, *Continue to Clinical Criteria Questions*

Clinical Questions:

1. Will the requested drug be used in combination with any other biologic or targeted synthetic drug for the same indication?
❒ Yes, *Continue to 2*
❒ No, *Continue to 2*

2. What is the diagnosis?
❒ Asthma, moderate-to-severe, *Continue to 23*
❒ Eosinophilic esophagitis (EoE), *Continue to 63*
❒ Atopic dermatitis, moderate-to-severe, *Continue to 3*
❒ Chronic rhinosinusitis with nasal polyposis (CRSwNP), *Continue to 42*
❒ Prurigo nodularis (PN), *Continue to 74*
❒ Chronic obstructive pulmonary disease (COPD), *Continue to 101*
❒ Chronic spontaneous urticaria (CSU), *Continue to 117*
❒ Immune checkpoint inhibitor-related toxicity, *Continue to 94*
❒ Bullous pemphigoid (BP), *Continue to 129*
❒ Other, please specify. _____, *No further questions*

3. Is the patient 6 months of age or older?
❒ Yes, *Continue to 4*
❒ No, *Continue to 4*

4. Is the requested drug being prescribed by or in consultation with a dermatologist or allergist/immunologist?
❒ Yes, *Continue to 5*
❒ No, *Continue to 5*

5. Is this request for continuation of therapy with the requested drug?
❒ Yes, *Continue to 6*
❒ No, *Continue to 8*

6. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program?
❒ Yes, *Continue to 8*
❒ No, *Continue to 7*
❒ Unknown, *Continue to 8*

7. Has the patient achieved or maintained a positive clinical response as evidenced by low disease activity (i.e., clear or almost clear skin) or improvement in signs and symptoms of atopic dermatitis (e.g., redness, itching, oozing/crusting) since starting treatment with the requested drug? ***ACTION REQUIRED***: If Yes, please attach chart note(s) or medical record documentation supporting positive clinical response. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

Has the patient received in the past year or is currently receiving a biologic (e.g., Adbry, Ebglyss, Nemluvio) or systemic targeted synthetic drug (e.g., Cibinqo, Rinvoq) indicated for moderate-to-severe atopic dermatitis (excluding receiving the drug via samples or a manufacturer's patient assistance program)? ***ACTION REQUIRED***: If Yes, please attach chart note(s), medical record documentation, or claims history supporting previous medications tried. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 20*
❒ No, *Continue to 9*

9. What is the percentage of body surface area (BSA) affected prior to initiation of the requested drug? Please indicate

BSA percentage. ***ACTION REQUIRED***: Please attach chart note(s) or medical record documentation of body surface area affected.
❒ Less than 10% of BSA _____ ***ACTION REQUIRED****: Submit supporting documentation, Continue to 10*
❒ Greater than or equal to 10% of BSA _____ ***ACTION REQUIRED****: Submit supporting documentation, Continue to 11*

10. Are crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) affected? ***ACTION REQUIRED***: If Yes, please attach chart note(s) or medical record documentation of affected area(s). ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 11*
❒ No, *Continue to 11*

11. Has the patient had an inadequate treatment response with a medium potency to super-high potency topical corticosteroid in the past year?
❒ Yes, *Continue to 12*
❒ No, *Continue to 13*

12. Is information on the active ingredient, strength, and dosage form of the medium to super-high potency topical steroid the patient had an inadequate treatment response to in the past year provided? Indicate drug strength in percentage. ***ACTION REQUIRED***: Please attach chart note(s), medical record documentation, or claims history supporting previous medications tried including drug name, dosage form, strength, and response to therapy.
_____ ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 20*
❒ No, *Continue to 13*

13. Has the patient had an inadequate treatment response with a topical calcineurin inhibitor in the past year? ***ACTION REQUIRED***: If Yes, please attach chart note(s), medical record documentation, or claims history supporting previous medications tried, including response to therapy. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 20*
❒ No, *Continue to 14*

14. Has the patient had an inadequate treatment response with a topical Janus kinase (JAK) inhibitor in the past year? ***ACTION REQUIRED***: If Yes, please attach chart note(s), medical record documentation, or claims history supporting previous medications tried, including response to therapy. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 20*
❒ No, *Continue to 15*

15. Has the patient had an inadequate treatment response with a topical phosphodiesterase-4 (PDE-4) inhibitor in the past year? ***ACTION REQUIRED***: If Yes, please attach chart note(s), medical record documentation, or claims history supporting previous medications tried, including response to therapy. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 20*
❒ No, *Continue to 16*

16. Is the use of medium potency to super-high potency topical corticosteroids not advisable for the patient (e.g., due to contraindications, prior intolerances, potency not appropriate for member's age)? ***ACTION REQUIRED***: If Yes, please attach chart note(s) or medical record documentation of clinical reason to avoid therapy. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 17*
❒ No, *Continue to 17*

17. Is the use of topical calcineurin inhibitors not advisable for the patient (e.g., due to contraindications or prior intolerances)? ***ACTION REQUIRED***: If Yes, please attach chart note(s) or medical record documentation of clinical reason to avoid therapy. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 18*
❒ No, *Continue to 18*

18. Is the use of topical Janus kinase (JAK) inhibitors not advisable for the patient (e.g., due to contraindications or prior intolerances)? ***ACTION REQUIRED***: If Yes, please attach chart note(s) or medical record documentation of clinical reason to avoid therapy. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 19*
❒ No, *Continue to 19*

19. Is the use of topical phsophodiesterase-4 (PDE-4) inhibitors not advisable for the patient (e.g., due to contraindications or prior intolerances)? ***ACTION REQUIRED***: If Yes, please attach chart note(s) or medical record documentation of clinical reason to avoid therapy. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 20*
❒ No, *Continue to 20*

20. Is a loading dose prescribed?
❒ Yes, *Continue to 21*
❒ No, *No Further Questions*

21. Does the prescribed loading dose exceed a dose of 600 mg?
❒ Yes, *Continue to 22*
❒ No, *Continue to 22*

22. What is the prescribed loading dose?
❒ 400 mg, *No further questions*
❒ 600 mg, *No further questions*

23. Is the requested drug being prescribed by or in consultation with an allergist/immunologist or a pulmonologist?
❒ Yes, *Continue to 24*
❒ No, *Continue to 24*

24. Is the patient 6 years of age or older?
❒ Yes, *Continue to 25*
❒ No, *Continue to 25*

25. Is the request for continuation of therapy with the requested drug?
❒ Yes, *Continue to 26*
❒ No, *Continue to 29*

26. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program?
❒ Yes, *Continue to 29*
❒ No, *Continue to 27*
❒ Unknown, *Continue to 29*

27. Has asthma control improved on Dupixent treatment, as demonstrated by at least one of the following: A) A reduction in the frequency and/or severity of symptoms and exacerbations, or B) A reduction in the daily maintenance

oral corticosteroid dose? ***ACTION REQUIRED***: If Yes, please attach supporting chart notes or medical record documentation of improved asthma control. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 28*
❒ No, *Continue to 28*

28. Will the patient continue to use maintenance asthma treatments (i.e., inhaled corticosteroid and additional controller) in combination with the requested drug?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

29. Has the patient received in the past year or is currently receiving a biologic drug (e.g., Nucala, Cinqair) indicated for treatment of asthma (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, including drug, dose, frequency, and duration. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 39*
❒ No, *Continue to 30*

30. Does the patient have uncontrolled asthma as demonstrated by experiencing two or more asthma exacerbations requiring oral or injectable corticosteroid treatment within the past year? ***ACTION REQUIRED***: If Yes, please submit supporting chart notes, medical records, or claims history of previous corticosteroid use for asthma exacerbations including drug, dose, frequency, and duration. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 33*
❒ No, *Continue to 31*

31. Does the patient have uncontrolled asthma as demonstrated by experiencing one or more asthma exacerbation(s) resulting in hospitalization or emergency medical care visit(s) within the past year? ***ACTION REQUIRED***: If Yes, please attach chart notes or medical record documentation of previous asthma exacerbation(s) requiring hospitalization or emergency medical visit(s). ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 33*
❒ No, *Continue to 32*

32. Does the patient have uncontrolled asthma as demonstrated by experiencing poor symptom control (frequent symptoms or reliever use, activity limited by asthma, night waking due to asthma) within the past year? ***ACTION REQUIRED***: If Yes, please attach chart notes or medical record documentation of poor symptom control. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 33*
❒ No, *Continue to 33*

33. Prior to initiating therapy with the requested drug, what was the patient's baseline (e.g., before significant oral steroid use) blood eosinophil count in cells per microliter? Indicate baseline blood eosinophil count in cells per microliter. ***ACTION REQUIRED***: Please attach supporting chart note(s) or medical record documentation with the patient's baseline blood eosinophil count.
❒ Greater than or equal to 150 cells per microliter _____ ***ACTION REQUIRED****: Submit supporting documentation, Continue to 34*
❒ Less than 150 cells per microliter _____ ***ACTION REQUIRED****: Submit supporting documentation, Continue to 35*
❒ Unknown, *Continue to 35*

34. Prior to initiating therapy with the requested drug, did the patient have inadequate asthma control despite current treatment with both of the following medications at optimized doses: A) Medium-to-high dose inhaled corticosteroid,

and B) Additional controller (i.e., long-acting beta2-agonist, long-acting muscarinic antagonist, leukotriene modifier, or sustained-release theophylline)? ***ACTION REQUIRED***: If Yes, please attach supporting chart notes, medical record documentation, or claims history supporting previous medications tried including drug, dose, frequency, and duration. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 38*
❒ No, *Continue to 38*

35. Prior to initiating therapy with the requested drug, did the patient have inadequate asthma control despite concomitant treatment with all of the following medications at optimized doses? A) High-dose inhaled corticosteroid, B) Additional controller (i.e., long-acting beta2-agonist, long-acting muscarinic antagonist, leukotriene modifier, or sustained-release theophylline), and C) Oral glucocorticoids (at least 5 mg per day of prednisone/prednisolone or equivalent). ***ACTION REQUIRED***: If Yes, please attach supporting chart notes, medical record documentation, or claims history supporting previous medications tried including drug, dose, frequency, and duration. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 36*
❒ No, *Continue to 36*

36. Has the patient received treatment with the inhaled corticosteroid and additional controller for at least the previous 3 months? ***ACTION REQUIRED***: If Yes, please attach supporting chart notes, medical record documentation, or claims history supporting previous medications tried including drug, dose, frequency, and duration. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 37*
❒ No, *Continue to 37*

37. Has the patient received treatment with oral glucocorticoids for most days during the previous 6 months (e.g., 50% of days, 3 steroid bursts in the previous 6 months)? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claim history of oral glucocorticoid use in the previous 6 months. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 38*
❒ No, *Continue to 38*

38. Will the patient continue to use maintenance asthma treatments (i.e., inhaled corticosteroid and additional controller) in combination with Dupixent?
❒ Yes, *Continue to 39*
❒ No, *Continue to 39*

39. Is a loading dose prescribed?
❒ Yes, *Continue to 40*
❒ No, *No Further Questions*

40. Does the prescribed loading dose exceed a dose of 600 mg?
❒ Yes, *Continue to 41*
❒ No, *Continue to 41*

41. What is the prescribed loading dose?
❒ 400 mg, *No further questions*
❒ 600 mg, *No further questions*

42. Is the requested drug being prescribed by or in consultation with an allergist/immunologist or an otolaryngologist?
❒ Yes, *Continue to 43*
❒ No, *Continue to 43*

43. Is the patient 12 years of age or older?
❒ Yes, *Continue to 44*
❒ No, *Continue to 44*

44. Is the request for continuation of therapy with the requested drug?
❒ Yes, *Continue to 45*
❒ No, *Continue to 49*

45. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program?
❒ Yes, *Continue to 49*
❒ No, *Continue to 46*
❒ Unknown, *Continue to 49*

46. Has the patient achieved or maintained a positive clinical response as evidenced by improvement in signs and symptoms of chronic rhinosinusitis with nasal polyps (CRSwNP) (e.g., improvement in nasal congestion, nasal polyp size, loss of smell, anterior or posterior rhinorrhea, sino-nasal inflammation, hyposmia and/or facial pressure or pain, or reduction in corticosteroid use)? ***ACTION REQUIRED***: If Yes, please attach chart notes or medical record documentation supporting positive clinical response. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 47*
❒ No, *Continue to 47*

47. Will the patient continue to use a daily intranasal corticosteroid while being treated with the requested drug?
❒ Yes, *No Further Questions*
❒ No, *Continue to 48*

48. Are intranasal corticosteroids contraindicated or not tolerated?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

49. Has the patient received in the past year or is currently receiving a biologic drug (e.g., Nucala, Xolair) indicated for treatment of chronic rhinosinusitis with nasal polyps (CRSwNP) (excluding receiving the drug via samples or a manufacturer's patient assistance program)? ***ACTION REQUIRED***: If Yes, please attach chart note(s), medical record documentation, or claims history supporting previous medications tried, including drug, dose, frequency, and duration. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *No Further Questions*
❒ No, *Continue to 50*

50. Does the patient have bilateral nasal polyposis and chronic symptoms of sinusitis?
❒ Yes, *Continue to 51*
❒ No, *Continue to 51*

51. Has the patient had intranasal corticosteroid treatment for at least 4 weeks? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including drug, dose, frequency, and duration. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 53*
❒ No, *Continue to 52*

52. Are intranasal corticosteroids contraindicated or not tolerated? ***ACTION REQUIRED***: If Yes, please attach documentation of clinical reason to avoid therapy. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 53*
❒ No, *Continue to 53*

53. Has the patient had prior sino-nasal surgery?
❒ Yes, *Continue to 56*
❒ No, *Continue to 54*

54. Has the patient had an inadequate response with systemic corticosteroids within the last two years? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried including drug, dose, frequency, and duration. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 56*
❒ No, *Continue to 55*

55. Are systemic corticosteroids contraindicated or not tolerated? ***ACTION REQUIRED***: If Yes, please attach documentation of clinical reason to avoid therapy. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 56*
❒ No, *Continue to 56*

56. Has the patient had a bilateral nasal endoscopy, anterior rhinoscopy, or computed tomography (CT) showing polyps reaching below the lower border of the middle turbinate or beyond in each nostril? ***ACTION REQUIRED***: If Yes, please attach chart notes or medical record showing nasal endoscopy, rhinoscopy, or CT details (e.g., polyps location, size). ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 59*
❒ No, *Continue to 57*

57. Does the patient have a Meltzer Clinical Score of 2 or higher in both nostrils? ***ACTION REQUIRED***: If Yes, please submit chart notes or medical record documentation of Meltzer Clinical score. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 59*
❒ No, *Continue to 58*

58. Does the patient have a total endoscopic nasal polyp score (NPS) of at least 5 with a minimum score of 2 for each nostril? ***ACTION REQUIRED***: If Yes, please submit chart notes or medical record documentation of endoscopic nasal polyp score. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 59*
❒ No, *Continue to 59*

59. Does the patient have symptoms of nasal blockage, congestion, or obstruction?
❒ Yes, *Continue to 60*
❒ No, *Continue to 60*

60. Does the patient have rhinorrhea (anterior/posterior), reduction or loss of smell, or facial pain or pressure?
❒ Yes, *Continue to 61*
❒ No, *Continue to 61*

61. Will the patient continue to use a daily intranasal corticosteroid while being treated with the requested drug?
❒ Yes, *No Further Questions*
❒ No, *Continue to 62*

62. Are intranasal corticosteroids contraindicated or not tolerated?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

63. Is the requested drug being prescribed by or in consultation with a gastroenterologist or an allergist/immunologist?
❒ Yes, *Continue to 64*
❒ No, *Continue to 64*

64. Is the patient 1 year of age or older?
❒ Yes, *Continue to 65*
❒ No, *Continue to 65*

65. Does the patient weigh 15 kg or more?
❒ Yes, *Continue to 66*
❒ No, *Continue to 66*

66. Is the request for continuation of therapy with the requested drug?
❒ Yes, *Continue to 67*
❒ No, *Continue to 69*

67. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program?
❒ Yes, *Continue to 69*
❒ No, *Continue to 68*
❒ Unknown, *Continue to 69*

68. Has the patient achieved or maintained a positive clinical response as evidenced by improvement in signs and symptoms of eosinophilic esophagitis (EoE) (e.g., dysphagia, heartburn, chest pain, emesis) since starting treatment with the requested drug? ***ACTION REQUIRED***: If Yes, please attach chart notes or medical record documentation supporting positive clinical response. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

69. Is the patient experiencing symptoms of esophageal dysfunction (e.g., dysphagia, food impaction, vomiting, abdominal pain, food refusal, failure to thrive)?
❒ Yes, *Continue to 70*
❒ No, *Continue to 70*

70. Has the diagnosis been confirmed by esophageal biopsy as characterized by 15 or more intraepithelial esophageal eosinophils per high power field? ***ACTION REQUIRED***: If Yes, please attach chart notes or medical record documentation of endoscopic biopsy details including esophageal eosinophil count. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 71*
❒ No, *Continue to 71*

71. Has the patient had an inadequate treatment response to a proton pump inhibitor? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *No Further Questions*
❒ No, *Continue to 72*

72. Has the patient had an inadequate response to swallowed topical corticosteroid therapies (e.g., budesonide, fluticasone [powder or suspension for inhalation])? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *No Further Questions*
❒ No, *Continue to 73*

73. Are swallowed topical corticosteroid therapies (e.g., budesonide, fluticasone [powder or suspension for inhalation]) contraindicated or not tolerated? ***ACTION REQUIRED***: If Yes, please attach documentation of clinical reason to avoid therapy. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

74. Is the requested drug being prescribed by or in consultation with a dermatologist or allergist/immunologist?
❒ Yes, *Continue to 75*
❒ No, *Continue to 75*

75. Is the patient an adult (18 years of age or older)?
❒ Yes, *Continue to 76*
❒ No, *Continue to 76*

76. Is this request for continuation of therapy with the requested drug?
❒ Yes, *Continue to 77*
❒ No, *Continue to 80*

77. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program?
❒ Yes, *Continue to 80*
❒ No, *Continue to 78*
❒ Unknown, *Continue to 80*

78. Has the patient achieved or maintained a positive clinical response as evidenced by low disease activity of prurigo nodularis (e.g., clear or almost clear skin) since starting treatment with the requested drug? ***ACTION REQUIRED***: If Yes, please attach chart note(s) or medical record documentation supporting positive clinical response. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *No Further Questions*
❒ No, *Continue to 79*

79. Has the patient achieved or maintained a positive clinical response as evidenced by a reduction in pruritus intensity and improvement in extent and severity of nodular lesions of prurigo nodularis since starting treatment with the requested drug? ***ACTION REQUIRED***: If Yes, please attach chart notes or medical record documentation supporting positive clinical response. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

80. Has the patient received or is currently receiving a biologic (e.g., Nemluvio) within the past year indicated for the treatment of prurigo nodularis (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. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *No Further Questions*
❒ No, *Continue to 81*

81. Does the patient have pruritus lasting at least 6 weeks? ***ACTION REQUIRED***: If Yes, please attach chart note(s) or medical record documentation of pruritus symptoms. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 82*
❒ No, *Continue to 82*

82. Does the patient have history or signs of repeated itch-scratch cycle (e.g., scratching, picking, or rubbing)? ***ACTION REQUIRED***: If Yes, please attach chart note(s) or medical record documentation of pruritus symptoms. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 83*
❒ No, *Continue to 83*

83. Does the patient have a minimum of 20 nodular lesions? ***ACTION REQUIRED***: If Yes, please attach chart note(s) or medical record documentation supporting the presence of nodular lesions. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 84*
❒ No, *Continue to 84*

84. Has the patient had an inadequate response to a medium potency to super-high potency topical corticosteroid?
❒ Yes, *Continue to 85*
❒ No, *Continue to 86*

85. Is information on the active ingredient, strength, and dosage form of the medium to super-high potency topical corticosteroid the patient had an inadequate treatment response to provided? Indicate drug strength in percentage. ***ACTION REQUIRED***: Please attach chart note(s), medical record documentation, or claims history supporting previous therapies tried including drug name, dosage form, strength, and response to therapy. _____ ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *No Further Questions*
❒ No, *Continue to 86*

86. Has the patient had an inadequate response to a topical calcineurin inhibitor? ***ACTION REQUIRED***: If Yes, please attach chart note(s), medical record documentation, or claims history supporting previous therapies tried, including response to therapy. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *No Further Questions*
❒ No, *Continue to 87*

87. Has the patient had an inadequate response to phototherapy (e.g., UVB, PUVA)? ***ACTION REQUIRED***: If Yes, please attach chart note(s), medical record documentation, or claims history supporting previous therapies tried, including response to therapy. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *No Further Questions*
❒ No, *Continue to 88*

88. Has the patient had an inadequate response to pharmacologic treatment with methotrexate or cyclosporine? ***ACTION REQUIRED***: If Yes, please attach chart note(s), medical record documentation, or claims history supporting previous therapies tried, including response to therapy. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *No Further Questions*
❒ No, *Continue to 89*

89. Has the patient had an intolerance or a clinical reason to avoid medium to super-high potency topical corticosteroids? ***ACTION REQUIRED***: If Yes, please attach chart note(s) or medical record documentation supporting intolerance or clinical reason to avoid therapy. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 90*
❒ No, *Continue to 91*

90. Has the patient had an intolerance or a clinical reason to avoid topical calcineurin inhibitors? ***ACTION REQUIRED***: If Yes, please attach chart note(s) or medical record documentation supporting intolerance or clinical reason to avoid therapy. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *No Further Questions*
❒ No, *Continue to 91*

91. Has the patient had an intolerance to pharmacologic treatment with methotrexate and cyclosporine? ***ACTION REQUIRED***: If Yes, please attach chart note(s), medical record documentation, or claims history supporting previous therapies tried, including response to therapy. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *No Further Questions*
❒ No, *Continue to 92*

92. Does the patient have a clinical reason to avoid pharmacologic treatment with methotrexate and cyclosporine?
❒ Yes, *Continue to 93*
❒ No, *Continue to 93*

93. Please indicate the clinical reason to avoid pharmacologic treatment with methotrexate and cyclosporine. ***ACTION REQUIRED***: Please attach documentation of clinical reason to avoid therapy.
❒ Clinical diagnosis of alcohol use disorder, alcoholic liver disease, or other chronic liver disease ***ACTION REQUIRED****: Submit supporting documentation, No further questions*
❒ Drug interaction ***ACTION REQUIRED****: Submit supporting documentation, No further questions*
❒ Risk of treatment-related toxicity ***ACTION REQUIRED****: Submit supporting documentation, No further questions*
❒ Pregnancy or currently planning pregnancy ***ACTION REQUIRED****: Submit supporting documentation, No further questions*
❒ Breastfeeding ***ACTION REQUIRED****: Submit supporting documentation, No further questions*
❒ Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension) ***ACTION REQUIRED****: Submit supporting documentation, No further questions*
❒ Hypersensitivity ***ACTION REQUIRED****: Submit supporting documentation, No further questions*
❒ History of intolerance or adverse event ***ACTION REQUIRED****: Submit supporting documentation, No further questions*
❒ Other, please specify. _____, *No further questions*

94. Is the requested drug being prescribed by or in consultation with a dermatologist, hematologist, or oncologist?
❒ Yes, *Continue to 95*
❒ No, *Continue to 95*

95. Is this request for continuation of therapy with the requested drug?
❒ Yes, *Continue to 96*
❒ No, *Continue to 98*

96. Please select the indication.
❒ Severe (G3) pruritis, *Continue to 97*
❒ Severe (G3) bullous dermatitis, *Continue to 97*
❒ Life-threatening (G4) bullous dermatitis, *Continue to 97*
❒ Other, please specify _____, *Continue to 97*

97. 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? ***ACTION REQUIRED***: If Yes, please attach chart note(s) or medical record documentation supporting positive clinical response. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

98. Please select the indication.
❒ Severe (G3) pruritus, *Continue to 99*
❒ Severe (G3) bullous dermatitis, *Continue to 100*
❒ Life-threatening (G4) bullous dermatitis, *Continue to 100*
❒ Other, please specify _____, *No further questions*

99. Did the patient have no response to gabapentinoids in one month?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

100. Will the requested drug be used as additional therapy for severe (G3) or life-threatening (G4) bullous dermatitis?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

101. Is the requested drug being prescribed by or in consultation with a pulmonologist or allergist/immunologist?
❒ Yes, *Continue to 102*
❒ No, *Continue to 102*

102. Is the patient an adult (18 years of age or older)?
❒ Yes, *Continue to 103*
❒ No, *Continue to 103*

103. Is the request for continuation of therapy with the requested drug?
❒ Yes, *Continue to 104*
❒ No, *Continue to 107*

104. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program?
❒ Yes, *Continue to 107*
❒ No, *Continue to 105*
❒ Unknown, *Continue to 107*

105. Has the patient achieved or maintained a positive clinical response as evidenced by improvement in signs and symptoms of COPD (e.g., decrease in exacerbations, improvement in pre-bronchodilator FEV1) or stabilization of disease? ***ACTION REQUIRED***: If Yes, please attach chart notes or medical record documentation supporting positive clinical response. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 106*
❒ No, *Continue to 106*

106. Will the patient continue to use maintenance chronic obstructive pulmonary disease (COPD) treatments (e.g., inhaled corticosteroid with long-acting muscarinic antagonist [LAMA] and long-acting beta2-agonist [LABA], LAMA and LABA) with the requested drug?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

107. Has the patient received in the past year or is currently receiving a biologic drug (e.g., Nucala) indicated for treatment of chronic obstructive pulmonary disease (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. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *No Further Questions*
❒ No, *Continue to 108*

108. Has the patient's diagnosis been confirmed by spirometry showing forced expiratory volume in one second (FEV1)/forced vital capacity (FVC) less than 0.7 post-bronchodilation?
❒ Yes, *Continue to 109*
❒ No, *Continue to 109*

109. Does the patient show classic signs or symptoms of chronic obstructive pulmonary disease (COPD) (e.g., dyspnea, wheezing, chest tightness, fatigue, activity limitation, cough with or without sputum production, chronic bronchitis)? ***ACTION REQUIRED***: If Yes, please attach chart notes or medical record documentation showing clinical signs and/or symptoms of COPD. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 110*
❒ No, *Continue to 110*

110. Is the patient currently receiving maintenance inhaled triple therapy (i.e., inhaled corticosteroid [ICS], long-acting muscarinic antagonist [LAMA], and long-acting beta2-agonist [LABA])? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history of prerequisite therapies. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 113*
❒ No, *Continue to 111*

111. Is the patient currently receiving a long-acting muscarinic antagonist (LAMA) and long-acting beta2-agonist (LABA)? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history of prerequisite therapies. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 112*
❒ No, *Continue to 112*

112. Does the patient have a contraindication to treatment with an inhaled corticosteroid (ICS)? ***ACTION REQUIRED***: If Yes, please attach documentation of clinical reason to avoid therapy. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 113*
❒ No, *Continue to 113*

113. Prior to initiating therapy with the requested drug, what is the patient's absolute blood eosinophil count (before significant oral steroid use) in cells per microliter? Indicate blood eosinophil count in cells per microliter. ***ACTION REQUIRED***: Please attach chart notes or medical record documentation with the patient's absolute blood eosinophil count prior to initiating therapy with the requested drug.
❒ Greater than or equal to 300 cells per microliter _____ ***ACTION REQUIRED****: Submit supporting documentation, Continue to 114*
❒ Less than 300 cells per microliter, *Continue to 114*
❒ Unknown, *Continue to 114*

114. Does the patient have inadequately controlled chronic obstructive pulmonary disease (COPD) as demonstrated by experiencing one or more severe exacerbation(s) requiring hospitalization or an emergency medical care visit within the last year? ***ACTION REQUIRED***: If Yes, please attach chart notes or medical record documentation of severe exacerbation(s) within the last year. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 116*
❒ No, *Continue to 115*

115. Does the patient have inadequately controlled chronic obstructive pulmonary disease (COPD) as demonstrated by experiencing at least two moderate exacerbations resulting in treatment with systemic glucocorticoids, antibiotics, or

both within the last year? ***ACTION REQUIRED***: If Yes, please attach chart notes or medical record documentation of moderate exacerbations within the last year. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 116*
❒ No, *Continue to 116*

116. Will the patient continue to use maintenance chronic obstructive pulmonary disease (COPD) treatments (e.g., inhaled corticosteroid with long-acting muscarinic antagonist [LAMA] and long-acting beta2-agonist [LABA], LAMA and LABA) with the requested drug?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

117. Is the medication being prescribed by or in consultation with an allergist, immunologist, or dermatologist?
❒ Yes, *Continue to 118*
❒ No, *Continue to 118*

118. Is the patient 12 years of age or older?
❒ Yes, *Continue to 119*
❒ No, *Continue to 119*

119. Is the request for continuation of therapy with the requested drug?
❒ Yes, *Continue to 120*
❒ No, *Continue to 122*

120. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program?
❒ Yes, *Continue to 122*
❒ No, *Continue to 121*
❒ Unknown, *Continue to 122*

121. Has the patient experienced a positive clinical response (e.g., improved symptoms, decrease in weekly urticaria activity score [UAS7]) since initiation of therapy? ***ACTION REQUIRED***: If Yes, please attach chart notes or medical record documentation supporting positive response to therapy. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

122. Has the patient received in the past year or is currently receiving a biologic drug (e.g., Xolair) indicated for treatment of chronic spontaneous urticaria (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. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 126*
❒ No, *Continue to 123*

123. For how long has the patient had a spontaneous onset of wheals (hives), angioedema, or both?
❒ Less than 6 weeks, *Continue to 124*
❒ 6 weeks or longer, *Continue to 124*

124. Does the patient remain symptomatic despite treatment with up-dosing (in accordance with EAACI/GA2LEN/EuroGuiDerm/APAAACI guidelines) of a second-generation H1 antihistamine (e.g., cetirizine,

fexofenadine, levocetirizine, loratadine) for at least 2 weeks? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried showing inadequate response to up-dosing of a second-generation H1 antihistamine. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 125*
❒ No, *Continue to 125*

125. Has the patient been evaluated for other causes of wheals (hives) and/or angioedema, including bradykinin-related angioedema and interleukin-1-associated urticarial syndromes (auto-inflammatory disorders, urticarial vasculitis)?
❒ Yes, *Continue to 126*
❒ No, *Continue to 126*

126. Is a loading dose prescribed?
❒ Yes, *Continue to 127*
❒ No, *No Further Questions*

127. Does the prescribed loading dose exceed a dose of 600 mg?
❒ Yes, *Continue to 128*
❒ No, *Continue to 128*

128. What is the prescribed loading dose?
❒ 400 mg, *No further questions*
❒ 600 mg, *No further questions*

129. Is the requested drug being prescribed by or in consultation with a dermatologist, hematologist, or oncologist?
❒ Yes, *Continue to 130*
❒ No, *Continue to 130*

130. Is the patient an adult (18 years of age or older)?
❒ Yes, *Continue to 131*
❒ No, *Continue to 131*

131. Is this request for continuation of therapy with the requested drug?
❒ Yes, *Continue to 132*
❒ No, *Continue to 135*

132. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program?
❒ Yes, *Continue to 135*
❒ No, *Continue to 133*
❒ Unknown, *Continue to 135*

133. Has the patient achieved or maintained a positive clinical response as evidenced by low disease activity of bullous pemphigoid (e.g., absence of new or established lesions) since starting treatment with the requested drug? ***ACTION REQUIRED***: If Yes, please attach chart note(s) or medical record documentation supporting positive clinical response. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *No Further Questions*
❒ No, *Continue to 134*

134. Has the patient achieved or maintained a positive clinical response as evidenced by a reduction in pruritus intensity and improvement in extent and severity of lesions of bullous pemphigoid (e.g., decrease in BPDAI score) since starting

treatment with the requested drug? ***ACTION REQUIRED***: If Yes, please attach chart notes or medical record documentation supporting positive clinical response. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

135. Has the patient's diagnosis been confirmed by direct immunofluorescence (DIF) study or immune serological test(s) (e.g., indirect immunofluorescence microscopy [IIF], ELISA)?
❒ Yes, *Continue to 136*
❒ No, *Continue to 136*

136. Does the patient show characteristic clinical features of bullous pemphigoid (e.g., urticarial or eczematous or erythematous plaques, bullae, pruritus)? ***ACTION REQUIRED***: If Yes, please attach chart notes or medical record documentation showing clinical features of bullous pemphigoid. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 137*
❒ No, *Continue to 137*

137. Does the patient have moderate to severe disease (e.g., Bullous Pemphigoid Disease Activity Index [BPDAI] score greater than or equal to 20)?
❒ Yes, *Continue to 138*
❒ No, *Continue to 138*

138. Has the patient had an inadequate treatment response with a super-high potency topical corticosteroid?
❒ Yes, *Continue to 139*
❒ No, *Continue to 140*

139. Is information on the active ingredient, strength, and dosage form of the super-high potency topical steroid the patient had an inadequate treatment response to provided? Indicate drug strength in percentage. ***ACTION REQUIRED***: Please attach chart note(s), medical record documentation, or claims history supporting previous medications tried including drug name, dosage form, strength, and response to therapy.
_____ ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *No Further Questions*
❒ No, *Continue to 141*

140. Is the use of a super-high potency topical corticosteroid not advisable for the patient (e.g., due to contraindications, prior intolerances)? ***ACTION REQUIRED***: If Yes, please attach chart note(s) or medical record documentation of clinical reason to avoid therapy. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *No Further Questions*
❒ No, *Continue to 141*

141. Has the patient had an inadequate treatment response with an oral corticosteroid? ***ACTION REQUIRED***: If Yes, please attach chart note(s), medical record documentation, or claims history supporting previous medications tried, including response to therapy. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *No Further Questions*
❒ No, *Continue to 142*

142. Is the use of an oral corticosteroid not advisable for the patient (e.g., due to contraindications, prior intolerances)? ***ACTION REQUIRED***: If Yes, please attach chart note(s) or medical record documentation of clinical reason to avoid therapy. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

Step Therapy Override 2197-D: Complete if Applicable for the state of Maryland.	Please Circle	
1. 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
2. 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
3. Is the alternate drug FDA-approved for the medical condition being treated? *If No, No Further Questions*	Yes	No
4. Has the prescriber documented in the patient's chart that the requested drug was ordered for the patient in the past 180 days? *If No, Skip to 6*	Yes	No
5. Has the prescriber documented in the patient's chart that in their opinion the requested drug is effective for the patient's condition? *If Yes or No*, *No Further Questions*	Yes	No
6. Is the alternate drug contraindicated or will likely cause an adverse reaction to the patient? *If Yes, No Further Questions*	Yes	No
7. Is the alternate drug expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug regimen? *If Yes, No Further Questions*	Yes	No
8. Is the patient stable on the requested drug for the medical condition under consideration? *If Yes, No Further Questions*	Yes	No
9. Has the patient tried a prescription drug while covered under their current policy or a previous source of coverage, that is in the same pharmacologic class or has the same mechanism of action as the alternate drug and it was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? *No Further Questions*	Yes	No

Step Therapy Override 3145-D: Complete if Applicable for the state of Virginia.	Please Circle	
1. 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
2. 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
3. Is the alternate drug contraindicated? *If Yes, No Further Questions*	Yes	No
4. Is the alternate drug expected to be ineffective based on the known clinical characteristics of the patient and the prescription drug regimen? *If Yes, No Further Questions*	Yes	No
5. Has the patient tried the alternate 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? NOTE: Pharmaceutical drug samples are not considered trial and failure of a preferred drug. *If Yes, No Further Questions*	Yes	No
6. Is the patient currently receiving a positive therapeutic outcome with the requested drug for their medical condition? *No Further Questions*	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