Ilumya

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, Ilumya SGM 2538-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 Ilumya SGM 2538-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 Ilumya SGM 2538-A Criteria Questions*
❒ No, *Skip to Ilumya SGM 2538-A Criteria Questions*

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 Ilumya SGM 2538-A Criteria Questions*
❒ No, *Skip to Ilumya SGM 2538-A Criteria Questions*

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*

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Psoriasis Enhanced SGM 4179-A Criteria Questions:

Is the diagnosis moderate or severe plaque psoriasis?

❒ Yes, *Continue to Question 1*

❒ No, *Skip to Ilumya SGM 2538-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 Ilumya SGM 2538-A Criteria Question 1*

2. What is the diagnosis?

❒ Plaque psoriasis, *Continue to 3*

❒ Plaque psoriasis with co-existing psoriatic arthritis, *Skip to Ilumya SGM 2538-A Criteria Question 1*

❒ Other, please specify: _____, *Skip to Ilumya SGM 2538-A 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 Ilumya SGM 2538-A 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 Ilumya SGM 2538-A Criteria Question 22*

❒ 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 Ilumya SGM 2538-A Criteria Question 22*
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 Ilumya SGM 2538-A Criteria Question 22*
❒ 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 Ilumya SGM 2538-A Criteria Question 22*
❒ 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. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Skip to Ilumya SGM 2538-A Criteria Question 22*
❒ 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. ***ACTION REQUIRED***: Submit supporting documentation
❒ 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 Ilumya SGM 2538-A Criteria Question 22*
❒ 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 Ilumya SGM 2538-A Criteria Question 22*
❒ 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 Ilumya SGM 2538-A Criteria Question 22*
❒ 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 Ilumya SGM 2538-A Criteria Question 22*
❒ Drug interaction, *Skip to Ilumya SGM 2538-A Criteria Question 22*
❒ Risk of treatment-related toxicity, *Skip to Ilumya SGM 2538-A Criteria Question 22*
❒ Pregnancy or currently planning pregnancy, *Skip to Ilumya SGM 2538-A Criteria Question 22*
❒ Breastfeeding, *Skip to Ilumya SGM 2538-A Criteria Question 22*
❒ Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension), *Skip to Ilumya SGM 2538-A Criteria Question 22*
❒ Hypersensitivity, *Skip to Ilumya SGM 2538-A Criteria Question 22*
❒ History of intolerance or adverse event, *Skip to Ilumya SGM 2538-A Criteria Question 22*
❒ Other, please specify. _____, *No Further Questions*

Ilumya SGM 2538-A Criteria Questions:

1. 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 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, *Continue to 6*

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 7*

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

7. Has the patient been diagnosed with moderate to severe plaque psoriasis?
❒ Yes, *Continue to 8*
❒ No, *Continue to 8*

8. Is the patient an adult (18 years of age or older)?
❒ Yes, *Continue to 9*
❒ No, *Continue to 9*

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

10. Is this request for continuation of therapy with the requested drug?
❒ Yes, *Continue to 11*
❒ No, *Continue to 15*

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

❒ Yes, *Continue to 15*

❒ No, *Continue to 12*

❒ Unknown, *Continue to 15*

12. 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 13*
❒ No, *Continue to 13*

13. 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 22*
❒ No, *Continue to 14*

14. 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 22*
❒ No, *Continue to 22*

15. 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 22*
❒ No, *Continue to 16*

16. 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 22*
❒ No, *Continue to 17*

17. Is the percentage of body surface area (BSA) affected (prior to starting the requested medication) less than 3%?
❒ Yes, *Continue to 18*
❒ No, *Continue to 18*

18. 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 19*
❒ Greater than or equal to 10% of BSA _____ ***ACTION REQUIRED****: Submit supporting documentation, Continue to 22*

19. 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. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 22*
❒ No, *Continue to 20*

20. 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 each therapy.
❒ Yes, *Continue to 21*
❒ No, *Continue to 21*

21. 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 22*

❒ Drug interaction, *Continue to 22*

❒ Risk of treatment-related toxicity, *Continue to 22*

❒ Pregnancy or currently planning pregnancy, *Continue to 22*

❒ Breastfeeding, *Continue to 22*

❒ Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension), *Continue to 22*

❒ Hypersensitivity, *Continue to 22*

❒ History of intolerance or adverse event, *Continue to 22*

❒ Other, please specify _____, *Continue to 22*

22. Is the patient currently receiving the requested drug?
❒ Yes, *Continue to 23*
❒ No, *Continue to 25*

23. Does the prescribed dose exceed 100 mg?
❒ Yes, *Continue to 24*
❒ No, *Continue to 24*

24. Is the prescribed frequency for the maintenance dose more frequent than one dose every 12 weeks?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

25. Does the prescribed dose exceed a loading dose of 100 mg at weeks 0 and 4, and a maintenance dose of 100 mg thereafter?
❒ Yes, *Continue to 26*
❒ No, *Continue to 26*

26. Is the prescribed frequency for the maintenance dose more frequent than one dose every 12 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