Orencia

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*

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, Orencia 2127-A SGM CFT SOC 5973-A – 01/2025.

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:

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 Site of Service 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 Site of Service 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 Site of Service Questions*
❒ No, *Skip to Site of Service 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 Site of Service Questions*
❒ No, *Skip to Site of Service 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 Site of Service Questions*
❒ No *Continue to Site of Service Questions*

Site of Service Questions (SOS):

A. Where will this drug be administered?
- ❑ Ambulatory surgical, *skip to Clinical Criteria Questions*
- ❑ Home infusion, *skip to Clinical Criteria Questions*
- ❑ Off-campus Outpatient Hospital, *Continue to B*
- ❑ On-campus Outpatient Hospital, *Continue to B*
- ❑ Physician office, *skip to Clinical Criteria Questions*
- ❑ Pharmacy, *skip to Clinical Criteria Questions*

B. Is the patient less than 14 years of age?
- ❑ Yes, *skip to Clinical Criteria Questions*
- ❑ No, *Continue to C*

C. Is this request to continue previously established treatment with the requested medication? ***ACTION REQUIRED: If No, please attach supporting clinical documentation.***
- ❑ Yes - This is a continuation of an existing treatment., *Continue to D*
- ❑ No - This is a new therapy request (patient has not received requested medication in the last 6 months)., *skip to Clinical Criteria Questions*

D. Has the patient experienced an adverse event with the requested product that has not responded to conventional interventions (eg acetaminophen, steroids, diphenhydramine, fluids, or other pre-medications) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after an infusion? ***ACTION REQUIRED: If Yes, please attach supporting clinical documentation.***
- ❑ Yes, *skip to Clinical Criteria Questions*
- ❑ No, *Continue to E*

E. Is the patient medically unstable which may include respiratory, cardiovascular, or renal conditions that may limit the member's ability to tolerate a large volume or load or predispose the member to a severe adverse event that cannot be managed in an alternate setting without appropriate medical personnel and equipment? ***ACTION REQUIRED: If Yes, please attach supporting clinical documentation.***
- ❑ Yes, *skip to Clinical Criteria Questions*
- ❑ No, *Continue to F*

F. Does the patient have severe venous access issues that require the use of special interventions only available in the outpatient hospital setting? ***ACTION REQUIRED: If Yes, please attach supporting clinical documentation.***
- ❑ Yes, *skip to Clinical Criteria Questions*
- ❑ No, *Continue to G*

G. Does the patient have significant behavioral issues and/or physical or cognitive impairment that would impact the safety of the infusion therapy AND the patient does not have access to a caregiver? ***ACTION REQUIRED: If Yes, please attach supporting clinical documentation.***
- ❑ Yes, *skip to Clinical Criteria Questions*
- ❑ No, *Continue to H*

H. Are ***all*** alternative infusion sites (pharmacy, physician office, ambulatory care, etc.) **greater than** 30 miles from the patient's home? ***ACTION REQUIRED: If Yes, please attach supporting documentation.***
- ❑ Yes, *Continue to Clinical Criteria Questions*
- ❑ No, *Continue to Clinical Criteria Questions*

Clinical 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?

❒ Rheumatoid arthritis, *Continue to 7*

❒ Polyarticular juvenile idiopathic arthritis (pJIA), *Continue to 21*

❒ Oligoarticular juvenile idiopathic arthritis, *Continue to 21*

❒ Psoriatic arthritis, *Continue to 34*

❒ Chronic graft versus host disease, *Continue to 49*

❒ Immune checkpoint inhibitor-related toxicity, *Continue to 52*

❒ Prophylaxis of acute graft versus host disease, *Continue to 56*

❒ Systemic juvenile idiopathic arthritis (sJIA), *No further questions*

❒ Other, please specify. _____, *No further questions*

7. Has the patient been diagnosed with moderately to severely active rheumatoid arthritis (RA)?
❒ 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 rheumatologist?

❒ 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 14*

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

❒ Yes, *Continue to 14*

❒ No, *Continue to 12*

❒ Unknown, *Continue to 14*

12. Has the patient achieved or maintained a positive clinical response since starting treatment with the requested drug?
❒ Yes, *Continue to 13*
❒ No, *Continue to 13*

13. Has the patient experienced substantial disease activity improvement (e.g., at least 20% from baseline) in tender joint count, swollen joint count, pain, or disability? ***ACTION REQUIRED***: If Yes, please attach chart notes or medical record documentation supporting positive clinical response and substantial disease activity improvement.
❒ Yes, *Continue to 60*
❒ No, *Continue to 60*

14. 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 moderately to severely active rheumatoid 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 60*
❒ No, *Continue to 15*

15. Does the patient meet either of the following: a) the patient was tested for the rheumatoid factor (RF) biomarker and the RF biomarker test was positive, or b) the patient was tested for the anti-cyclic citrullinated peptide (anti-CCP) biomarker and the anti-CCP biomarker test was positive? ***ACTION REQUIRED***: If Yes, please attach laboratory results, chart notes, or medical record documentation of biomarker testing.
❒ Yes, *Continue to 17*
❒ No, *Continue to 16*

16. Has the patient been tested for all of the following biomarkers: a) rheumatoid factor (RF), b) anti-cyclic citrullinated peptide (anti-CCP), and c) C-reactive protein (CRP) and/or erythrocyte sedimentation rate (ESR)? ***ACTION REQUIRED***: If Yes, please attach laboratory results, chart notes, or medical record documentation of biomarker testing.
❒ Yes, *Continue to 17*
❒ No, *Continue to 17*

17. Has the patient experienced an inadequate response after at least 3 months of treatment with methotrexate at a dose greater than or equal to 15 mg per week? ***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 60*
❒ No, *Continue to 18*

18. 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 60*
❒ No, *Continue to 19*

19. Does the patient have a contraindication to methotrexate? ***ACTION REQUIRED***: If Yes, please attach documentation of clinical reason to avoid therapy.
❒ Yes, *Continue to 20*
❒ No, *Continue to 20*

20. Please indicate the contraindication to methotrexate.

❒ Clinical diagnosis of alcohol use disorder, alcoholic liver disease, or other chronic liver disease, *Continue to 60*

❒ Drug interaction, *Continue to 60*

❒ Risk of treatment-related toxicity, *Continue to 60*

❒ Pregnancy or currently planning pregnancy, *Continue to 60*

❒ Breastfeeding, *Continue to 60*
❒ Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension), *Continue to 60*

❒ Hypersensitivity, *Continue to 60*

❒ History of intolerance or adverse event, *Continue to 60*

❒ Other, please specify. _____, *Continue to 60*

21. Has the patient been diagnosed with moderately to severely active articular juvenile idiopathic arthritis?
❒ Yes, *Continue to 22*
❒ No, *Continue to 22*

22. Is the patient 2 years of age or older?
❒ Yes, *Continue to 23*
❒ No, *Continue to 23*

23. Is the requested drug being prescribed by or in consultation with a rheumatologist?
❒ Yes, *Continue to 24*
❒ No, *Continue to 24*

24. Is this request for continuation of therapy with the requested drug?
❒ Yes, *Continue to 25*
❒ No, *Continue to 28*

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

❒ Yes, *Continue to 28*

❒ No, *Continue to 26*

❒ Unknown, *Continue to 28*

26. Has the patient achieved or maintained a positive clinical response to treatment 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 27*
❒ No, *Continue to 27*

27. 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 joints with active arthritis (e.g., swelling, pain, limitation of motion) ***ACTION REQUIRED****: Submit supporting documentation, Continue to 60*
❒ Number of joints with limitation of movement ***ACTION REQUIRED****: Submit supporting documentation, Continue to 60*
❒ Functional ability ***ACTION REQUIRED****: Submit supporting documentation, Continue to 60*
❒ None of the above, *Continue to 60*

28. Has the patient ever received or is currently receiving a biologic (e.g., Humira) or targeted synthetic drug (e.g., Xeljanz) indicated for the treatment of moderately to severely active articular juvenile idiopathic 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 60*
❒ No, *Continue to 29*

29. Has the patient had an inadequate response to methotrexate or another conventional synthetic drug (e.g., leflunomide, sulfasalazine, hydroxychloroquine) 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 60*
❒ No, *Continue to 30*

30. Has the patient had an inadequate response to a trial of scheduled non-steroidal anti-inflammatory drugs (NSAIDs) and/or intra-articular glucocorticoids (e.g., triamcinolone hexacetonide)? ***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 31*
❒ No, *Continue to 32*

31. Does the patient have one of the following risk factors for poor outcome: a) involvement of ankle, wrist, hip, sacroiliac joint, and/or temporomandibular joint (TMJ), b) presence of erosive disease or enthesitis, c) delay in diagnosis, d) elevated levels of inflammation markers, or e) symmetric disease?
❒ Yes, *Continue to 60*
❒ No, *Continue to 32*

32. Does the patient have any of the following risk factors for disease severity and potentially a more refractory disease course: a) positive rheumatoid factor, b) positive anti-cyclic citrullinated peptide antibodies, or c) pre-existing joint damage?
❒ Yes, *Continue to 33*
❒ No, *Continue to 33*

33. Does the patient meet any of the following: a) high-risk joints are involved (e.g., cervical spine, wrist, or hip), b) high disease activity, or c) high risk for disabling joint disease?
❒ Yes, *Continue to 60*
❒ No, *Continue to 60*

34. Is the patient 2 years of age or older?

❒ Yes, *Continue to 35*
❒ No, *Continue to 35*

35. Is the requested drug being prescribed by or in consultation with a rheumatologist or dermatologist?
❒ 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 40*

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

❒ Yes, *Continue to 40*

❒ No, *Continue to 38*

❒ Unknown, *Continue to 40*

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 39*

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 60*

❒ Number of tender joints ***ACTION REQUIRED****: Submit supporting documentation, Continue to 60*

❒ Dactylitis ***ACTION REQUIRED****: Submit supporting documentation, Continue to 60*

❒ Enthesitis ***ACTION REQUIRED****: Submit supporting documentation, Continue to 60*

❒ Skin and/or nail involvement ***ACTION REQUIRED****: Submit supporting documentation, Continue to 60*

❒ Functional status ***ACTION REQUIRED****: Submit supporting documentation, Continue to 60*

❒ C-reactive protein (CRP) ***ACTION REQUIRED****: Submit supporting documentation, Continue to 60*

❒ None of the above, *Continue to 60*

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

41. Has the patient ever received (including current utilizers) 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 60*
❒ No, *Continue to 42*

42. What is the patient's disease severity?

❒ Mild to moderate, *Continue to 43*

❒ Severe, *Continue to 60*

43. Does the patient have enthesitis?

❒ Yes, *Continue to 60*
❒ No, *Continue to 44*

44. 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 60*
❒ No, *Continue to 45*

45. 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 60*
❒ No, *Continue to 46*

46. 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 48*
❒ No, *Continue to 47*

47. 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 60*
❒ No, *Continue to 60*

48. Please indicate the contraindication to methotrexate or leflunomide.

❒ Clinical diagnosis of alcohol use disorder, alcoholic liver disease, or other chronic liver disease, *Continue to 60*

❒ Drug interaction, *Continue to 60*

❒ Risk of treatment-related toxicity, *Continue to 60*

❒ Pregnancy or currently planning pregnancy, *Continue to 60*

❒ Breastfeeding, *Continue to 60*
❒ Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension), *Continue to 60*

❒ Hypersensitivity, *Continue to 60*

❒ History of intolerance or adverse event, *Continue to 60*

❒ Other, please specify. _____, *Continue to 60*

49. Is the requested drug being prescribed by or in consultation with an oncologist or hematologist?
❒ Yes, *Continue to 50*
❒ No, *Continue to 50*

50. Has the patient experienced an inadequate response to systemic corticosteroids? ***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 60*
❒ No, *Continue to 51*

51. Does the patient have an intolerance or contraindication to corticosteroids? ***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 60*
❒ No, *Continue to 60*

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

53. Does the patient have myocarditis?
❒ Yes, *Continue to 54*
❒ No, *Continue to 54*

54. Has the patient experienced an inadequate response to systemic corticosteroids? ***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 60*
❒ No, *Continue to 55*

55. Does the patient have an intolerance or contraindication to corticosteroids? ***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 60*
❒ No, *Continue to 60*

56. Is the patient 2 years of age or older?
❒ Yes, *Continue to 57*
❒ No, *Continue to 57*

57. Is the requested drug being prescribed by or in consultation with an oncologist or hematologist?
❒ Yes, *Continue to 58*
❒ No, *Continue to 58*

58. Is the patient undergoing hematopoietic stem cell transplantation (HSCT) from a matched or 1 allele-mismatched unrelated donor?
❒ Yes, *Continue to 59*
❒ No, *Continue to 59*

59. Will the requested medication be used in combination with a calcineurin inhibitor (e.g., cyclosporine, tacrolimus) and methotrexate?
❒ Yes, *Continue to 60*
❒ No, *Continue to 60*

60. What is the diagnosis?

❒ Rheumatoid arthritis, *Continue to 61*

❒ Polyarticular juvenile idiopathic arthritis (pJIA), *Continue to 84*

❒ Oligoarticular juvenile idiopathic arthritis, *Continue to 84*

❒ Psoriatic arthritis, *Continue to 102*

❒ Chronic graft versus host disease, *Continue to 122*

❒ Immune checkpoint inhibitor-related toxicity, *Continue to 129*

❒ Prophylaxis of acute graft versus host disease, *Continue to 133*

61. Is the patient currently receiving Orencia?
❒ Yes, *Continue to 62*
❒ No, *Continue to 70*

62. What is the route of administration?

❒ Intravenous, *Continue to 63*

❒ Subcutaneous, *Continue to 68*

63. Is the prescribed frequency for the maintenance dose more frequent than one dose every four weeks?
❒ Yes, *Continue to 64*
❒ No, *Continue to 64*

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

❒ Less than 60 kg _____, *Continue to 65*

❒ Greater than or equal to 60 kg to less than or equal to 100 kg _____, *Continue to 66*

❒ Greater than 100 kg _____, *Continue to 67*

65. Does the prescribed dose exceed 500 mg?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

66. Does the prescribed dose exceed 750 mg?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

67. Does the prescribed dose exceed 1000 mg?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

68. Does the prescribed maintenance dose exceed 125 mg?
❒ Yes, *Continue to 69*
❒ No, *Continue to 69*

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

70. What is the route of administration?

❒ Intravenous, *Continue to 71*

❒ Intravenous loading dose followed by subcutaneous maintenance, *Continue to 76*

❒ Subcutaneous, *Continue to 82*

71. Is the prescribed frequency for the maintenance dose more frequent than one dose every 4 weeks?
❒ Yes, *Continue to 72*
❒ No, *Continue to 72*

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

❒ Less than 60 kg _____, *Continue to 73*

❒ Greater than or equal to 60 kg to less than or equal to 100 kg _____, *Continue to 74*

❒ Greater than 100 kg _____, *Continue to 75*

73. Does the prescribed dose exceed a loading dose of 500 mg at week 0, week 2, week 4, and a maintenance dose of 500 mg thereafter?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

74. Does the prescribed dose exceed a loading dose of 750 mg at week 0, week 2, week 4, and a maintenance dose of 750 mg thereafter?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

75. Does the prescribed dose exceed a loading dose of 1000 mg at week 0, week 2, week 4, and a maintenance dose of 1000 mg thereafter?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

76. Is the prescribed frequency for the maintenance dose more frequent than one dose every week?
❒ Yes, *Continue to 77*
❒ No, *Continue to 77*

77. Does the prescribed maintenance dose exceed 125 mg?
❒ Yes, *Continue to 78*
❒ No, *Continue to 78*

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

❒ Less than 60 kg _____, *Continue to 79*

❒ Greater than or equal to 60 kg to less than or equal to 100 kg _____, *Continue to 80*

❒ Greater than 100 kg _____, *Continue to 81*

79. Does the prescribed loading dose exceed 500 mg as an intravenous infusion?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

80. Does the prescribed loading dose exceed 750 mg as an intravenous infusion?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

81. Does the prescribed loading dose exceed 1000 mg as an intravenous infusion?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

82. Does the prescribed dose exceed 125 mg?
❒ Yes, *Continue to 83*
❒ No, *Continue to 83*

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

84. What is the route of administration?

❒ Intravenous, *Continue to 85*

❒ Subcutaneous, *Continue to 97*

85. What is the patient's age?

❒ 2 years to less than 6 years of age, *Continue to 86*

❒ 6 years of age or older, *Continue to 86*

86. Is the patient currently receiving Orencia?
❒ Yes, *Continue to 87*
❒ No, *Continue to 92*

87. Is the prescribed frequency for the maintenance dose more frequent than one dose every four weeks?
❒ Yes, *Continue to 88*
❒ No, *Continue to 88*

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

❒ Less than 75 kg _____, *Continue to 89*

❒ Greater than or equal to 75 kg to less than or equal to 100 kg _____, *Continue to 90*

❒ Greater than 100 kg _____, *Continue to 91*

89. Does the prescribed dose exceed 10 mg per kg?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

90. Does the prescribed dose exceed 750 mg?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

91. Does the prescribed dose exceed 1000 mg?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

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

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

❒ Less than 75 kg _____, *Continue to 94*

❒ Greater than or equal to 75 kg to less than or equal to 100 kg _____, *Continue to 95*

❒ Greater than 100 kg _____, *Continue to 96*

94. Does the prescribed dose exceed a loading dose of 10 mg per kg at week 0, week 2, week 4, and a maintenance dose of 10 mg per kg thereafter?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

95. Does the prescribed dose exceed a loading dose of 750 mg at week 0, week 2, week 4, and a maintenance dose of 750 mg thereafter?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

96. Does the prescribed dose exceed a loading dose of 1000 mg at week 0, week 2, week 4, and a maintenance dose of 1000 mg thereafter?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

97. Is the prescribed frequency for the maintenance dose more frequent than one dose every week?
❒ Yes, *Continue to 98*
❒ No, *Continue to 98*

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

❒ Less than 10 kg _____, *No further questions*

❒ Greater than or equal to 10 kg to less than 25 kg _____, *Continue to 99*

❒ Greater than or equal to 25 kg to less than 50 kg _____, *Continue to 100*

❒ Greater than or equal to 50 kg _____, *Continue to 101*

99. Does the prescribed dose exceed 50 mg?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

100. Does the prescribed dose exceed 87.5 mg?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

101. Does the prescribed dose exceed 125 mg?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

102. What is the route of administration?

❒ Intravenous, *Continue to 103*

❒ Subcutaneous, *Continue to 115*

103. What is the patient's age?

❒ 2 years to less than 18 years of age, *Continue to 104*

❒ 18 years of age or older, *Continue to 104*

104. Is the patient currently receiving Orencia?
❒ Yes, *Continue to 105*
❒ No, *Continue to 110*

105. Is the prescribed frequency for the maintenance dose more frequent than one dose every four weeks?
❒ Yes, *Continue to 106*
❒ No, *Continue to 106*

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

❒ Less than 60 kg _____, *Continue to 107*

❒ Greater than or equal to 60 kg to less than or equal to 100 kg _____, *Continue to 108*

❒ Greater than 100 kg _____, *Continue to 109*

107. Does the prescribed dose exceed 500 mg?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

108. Does the prescribed dose exceed 750 mg?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

09. Does the prescribed dose exceed 1000 mg?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

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

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

❒ Less than 60 kg _____, *Continue to 112*

❒ Greater than or equal to 60 kg to less than or equal to 100 kg _____, *Continue to 113*

❒ Greater than 100 kg _____, *Continue to 114*

112. Does the prescribed dose exceed a loading dose of 500 mg at week 0, week 2, week 4, and a maintenance dose of 500 mg thereafter?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

113. Does the prescribed dose exceed a loading dose of 750 mg at week 0, week 2, week 4, and a maintenance dose of 750 mg thereafter?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

114. Does the prescribed dose exceed a loading dose of 1000 mg at week 0, week 2, week 4, and a maintenance dose of 1000 mg thereafter?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

115. What is the patient's age?

❒ 2 years to less than 18 years of age, *Continue to 116*

❒ 18 years of age or older, *Continue to 120*

116. Is the prescribed frequency for the maintenance dose more frequent than one dose every week?
❒ Yes, *Continue to 120*
❒ No, *Continue to 117*

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

❒ Less than 10 kg, *No further questions*

❒ Greater than or equal to 10 kg to less than 25 kg, *Continue to 118*

❒ Greater than or equal to 25 kg to less than 50 kg, *Continue to 119*

❒ Greater than or equal to 50 kg, *Continue to 121*

118. Does the prescribed dose exceed 50 mg?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

119. Does the prescribed dose exceed 87.5 mg?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

120. Is the prescribed frequency for the maintenance dose more frequent than one dose every week?
❒ Yes, *Continue to 121*
❒ No, *Continue to 121*

121. Does the prescribed dose exceed 125 mg?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

122. Is the requested quantity supported by dosing guidelines found in the compendia or current literature (e.g., Micromedex DrugDex, NCCN compendia, current treatment guidelines)?
❒ Yes, *Continue to 123*
❒ No, *Continue to 123*

123. What is the route of administration?

❒ Intravenous, *Continue to 124*

❒ Subcutaneous, *Continue to 124*

124. Is the patient currently receiving Orencia?
❒ Yes, *Continue to 125*
❒ No, *Continue to 127*

125. Does the prescribed maintenance dose exceed 10 mg per kg?
❒ Yes, *Continue to 126*
❒ No, *Continue to 126*

126. Is the prescribed frequency for the maintenance dose more frequent than one dose every four weeks?

❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

127. Does the prescribed dose exceed a loading dose of 10 mg per kg at week 0, week 2, and week 4, followed by a maintenance dose of 10 mg per kg thereafter?
❒ Yes, *Continue to 128*
❒ No, *Continue to 128*

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

129. Is the requested quantity supported by dosing guidelines found in the compendia or current literature (e.g., Micromedex DrugDex, NCCN compendia, current treatment guidelines)?
❒ Yes, *Continue to 130*
❒ No, *Continue to 130*

130. What is the route of administration?

❒ Intravenous, *Continue to 131*

❒ Subcutaneous, *Continue to 131*

131. Does the prescribed dose exceed 10 mg per kg?
❒ Yes, *Continue to 132*
❒ No, *Continue to 132*

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

133. What is the route of administration?

❒ Intravenous, *Continue to 134*

❒ Subcutaneous, *Continue to 134*

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

❒ 2 years to less than 6 years of age _____, *Continue to 135*

❒ 6 years of age or older _____, *Continue to 136*

135. Does the prescribed dose exceed 15 mg per kg on the day before transplantation (Day -1) followed by 12 mg per kg on Days 5, 14, and 28 after transplantation?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

136. Does the prescribed dose exceed 10 mg per kg (maximum 1000 mg) on the day before transplantation (Day -1) and on Days 5, 14, and 28 after transplantation?
❒ 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