Tremfya IV/SC

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

 Tremfya SGM 2156-A – 12/2024.

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

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 6*

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 9*

❒ Psoriatic arthritis WITH co-existent plaque psoriasis, *Continue to 7*

❒ Psoriatic arthritis, *Continue to 24*

❒ Ulcerative colitis, *Continue to 39*

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

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

8. What is the primary diagnosis being treated?

❒ Psoriatic arthritis, *Continue to 25*

❒ Plaque psoriasis, *Continue to 10*

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

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

11. Is the patient an adult (18 years of age or older)?
❒ Yes, *Continue to 12*
❒ No, *Continue to 12*

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

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

❒ Yes, *Continue to 17*

❒ No, *Continue to 14*

❒ Unknown, *Continue to 17*

14. Has the patient achieved or maintained a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition since starting treatment with the requested drug?
❒ Yes, *Continue to 15*
❒ No, *Continue to 15*

15. Has the patient experienced a reduction in body surface area (BSA) affected from baseline? ***ACTION REQUIRED***: If Yes, please attach chart notes or medical record documentation of decreased body surface area affected.
❒ Yes, *Continue to 45*
❒ No, *Continue to 16*

16. Has the patient experienced an improvement in signs and symptoms of the condition from baseline (e.g., itching, redness, flaking, scaling, burning, cracking, pain)? ***ACTION REQUIRED***: If Yes, please attach chart notes or medical record documentation of improvement in signs and symptoms.
❒ Yes, *Continue to 45*
❒ No, *Continue to 45*

17. Has the patient ever received or is currently receiving a biologic (e.g., Humira) or targeted synthetic drug (e.g., Sotyktu, Otezla) indicated for the treatment of moderate to severe plaque psoriasis (excluding receiving the drug via samples or a manufacturer's patient assistance program)? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried.
❒ Yes, *Continue to 45*
❒ No, *Continue to 18*

18. Are crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) affected?
ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation of affected areas.
ACTION REQUIRED: Submit supporting documentation
❒ Yes, *Continue to 45*
❒ No, *Continue to 19*

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

20. What is the percentage of body surface area (BSA) affected (prior to starting the requested medication)? Indicate percentage. ***ACTION REQUIRED***: Please attach chart notes or medical record documentation of body surface area affected.
❒ Greater than or equal to 3% to less than 10% of BSA _____ ***ACTION REQUIRED****: Submit supporting documentation, Continue to 21*
❒ Greater than or equal to 10% of BSA _____ ***ACTION REQUIRED****: Submit supporting documentation, Continue to 45*

21. Has the patient experienced an inadequate response, or has an intolerance to phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy.
❒ Yes, *Continue to 45*
❒ No, *Continue to 22*

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

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

❒ Clinical diagnosis of alcohol use disorder, alcoholic liver disease, or other chronic liver disease, *Continue to 45*

❒ Drug interaction, *Continue to 45*

❒ Risk of treatment-related toxicity, *Continue to 45*

❒ Pregnancy or currently planning pregnancy, *Continue to 45*

❒ Breastfeeding, *Continue to 45*
❒ Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension), *Continue to 45*

❒ Hypersensitivity, *Continue to 45*

❒ History of intolerance or adverse event, *Continue to 45*

❒ Other, please specify _____, *Continue to 45*

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

25. Is the patient an adult (18 years of age or older)?
❒ Yes, *Continue to 26*
❒ No, *Continue to 26*

26. Is this request for continuation of therapy with the requested drug?
❒ Yes, *Continue to 27*
❒ No, *Continue to 30*

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

❒ Yes, *Continue to 30*

❒ No, *Continue to 28*

❒ Unknown, *Continue to 30*

28. Has the patient achieved or maintained a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition since starting treatment with the requested drug?
❒ Yes, *Continue to 29*
❒ No, *Continue to 29*

29. Has the patient experienced improvement in any of the following 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 45*

❒ Number of tender joints ***ACTION REQUIRED****: Submit supporting documentation, Continue to 45*

❒ Dactylitis ***ACTION REQUIRED****: Submit supporting documentation, Continue to 45*

❒ Enthesitis ***ACTION REQUIRED****: Submit supporting documentation, Continue to 45*

❒ Skin and/or nail involvement ***ACTION REQUIRED****: Submit supporting documentation, Continue to 45*

❒ Functional status ***ACTION REQUIRED****: Submit supporting documentation, Continue to 45*

❒ C-reactive protein (CRP) ***ACTION REQUIRED****: Submit supporting documentation, Continue to 45*

❒ None of the above, *Continue to 45*

30. Has the patient been diagnosed with active psoriatic arthritis (PsA)?
❒ Yes, *Continue to 31*
❒ No, *Continue to 31*

31. Has the patient ever received or is currently receiving a biologic (e.g., Humira) or targeted synthetic drug (e.g., Rinvoq, Otezla) indicated for the treatment of active psoriatic arthritis (excluding receiving the drug via samples or a manufacturer's patient assistance program)? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried.
❒ Yes, *Continue to 45*
❒ No, *Continue to 32*

32. What is the patient's disease severity?

❒ Mild to moderate, *Continue to 33*

❒ Severe, *Continue to 45*

33. Does the patient have enthesitis?
❒ Yes, *Continue to 45*
❒ No, *Continue to 34*

34. 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 45*
❒ No, *Continue to 35*

35. 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 45*
❒ No, *Continue to 36*

36. 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 37*
❒ No, *Continue to 38*

37. Please indicate the contraindication to methotrexate or leflunomide.

❒ Clinical diagnosis of alcohol use disorder, alcoholic liver disease, or other chronic liver disease, *Continue to 45*

❒ Drug interaction, *Continue to 45*

❒ Risk of treatment-related toxicity, *Continue to 45*

❒ Pregnancy or currently planning pregnancy, *Continue to 45*

❒ Breastfeeding, *Continue to 45*
❒ Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension), *Continue to 45*

❒ Hypersensitivity, *Continue to 45*

❒ History of intolerance or adverse event, *Continue to 45*

❒ Other, please specify. _____, *Continue to 45*
38. 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 45*
❒ No, *Continue to 45*

39. Has the patient been diagnosed with moderately to severely active ulcerative colitis (UC)?
❒ Yes, *Continue to 40*
❒ No, *Continue to 40*

40. Is the patient an adult (18 years of age or older)?
❒ Yes, *Continue to 41*
❒ No, *Continue to 41*

41. Is the requested drug being prescribed by or in consultation with a gastroenterologist?
❒ Yes, *Continue to 42*
❒ No, *Continue to 42*

42. Which of the following applies to this request for the requested drug?

❒ Initiation of the intravenous (IV) loading dose, *Continue to 45*

❒ Initiation of the subcutaneous (SQ) maintenance dose, *Continue to 45*

❒ Continuation of the subcutaneous (SQ) maintenance dose, *Continue to 43*

43. Has the patient achieved or maintained remission OR 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? ***ACTION REQUIRED***: If Yes, please attach chart notes or medical record documentation of remission.

❒ Yes, achieved or maintained remission ***ACTION REQUIRED****: Submit supporting documentation, Continue to 45*

❒ Yes, achieved or maintained a positive clinical response, *Continue to 44*

❒ No or none of the above, *Continue to 44*

44. 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 to therapy.

❒ Stool frequency ***ACTION REQUIRED****: Submit supporting documentation, Continue to 45*

❒ Rectal bleeding ***ACTION REQUIRED****: Submit supporting documentation, Continue to 45*

❒ Urgency of defecation ***ACTION REQUIRED****: Submit supporting documentation, Continue to 45*

❒ C-reactive protein (CRP) ***ACTION REQUIRED****: Submit supporting documentation, Continue to 45*

❒ Fecal calprotectin (FC) ***ACTION REQUIRED****: Submit supporting documentation, Continue to 45*

❒ Appearance of the mucosa on endoscopy, computed tomography enterography (CTE), magnetic resonance enterography (MRE), or intestinal ultrasound ***ACTION REQUIRED****: Submit supporting documentation, Continue to 45*

❒ Improvement on a disease activity scoring tool (e.g., Ulcerative Colitis Endoscopic Index of Severity [UCEIS], Mayo Score) ***ACTION REQUIRED****: Submit supporting documentation, Continue to 45*

❒ None of the above, *Continue to 45*

45. What is the diagnosis?

❒ Plaque psoriasis, *Continue to 46*

❒ Psoriatic arthritis WITH co-existent plaque psoriasis, *Continue to 46*

❒ Psoriatic arthritis, *Continue to 46*

❒ Ulcerative colitis, *Continue to 51*

46. Is the patient currently receiving Tremfya?

❒ Yes, *Continue to 49*

❒ No, *Continue to 47*

47. 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 48*

❒ No, *Continue to 48*

48. Is the prescribed frequency for the maintenance dose more frequent than one dose every 8 weeks?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

49. Does the prescribed dose exceed 100 mg?
❒ Yes, *Continue to 50*
❒ No, *Continue to 50*

50. Is the prescribed frequency for the maintenance dose more frequent than one dose every 8 weeks?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

51. Which of the following applies to this request for the requested drug?

❒ Initiation of the intravenous (IV) loading dose, *Continue to 52*

❒ Initiation of the subcutaneous (SQ) maintenance dose, *Continue to 54*

❒ Continuation of the subcutaneous (SQ) maintenance dose, *Continue to 54*

52. Does the prescribed dose exceed a loading dose of 200 mg at weeks 0, 4, and 8, and a maintenance dose of 200 mg thereafter?
❒ Yes, *Continue to 53*
❒ No, *Continue to 53*

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

54. Does the prescribed dose exceed 200 mg?
❒ Yes, *Continue to 55*
❒ No, *Continue to 55*

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

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