Rituxan, Ruxience, Truxima, Riabni

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? _____

What product is being requested? ❒ Rituxan ❒ Ruxience ❒ Riabni ❒ Truxima

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

 Carefirst MR C26689-A Rituxan, Ruxience, Truxima, Riabni SGM 1704-A – 02/2025.

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. What is the requested product?

❒Riabni, *Continue to B*

❒ Truxima, *Skip to Clinical Criteria Questions*

❒ Rituxan, *Continue to B*

❒ Ruxience, *Skip to Clinical Criteria Questions*

B. The preferred products for your patient's health plan are Ruxience and Truxima. Can the patient's treatment be switched to one of the preferred products?

❒ Yes, Ruxience, *Skip to Clinical Criteria Questions.*

❒ Yes, Truxima, *Skip to Clinical Criteria Questions*

❒ No, *Continue to Question C*

C. Did the patient have a documented intolerable adverse event to both preferred products (Ruxience and Truxima)? ***Action Required***: If 'Yes', attach supporting chart note(s)

❒ Yes, *Continue to Question D*

❒ No, *Continue to Question E*

D. Was the documented intolerable adverse event an expected adverse event attributed to the active ingredient as described in the prescribing information (i.e., known adverse reaction for both the reference product and biosimilar products)? ***Action Required***: If 'Yes', attach supporting chart note(s)

❒ Yes, *Continue to Question E*

❒ No, *Skip to Clinical Criteria Questions*

E. Did the patient have a documented inadequate response to both preferred products (Ruxience and Truxima)? ***Action Required***: If 'Yes', attach supporting chart note(s)

❒ Yes, *Skip to Clinical Criteria Questions*

❒ No, *Continue to Question F*

F. Does the patient have a contraindication to both preferred products (Ruxience and Truxima)? ***Action Required***: If 'Yes', attach supporting chart note(s)

❒ Yes, *Continue to Clinical Criteria Questions*

❒ No, *Continue to Clinical Criteria Questions*

Criteria Questions:

1. What is the diagnosis?

❒ Autoimmune blistering disease (e.g., pemphigus vulgaris, pemphigus foliaceus, bullous pemphigoid, cicatricial pemphigoid, epidermolysis bullosa acquisita and paraneoplastic pemphigus), *Continue to 7*

❒ Autoimmune hemolytic anemia, *Continue to 10*

❒ B-cell acute lymphoblastic leukemia (ALL), CD20 positive, *Continue to 2*

❒ B-cell lymphoblastic lymphoma, CD20 positive, *Continue to 2*

❒ Burkitt lymphoma, CD20 positive, *Continue to 2*

❒ Castleman's disease, CD20 positive, *Continue to 2*

❒ Chronic graft-versus-host disease, *Continue to 10*

❒ Chronic lymphocytic leukemia (CLL), CD20 positive, *Continue to 2*

❒ Churg-Strauss syndrome, *Continue to 9*

❒ Cryoglobulinemia, *Continue to 53*

❒ Diffuse large B-cell lymphoma (DLBCL), CD20 positive, *Continue to 2*

❒ Extranodal marginal zone lymphoma (gastric and non-gastric MALT lymphoma), CD20 positive, *Continue to 2*

❒ Follicular lymphoma, CD20 positive, *Continue to 2*

❒ Granulomatosis with polyangiitis (GPA) (Wegener's granulomatosis), *Continue to 9*

❒ Hairy cell leukemia, CD20 positive, *Continue to 2*

❒ High-grade B-cell lymphoma with translocations of MYC and BCL2 and/or BCL6 (double/triple hit lymphoma), CD20 positive, *Continue to 2*

❒ High-grade B-cell lymphoma, not otherwise specified, CD20 positive, *Continue to 2*

❒ Histological transformation from indolent lymphoma to diffuse large B-cell lymphoma, CD20 positive, *Continue to 2*

❒ Histological transformation of indolent lymphomas to high-grade B-cell lymphoma with MYC and BCL6 without BCL2 rearrangements, CD20 positive, *Continue to 2*

❒ HIV-related B-cell lymphoma, CD20 positive, *Continue to 2*

❒ Hodgkin's lymphoma, nodular lymphocyte-predominant, CD20 positive, *Continue to 2*

❒ Immune checkpoint inhibitor-related toxicities, *Continue to 5*

❒ Immune or idiopathic thrombocytopenic purpura (ITP), refractory, *Continue to 10*

❒ Leptomeningeal metastases from lymphomas, CD20 positive, *Continue to 2*

❒ Mantle cell lymphoma, CD20 positive, *Continue to 2*

❒ Nodal marginal zone lymphoma, CD20 positive, *Continue to 2*

❒ Microscopic polyangiitis (MPA), *Continue to 9*

❒ Multiple sclerosis (MS), *Continue to 42*

❒ Myasthenia gravis, refractory, *Continue to 8*

❒ Neuromyelitis optica (i.e., neuromyelitis optica spectrum disorder, NMOSD, Devic disease), *Continue to 50*

❒ Opsoclonus-myoclonus-ataxia, *Continue to 58*

❒ Pauci-immune glomerulonephritis, *Continue to 9*

❒ Pediatric aggressive mature B-cell lymphomas, CD20 positive, *Continue to 2*

❒ Post-transplant lymphoproliferative disorder (PTLD), CD20 positive, *Continue to 2*

❒ Prevention of Epstein-Barr virus (EBV) related post-transplant lymphoproliferative disorder (PTLD), *Continue to 10*

❒ Primary central nervous system (CNS) lymphoma, CD20 positive, *Continue to 2*

❒ Primary cutaneous B-cell lymphoma, CD20 positive, *Continue to 2*

❒ Primary Mediastinal Large B-Cell Lymphoma, CD20 positive, *Continue to 2*

❒ Rheumatoid arthritis (RA), *Continue to 16*

❒ Rosai-Dorfman disease, CD20 positive, *Continue to 2*

❒ Sjogren's syndrome, *Continue to 47*

❒ Small lymphocytic lymphoma (SLL), CD20 positive, *Continue to 2*

❒ Treatment of solid organ transplant and prevention of antibody-mediated rejection in solid organ transplant, *Continue to 56*

❒ Splenic marginal zone lymphoma, CD20 positive, *Continue to 2*

❒ Systemic lupus erythematosus (SLE), *Continue to 12*

❒ Thrombotic thrombocytopenic purpura (TTP), *Continue to 10*

❒ Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma (LPL), Bing-Neel syndrome, CD20 positive, *Continue to 2*

❒ Membranous nephropathy, *Continue to 63*

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

2. Is this a request for continuation of therapy with the requested drug?
❒ Yes, *Continue to 4*
❒ No, *Continue to 3*

3. Does the patient have CD20 positive disease that was confirmed by testing or analysis? ***ACTION REQUIRED***: If Yes, attach chart note(s) or test results confirming CD20 protein on the surface of the B-cell.

❒ Yes ***ACTION REQUIRED****: Submit supporting documentation, No further questions*

❒ No, *No further questions*

❒ Unknown, *No further questions*

4. Is there evidence of unacceptable toxicity while on the current regimen?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

5. Is this a request for continuation of therapy with the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 6*
❒ No, *No Further Questions*

6. Is the patient experiencing benefit from therapy?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

7. Will the requested drug be prescribed by or in consultation with a dermatologist or immunologist?
❒ Yes, *Continue to 10*
❒ No, *Continue to 10*

8. Will the requested drug be prescribed by or in consultation with a neurologist, rheumatologist, or immunologist?

❒ Yes, *Continue to 10*
❒ No, *Continue to 10*

9. Will the requested drug be prescribed by or in consultation with a rheumatologist, immunologist, or nephrologist?
❒ Yes, *Continue to 10*
❒ No, *Continue to 10*

10. Is this a request for continuation of therapy with the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 11*
❒ No, *No Further Questions*

11. Is the patient experiencing benefit from therapy?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

12. Will the requested drug be prescribed by or in consultation with a rheumatologist, immunologist, or nephrologist?
❒ Yes, *Continue to 13*
❒ No, *Continue to 13*

13. Is this a request for continuation of therapy with the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 15*
❒ No, *Continue to 14*

14. Is the disease refractory to immunosuppressive therapy? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy.
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

15. Is the patient experiencing benefit from therapy?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

16. 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 rheumatoid arthritis?
❒ Yes, *Continue to 17*
❒ No, *Continue to 17*

17. Has the patient been diagnosed with moderately to severely active rheumatoid arthritis (RA)?
❒ Yes, *Continue to 18*
❒ No, *Continue to 18*

18. Is the patient an adult (18 years of age or older)?
❒ Yes, *Continue to 19*
❒ No, *Continue to 19*

19. Will the requested drug be prescribed by or in consultation with a rheumatologist, immunologist, or nephrologist?
❒ Yes, *Continue to 20*
❒ No, *Continue to 20*

20. Is the planned date of administration at least 16 weeks after the date of the last dose received?
❒ Yes, *Continue to 21*
❒ No, *Continue to 21*
❒ Not applicable - Patient has not received any previous doses, *Continue to 21*

21. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 22*
❒ No, *Continue to 26*

22. Is the patient currently receiving the requested drug or a biosimilar of the requested drug through samples or a manufacturer's patient assistance program?
❒ Yes, *Continue to 26*
❒ No, *Continue to 23*
❒ Unknown, *Continue to 26*

23. How many doses in total has the patient received since starting treatment with the requested medication?
❒ 1 dose, *Continue to 26*
❒ 2 doses (one complete course) or more, *Continue to 24*

24. Has the patient achieved or maintained a positive clinical response since starting treatment with the requested medication?
❒ Yes, *Continue to 25*
❒ No, *Continue to 25*

25. 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, *No Further Questions*
❒ No, *No Further Questions*

26. 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 27*
❒ No, *Continue to 31*

27. Is the requested medication being prescribed in combination with methotrexate or leflunomide?
❒ Yes, *No Further Questions*
❒ No, *Continue to 28*

28. Has the patient experienced an intolerance to methotrexate or leflunomide? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy.
❒ Yes, *No Further Questions*
❒ No, *Continue to 29*

29. 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 30*
❒ No, *Continue to 30*

30. Please indicate the contraindication.
❒ Clinical diagnosis of alcohol use disorder, alcoholic liver disease or other chronic liver disease, *No further questions*
❒ Drug interaction, *No further questions*
❒ Risk of treatment-related toxicity, *No further questions*
❒ Pregnancy or currently planning pregnancy, *No further questions*
❒ Breastfeeding, *No further questions*
❒ Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension), *No further questions*
❒ Hypersensitivity, *No further questions*
❒ History of intolerance or adverse event, *No further questions*
❒ Other, please specify. _____, *No further questions*

31. 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 33*
❒ No, *Continue to 32*

32. 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 33*
❒ No, *Continue to 33*

33. Is the requested drug being prescribed in combination with methotrexate or leflunomide?
❒ Yes, *Continue to 37*
❒ No, *Continue to 34*

34. Has the patient experienced an intolerance to methotrexate or leflunomide? ***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 37*
❒ No, *Continue to 35*

35. 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 36*
❒ No, *Continue to 36*

36. Please indicate the contraindication.

❒ Clinical diagnosis of alcohol use disorder, alcoholic liver disease or other chronic liver disease, *Continue to 37*

❒ Drug interaction, *Continue to 37*

❒ Risk of treatment-related toxicity, *Continue to 37*

❒ Pregnancy or currently planning pregnancy, *Continue to 37*

❒ Breastfeeding, *Continue to 37*
❒ Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension), *Continue to 37*

❒ Hypersensitivity, *Continue to 37*

❒ History of intolerance or adverse event, *Continue to 37*

❒ Other, please specify. _____, *Continue to 37*

37. 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, *No Further Questions*
❒ No, *Continue to 38*

38. 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 41*
❒ No, *Continue to 39*

39. Does the patient have a contraindication to methotrexate? ***ACTION REQUIRED***: If Yes, please attach documentation of clinical reason to avoid therapy.
❒ Yes, *Continue to 40*
❒ No, *Continue to 40*

40. Please indicate the contraindication.

❒ Clinical diagnosis of alcohol use disorder, alcoholic liver disease or other chronic liver disease, *Continue to 41*

❒ Drug interaction, *Continue to 41*

❒ Risk of treatment-related toxicity, *Continue to 41*

❒ Pregnancy or currently planning pregnancy, *Continue to 41*

❒ Breastfeeding, *Continue to 41*
❒ Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension), *Continue to 41*

❒ Hypersensitivity, *Continue to 41*

❒ History of intolerance or adverse event, *Continue to 41*

❒ Other, please specify. _____, *Continue to 41*

41. Has the patient experienced an inadequate response with another conventional drug (e.g., hydroxychloroquine, leflunomide, sulfasalazine)? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy.
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

42. Has the patient been diagnosed with relapsing-remitting multiple sclerosis (RRMS)?
❒ Yes, *Continue to 43*
❒ No, *Continue to 43*

43. Will the patient be taking the requested drug with any other drug used for the treatment of multiple sclerosis excluding Ampyra?
❒ Yes, *Continue to 44*
❒ No, *Continue to 44*

44. Will the requested drug be prescribed by or in consultation with a neurologist, rheumatologist, or immunologist?
❒ Yes, *Continue to 45*
❒ No, *Continue to 45*

45. Is this a request for continuation of therapy with the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 46*
❒ No, *No Further Questions*

46. Is the patient experiencing disease stability or improvement while receiving the requested drug?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

47. Will the requested drug be prescribed by or in consultation with a rheumatologist, ophthalmologist, or immunologist?
❒ Yes, *Continue to 48*
❒ No, *Continue to 48*

48. Is this a request for continuation of therapy with the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 62*
❒ No, *Continue to 49*

49. Have corticosteroids and other immunosuppressive agents been ineffective? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy.
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

50. Will the requested drug be prescribed by or in consultation with a neurologist, rheumatologist, or immunologist?
❒ Yes, *Continue to 51*
❒ No, *Continue to 51*

51. Will the patient receive the requested drug concomitantly with other biologics for the treatment of neuromyelitis optica spectrum disorder (NMOSD)?
❒ Yes, *Continue to 52*
❒ No, *Continue to 52*

52. Is this a request for continuation of therapy with the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 62*
❒ No, *No Further Questions*

53. Will the requested drug be prescribed by or in consultation with a hematologist, rheumatologist, neurologist, or nephrologist?
❒ Yes, *Continue to 54*
❒ No, *Continue to 54*

54. Is this a request for continuation of therapy with the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 62*
❒ No, *Continue to 55*

55. Have corticosteroids and other immunosuppressive agents been ineffective? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy.
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

56. Will the requested drug be prescribed by or in consultation with an immunologist or transplant specialist?
❒ Yes, *Continue to 57*
❒ No, *Continue to 57*

57. Is this a request for continuation of therapy with the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 62*
❒ No, *No Further Questions*

58. Will the requested drug be prescribed by or in consultation with a neurologist, rheumatologist, or immunologist?
❒ Yes, *Continue to 59*
❒ No, *Continue to 59*

59. Is this a request for continuation of therapy with the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 62*
❒ No, *Continue to 60*

60. Is the requested drug being used for opsoclonus-myoclonus-ataxia associated with neuroblastoma?
❒ Yes, *Continue to 61*
❒ No, *Continue to 61*

61. Is the patient refractory to steroids and chemotherapy? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy.

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

62. Is the patient experiencing benefit from therapy?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

63. Will the requested drug be prescribed by or in consultation with a nephrologist?
❒ Yes, *Continue to 64*
❒ No, *Continue to 64*

64. Is the request for continuation of therapy with the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 66*
❒ No, *Continue to 65*

65. Is the patient at moderate to high risk for disease progression?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

66. Is the patient experiencing benefit from therapy?
❒ 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