Remicade and Biosimilars

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 C26635-D, Remicade and biosimilars SOC SGM 2182-A, 5960-A – 01/2025

Exception Criteria Questions:

A. What product is being requested?

❑ Avsola, *Continue to Skip to Site of Service Questions*
❑ Inflectra, *Continue to Skip to Site of Service Questions*
❑ Renflexis, *Continue to Question B*
❑ Infliximab, *Continue to Question B*
❑ Remicade, *Continue to Question B*

B. The preferred products for your patient's health plan are Avsola, and Inflectra. Can the patient's treatment be switched to the preferred product?

❒ Yes, Avsola, *Skip to Site of Service Questions*
❒ Yes, Inflectra, *Skip to Site of Service Questions*
❒ No, *Continue to Question C*

C. Did the patient have a documented intolerable adverse event to BOTH of the preferred products (Avsola and Inflectra)? ***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 'no', attach supporting chart note(s)*

❒ Yes, *Continue to Question E*

❒ No, *Skip to Site of Service Questions*

E. Did the patient have a documented inadequate response to BOTH of the preferred products (Avsola and Inflectra)? ***ACTION REQUIRED****: If yes, attach supporting chart note(s)*

❒ Yes, *Skip to Site of Service Questions*

❒ No, *Continue to Question F*

F. Does the patient have a contraindication to BOTH of the preferred products (Avsola and Inflectra)? ***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:

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?
❑ Yes – This is a continuation of an existing treatment, *Continue to D*
❑ Yes – This is a continuation request, however a gap in therapy of greater than 2 doses has occurred, ***ACTION REQUIRED: Please attach supporting clinical documentation.*** *Skip to Clinical Criteria Questions*
❑ No – This is a new therapy request (patient has not received requested medication in the last 6 months), ***ACTION REQUIRED: Please attach supporting clinical documentation.*** *Skip to Clinical Criteria Questions*
❑ No – This is a request for a different brand infliximab product that the patient has not received previously, ***ACTION REQUIRED: Please attach supporting clinical documentation.*** *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, other pre-medications or slowing of the infusion rate) 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. Does the patient have laboratory confirmed antibodies to infliximab? ***ACTION REQUIRED: If Yes, please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions*
❑ No, *Continue to F*

F. 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 G*

G. 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 H*

H. 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 I*

I. 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*

Criteria Questions:

What product is being requested? ❑ Remicade ❑ Avsola ❑ Inflectra ❑ Renflexis ❑ Zymfentra

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 (TB)?

❒ 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?

❒ Crohn's disease, *Continue to 9*
❒ Ulcerative colitis, *Continue to 18*
❒ Rheumatoid arthritis, *Continue to 27*
❒ Ankylosing spondylitis, *Continue to 46*
❒ Non-radiographic axial spondyloarthritis, *Continue to 46*
❒ Psoriatic arthritis, *Continue to 56*
❒ Psoriatic arthritis WITH co-existent plaque psoriasis, *Continue to 7*
❒ Plaque psoriasis, *Continue to 72*
❒ Behcet's disease, *Continue to 88*
❒ Hidradenitis suppurativa, *Continue to 95*
❒ Pyoderma gangrenosum, *Continue to 106*
❒ Sarcoidosis, *Continue to 114*
❒ Takayasu's arteritis, *Continue to 121*
❒ Uveitis, *Continue to 129*

❒ Reactive arthritis, *Continue to 138*

❒ Immune checkpoint inhibitor-related toxicity, *Continue to 150*

❒ Immune checkpoint inhibitor-related inflammatory arthritis, *Continue to 154*

❒ Acute graft versus host disease, *Continue to 164*

❒ 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 57*

❒ Plaque psoriasis, *Continue to 73*

9. Has the patient been diagnosed with moderately to severely active Crohn's disease (CD)?
❒ Yes, *Continue to 10*
❒ No, *Continue to 10*

10. Is the patient 6 years of age or older?
❒ Yes, *Continue to 11*
❒ No, *Continue to 11*

11. Is the requested drug being prescribed by or in consultation with a gastroenterologist?
❒ Yes, *Continue to 12*
❒ No, *Continue to 12*

12. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 13*
❒ No, *Continue to 168*

13. Has the patient achieved or maintained remission? ***ACTION REQUIRED***: If Yes, please attach chart notes or medical record documentation of remission.
❒ Yes, *Continue to 168*
❒ No, *Continue to 14*

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 or a biosimilar of the requested drug?
❒ Yes, *Continue to 15*
❒ No, *Continue to 16*

15. 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.

❒ Abdominal pain or tenderness ***ACTION REQUIRED****: Submit supporting documentation, Continue to 168*

❒ Diarrhea ***ACTION REQUIRED****: Submit supporting documentation, Continue to 168*

❒ Body weight ***ACTION REQUIRED****: Submit supporting documentation, Continue to 168*

❒ Abdominal mass ***ACTION REQUIRED****: Submit supporting documentation, Continue to 168*

❒ Hematocrit ***ACTION REQUIRED****: Submit supporting documentation, Continue to 168*

❒ Appearance of the mucosa on endoscopy, computed tomography enterography (CTE), magnetic resonance enterography (MRE), or intestinal ultrasound ***ACTION REQUIRED****: Submit supporting documentation, Continue to 168*

❒ Improvement on a disease activity scoring tool (e.g., Crohn's Disease Activity Index [CDAI] score) ***ACTION REQUIRED****: Submit supporting documentation, Continue to 168*

❒ None of the above, *Continue to 16*

16. Is the request for Zymfentra?
❒ Yes, *No Further Questions*
❒ No, *Continue to 17*

17. Is this request for an increase in dosing regimen due to the patient not achieving an adequate clinical response at the current dose?
❒ Yes, *Continue to 168*
❒ No, *Continue to 168*

18. Has the patient been diagnosed with moderately to severely active ulcerative colitis (UC)?
❒ Yes, *Continue to 19*
❒ No, *Continue to 19*

19. Is the patient 6 years of age or older?
❒ Yes, *Continue to 20*
❒ No, *Continue to 20*

20. Is the requested drug being prescribed by or in consultation with a gastroenterologist?
❒ Yes, *Continue to 21*
❒ No, *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 168*

22. Has the patient achieved or maintained remission? ***ACTION REQUIRED***: If Yes, please attach chart notes or medical record documentation of remission.
❒ Yes, *Continue to 168*
❒ No, *Continue to 23*

23. 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 24*
❒ No, *Continue to 25*

24. 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 168*

❒ Rectal bleeding ***ACTION REQUIRED****: Submit supporting documentation, Continue to 168*

❒ Urgency of defecation ***ACTION REQUIRED****: Submit supporting documentation, Continue to 168*

❒ C-reactive protein (CRP) ***ACTION REQUIRED****: Submit supporting documentation, Continue to 168*

❒ Fecal calprotectin (FC) ***ACTION REQUIRED****: Submit supporting documentation, Continue to 168*

❒ Appearance of the mucosa on endoscopy, computed tomography enterography (CTE), magnetic resonance enterography (MRE), or intestinal ultrasound ***ACTION REQUIRED****: Submit supporting documentation, Continue to 168*

❒ 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 168*

❒ None of the above, *Continue to 25*

25. Is the request for Zymfentra?
❒ Yes, *Continue to 26*
❒ No, *Continue to 26*

26. Is this request for an increase in dosing regimen due to the patient not achieving an adequate clinical response at the current dose?
❒ Yes, *Continue to 168*
❒ No, *Continue to 168*

27. Has the patient been diagnosed with moderately to severely active rheumatoid arthritis (RA)?
❒ Yes, *Continue to 28*
❒ No, *Continue to 28*

28. Is the patient an adult (18 years of age or older)?
❒ Yes, *Continue to 29*
❒ No, *Continue to 29*

29. Is the requested drug being prescribed by or in consultation with a rheumatologist?
❒ Yes, *Continue to 30*
❒ No, *Continue to 30*

30. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 31*
❒ No, *Continue to 35*

31. 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 35*

❒ No, *Continue to 32*

❒ Unknown, *Continue to 35*

32. Has the patient achieved or maintained a positive clinical response since starting treatment with the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 33*
❒ No, *Continue to 34*

33. 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 168*
❒ No, *Continue to 34*

34. Is this a request for an increase in dosing regimen due to the patient not achieving an adequate clinical response at the current dose or frequency?
❒ Yes, *Continue to 168*
❒ No, *Continue to 168*

35. 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 36*
❒ No, *Continue to 38*

36. Is the requested medication being prescribed in combination with methotrexate or leflunomide?
❒ Yes, *Continue to 168*
❒ No, *Continue to 37*

37. Please indicate a clinical reason for the patient to not use methotrexate or leflunomide.
❒ Clinical diagnosis of alcohol use disorder, alcoholic liver disease, or other chronic liver disease, *Continue to 168*

❒ Drug interaction, *Continue to 168*

❒ Risk of treatment-related toxicity, *Continue to 168*

❒ Pregnancy or currently planning pregnancy, *Continue to 168*

❒ Breastfeeding, *Continue to 168*
❒ Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension), *Continue to 168*

❒ Hypersensitivity, *Continue to 168*

❒ History of intolerance or adverse event, *Continue to 168*

❒ Other, please specify. _____, *Continue to 168*

❒ No clinical reason not to use methotrexate or leflunomide, *Continue to 168*

38. 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 40*
❒ No, *Continue to 39*

39. 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 40*
❒ No, *Continue to 40*

40. Is the requested medication being prescribed in combination with methotrexate or leflunomide?
❒ Yes, *Continue to 42*
❒ No, *Continue to 41*

41. Please indicate a clinical reason for the patient to not use methotrexate or leflunomide.

❒ Clinical diagnosis of alcohol use disorder, alcoholic liver disease, or other chronic liver disease, *Continue to 42*

❒ Drug interaction, *Continue to 42*

❒ Risk of treatment-related toxicity, *Continue to 42*

❒ Pregnancy or currently planning pregnancy, *Continue to 42*

❒ Breastfeeding, *Continue to 42*
❒ Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension), *Continue to 42*

❒ Hypersensitivity, *Continue to 42*

❒ History of intolerance or adverse event, *Continue to 42*

❒ Other, please specify. _____, *Continue to 42*

❒ No clinical reason not to use methotrexate or leflunomide, *Continue to 42*

42. 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 168*
❒ No, *Continue to 43*

43. 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 168*
❒ No, *Continue to 44*

44. Does the patient have a contraindication to methotrexate? ***ACTION REQUIRED***: If Yes, please attach documentation of clinical reason to avoid therapy.
❒ Yes, *Continue to 45*
❒ No, *Continue to 45*

45. Please indicate the contraindication to methotrexate.
❒ Clinical diagnosis of alcohol use disorder, alcoholic liver disease, or other chronic liver disease, *Continue to 168*

❒ Drug interaction, *Continue to 168*

❒ Risk of treatment-related toxicity, *Continue to 168*

❒ Pregnancy or currently planning pregnancy, *Continue to 168*

❒ Breastfeeding, *Continue to 168*

❒ Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension), *Continue to 168*

❒ Hypersensitivity, *Continue to 168*

❒ History of intolerance or adverse event, *Continue to 168*

❒ Other, please specify _____, *Continue to 168*

46. Is the patient an adult (18 years of age or older)?
❒ Yes, *Continue to 47*
❒ No, *Continue to 47*

47. Is the requested drug being prescribed by or in consultation with a rheumatologist?
❒ Yes, *Continue to 48*
❒ No, *Continue to 48*

48. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 49*
❒ No, *Continue to 53*

49. 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 53*

❒ No, *Continue to 50*

❒ Unknown, *Continue to 53*

50. 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 51*
❒ No, *Continue to 52*

51. 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.

❒ Functional status ***ACTION REQUIRED****: Submit supporting documentation, Continue to 168*

❒ Total spinal pain ***ACTION REQUIRED****: Submit supporting documentation, Continue to 168*
❒ Inflammation (e.g., morning stiffness) ***ACTION REQUIRED****: Submit supporting documentation, Continue to 168*

❒ Swollen joints ***ACTION REQUIRED****: Submit supporting documentation, Continue to 168*

❒ Tender joints ***ACTION REQUIRED****: Submit supporting documentation, Continue to 168*

❒ C-reactive protein (CRP) ***ACTION REQUIRED****: Submit supporting documentation, Continue to 168*

❒ None of the above, *Continue to 52*

52. Is this request for an increase in dosing regimen due to the patient not achieving an adequate clinical response at the current dose?

❒ Yes, *Continue to 168*
❒ No, *Continue to 168*

53. Has the patient been diagnosed with active ankylosing spondylitis (AS) or active non-radiographic axial spondyloarthritis (nr-axSpA)?

❒ Yes - Active ankylosing spondylitis, *Continue to 54*

❒ Yes - Active non-radiographic axial spondyloarthritis, *Continue to 54*

❒ No, *Continue to 54*

54. 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 active ankylosing spondylitis or active non-radiographic axial spondyloarthritis (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 168*
❒ No, *Continue to 55*

55. Has the patient experienced an inadequate response with at least TWO non-steroidal anti-inflammatory drugs (NSAIDs), or has an intolerance or contraindication to at least two NSAIDs? ***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 168*
❒ No, *Continue to 168*

56. Is the requested drug being prescribed by or in consultation with a rheumatologist or dermatologist?
❒ Yes, *Continue to 57*
❒ No, *Continue to 57*

57. Is the patient an adult (18 years of age or older)?
❒ Yes, *Continue to 58*
❒ No, *Continue to 58*

58. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 59*
❒ No, *Continue to 63*

59. 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 63*

❒ No, *Continue to 60*

❒ Unknown, *Continue to 63*

60. 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 61*
❒ No, *Continue to 62*

61. 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 168*

❒ Number of tender joints ***ACTION REQUIRED****: Submit supporting documentation, Continue to 168*

❒ Dactylitis ***ACTION REQUIRED****: Submit supporting documentation, Continue to 168*

❒ Enthesitis ***ACTION REQUIRED****: Submit supporting documentation, Continue to 168*

❒ Axial disease ***ACTION REQUIRED****: Submit supporting documentation, Continue to 168*

❒ Skin and/or nail involvement ***ACTION REQUIRED****: Submit supporting documentation, Continue to 168*

❒ Functional status ***ACTION REQUIRED****: Submit supporting documentation, Continue to 168*

❒ C-reactive protein (CRP) ***ACTION REQUIRED****: Submit supporting documentation, Continue to 168*

❒ None of the above, *Continue to 62*

62. Is this request for an increase in dosing regimen due to the patient not achieving an adequate clinical response at the current dose?
❒ Yes, *Continue to 168*
❒ No, *Continue to 168*

63. Has the patient been diagnosed with active psoriatic arthritis (PsA)?
❒ Yes, *Continue to 64*
❒ No, *Continue to 64*

64. Has the patient ever received or is currently receiving a biologic (e.g., Humira) or targeted synthetic drug (e.g., Rinvoq, Otezla) indicated for 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 168*
❒ No, *Continue to 65*

65. What is the patient's disease severity?

❒ Mild to moderate, *Continue to 66*

❒ Severe, *Continue to 168*

66. Does the patient have enthesitis or predominantly axial disease?
❒ Yes, *Continue to 168*
❒ No, *Continue to 67*

67. 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 168*
❒ No, *Continue to 68*

68. 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 168*
❒ No, *Continue to 69*

69. 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 70*
❒ No, *Continue to 71*

70. Please indicate the contraindication to methotrexate or leflunomide.
❒ Clinical diagnosis of alcohol use disorder, alcoholic liver disease, or other chronic liver disease, *Continue to 168*

❒ Drug interaction, *Continue to 168*

❒ Risk of treatment-related toxicity, *Continue to 168*

❒ Pregnancy or currently planning pregnancy, *Continue to 168*

❒ Breastfeeding, *Continue to 168*
❒ Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension), *Continue to 168*

❒ Hypersensitivity, *Continue to 168*

❒ History of intolerance or adverse event, *Continue to 168*

❒ Other, please specify _____, *Continue to 168*

71. 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 168*
❒ No, *Continue to 168*

72. Is the requested drug being prescribed by or in consultation with a dermatologist?
❒ Yes, *Continue to 73*
❒ No, *Continue to 73*

73. Has the patient been diagnosed with moderate to severe plaque psoriasis?
❒ Yes, *Continue to 74*
❒ No, *Continue to 74*

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

75. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 76*
❒ No, *Continue to 81*

76. 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 81*

❒ No, *Continue to 77*

❒ Unknown, *Continue to 81*

77. 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 78*
❒ No, *Continue to 80*

78. 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 168*
❒ No, *Continue to 79*

79. 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 168*
❒ No, *Continue to 80*

80. Is this request for an increase in dosing regimen due to the patient not achieving an adequate clinical response at the current dose?
❒ Yes, *Continue to 168*
❒ No, *Continue to 168*

81. 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 168*
❒ No, *Continue to 82*

82. 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 168*
❒ No, *Continue to 83*

83. Is the percentage of body surface area (BSA) affected (prior to starting the requested medication) less than 3%?
❒ Yes, *Continue to 84*
❒ No, *Continue to 84*

84. 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 affected areas and body surface area affected.
❒ Greater than or equal to 3% to less than 10% of BSA _____ ***ACTION REQUIRED****: Submit supporting documentation, Continue to 85*
❒ Greater than or equal to 10% of BSA _____ ***ACTION REQUIRED****: Submit supporting documentation, Continue to 168*

85. 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 168*
❒ No, *Continue to 86*

86. 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 therapy.
❒ Yes, *Continue to 87*
❒ No, *Continue to 168*

87. Please indicate 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 168*

❒ Drug interaction, *Continue to 168*

❒ Risk of treatment-related toxicity, *Continue to 168*

❒ Pregnancy or currently planning pregnancy, *Continue to 168*

❒ Breastfeeding, *Continue to 168*
❒ Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension), *Continue to 168*

❒ Hypersensitivity, *Continue to 168*

❒ History of intolerance or adverse event, *Continue to 168*

❒ Other, please specify. _____, *Continue to 168*

88. Is the requested drug being prescribed by or in consultation with a rheumatologist?
❒ Yes, *Continue to 89*
❒ No, *Continue to 89*

89. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 90*
❒ No, *Continue to 93*

90. 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 93*

❒ No, *Continue to 91*

❒ Unknown, *Continue to 93*

91. 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 168*
❒ No, *Continue to 92*

92. Is this request for an increase in dosing regimen due to the patient not achieving an adequate clinical response at the current dose?
❒ Yes, *Continue to 168*
❒ No, *Continue to 168*

93. Has the patient ever received or is currently receiving Otezla or a biologic (e.g., Humira) indicated for the treatment of Behcet's disease (excluding receiving the drug via samples or a manufacturer's patient assistance program)? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried.
❒ Yes, *Continue to 168*
❒ No, *Continue to 94*

94. Has the patient had an inadequate response to at least one non-biologic medication for Behcet's disease (e.g., azathioprine, colchicine, cyclosporine, 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 168*
❒ No, *Continue to 168*

95. Has the patient been diagnosed with severe, refractory hidradenitis suppurativa?
❒ Yes, *Continue to 96*
❒ No, *Continue to 96*

96. Is the requested drug being prescribed by or in consultation with a rheumatologist or dermatologist?
❒ Yes, *Continue to 97*
❒ No, *Continue to 97*

97. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 98*
❒ No, *Continue to 102*

98. 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 102*

❒ No, *Continue to 99*

❒ Unknown, *Continue to 102*

99. 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 100*
❒ No, *Continue to 101*

100. Which of the following signs and symptoms has the patient experienced an improvement in from baseline? ***ACTION REQUIRED***: Please attach chart notes or medical record documentation supporting positive clinical response.
❒ Reduction in abscess and inflammatory nodule count from baseline ***ACTION REQUIRED****: Submit supporting documentation, Continue to 168*
❒ Reduced formation of new sinus tracts and scarring ***ACTION REQUIRED****: Submit supporting documentation, Continue to 168*

❒ Decrease in frequency of inflammatory lesions from baseline ***ACTION REQUIRED****: Submit supporting documentation, Continue to 168*

❒ Reduction in pain from baseline ***ACTION REQUIRED****: Submit supporting documentation, Continue to 168*
❒ Reduction in suppuration from baseline ***ACTION REQUIRED****: Submit supporting documentation, Continue to 168*
❒ Improvement in frequency of relapses from baseline ***ACTION REQUIRED****: Submit supporting documentation, Continue to 168*
❒ Improvement in quality of life from baseline ***ACTION REQUIRED****: Submit supporting documentation, Continue to 168*
❒ Improvement on a disease severity assessment tool from baseline ***ACTION REQUIRED****: Submit supporting documentation, Continue to 168*

❒ None of the above, *Continue to 101*

101. Is this request for an increase in dosing regimen due to the patient not achieving an adequate clinical response at the current dose?
❒ Yes, *Continue to 168*
❒ No, *Continue to 168*

102. Has the patient ever received or is currently receiving a biologic (e.g., Humira) indicated for the treatment of severe, refractory hidradenitis suppurativa (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 168*
❒ No, *Continue to 103*

103. Has the patient had an inadequate response after at least 90 days of treatment with an oral antibiotic used for the treatment of hidradenitis suppurativa (e.g., clindamycin, metronidazole, moxifloxacin, rifampin, tetracyclines)? ***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 168*
❒ No, *Continue to 104*

104. Has the patient had an intolerance to oral antibiotics used for the treatment of hidradenitis suppurativa? ***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 168*
❒ No, *Continue to 105*

105. Does the patient have a contraindication to oral antibiotics used for the treatment of hidradenitis suppurativa? ***ACTION REQUIRED***: If Yes, please attach documentation of clinical reason to avoid therapy.
❒ Yes, *Continue to 168*
❒ No, *Continue to 168*

106. Is the requested drug being prescribed by or in consultation with a dermatologist?
❒ Yes, *Continue to 107*
❒ No, *Continue to 107*

107. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 108*
❒ No, *Continue to 111*

108. 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 111*

❒ No, *Continue to 109*

❒ Unknown, *Continue to 111*

109. 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 168*
❒ No, *Continue to 110*

110. Is this request for an increase in dosing regimen due to the patient not achieving an adequate clinical response at the current dose?
❒ Yes, *Continue to 168*
❒ No, *Continue to 168*

111. Has the patient ever received or is currently receiving a biologic (e.g., Humira) indicated for the treatment of pyoderma gangrenosum (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 168*
❒ No, *Continue to 112*

112. Has the patient had an inadequate response to corticosteroids or immunosuppressive therapy (e.g., cyclosporine, mycophenolate mofetil)? ***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 168*
❒ No, *Continue to 113*

113. Does the patient have an intolerance or contraindication to corticosteroids and immunosuppressive therapy (e.g., cyclosporine, mycophenolate mofetil)? ***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 provide clinical reason to avoid therapy.
❒ Yes, *Continue to 168*
❒ No, *Continue to 168*

114. Is the requested drug being prescribed by or in consultation with a dermatologist, pulmonologist, rheumatologist, cardiologist, neurologist, or ophthalmologist?
❒ Yes, *Continue to 115*
❒ No, *Continue to 115*

115. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 116*
❒ No, *Continue to 119*

116. 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 119*

❒ No, *Continue to 117*

❒ Unknown, *Continue to 119*

117. 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 168*
❒ No, *Continue to 118*

118. Is this request for an increase in dosing regimen due to the patient not achieving an adequate clinical response at the current dose?
❒ Yes, *Continue to 168*
❒ No, *Continue to 168*

119. Has the patient had an inadequate response to corticosteroids or immunosuppressive therapy (e.g., azathioprine, 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 168*
❒ No, *Continue to 120*

120. Does the patient have an intolerance or contraindication to corticosteroids and immunosuppressive therapy (e.g., azathioprine, 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 168*
❒ No, *Continue to 168*

121. Has the patient been diagnosed with refractory Takayasu's arteritis?
❒ Yes, *Continue to 122*
❒ No, *Continue to 122*

122. Is the requested drug being prescribed by or in consultation with a rheumatologist?
❒ Yes, *Continue to 123*
❒ No, *Continue to 123*

123. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 124*
❒ No, *Continue to 127*

124. 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 127*

❒ No, *Continue to 125*

❒ Unknown, *Continue to 127*

125. 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 168*
❒ No, *Continue to 126*

126. Is this request for an increase in dosing regimen due to the patient not achieving an adequate clinical response at the current dose?
❒ Yes, *Continue to 168*
❒ No, *Continue to 168*

127. Has the patient had an inadequate response to corticosteroids or immunosuppressive therapy (e.g., methotrexate, azathioprine, mycophenolate mofetil)? ***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 168*
❒ No, *Continue to 128*

128. Does the patient have an intolerance or contraindication to corticosteroids and immunosuppressive therapy (e.g., methotrexate, azathioprine, mycophenolate mofetil)? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy. If therapy is not advisable, please provide clinical reason to avoid therapy.
❒ Yes, *Continue to 168*
❒ No, *Continue to 168*

129. Is the requested drug being prescribed by or in consultation with an ophthalmologist or rheumatologist?
❒ Yes, *Continue to 130*
❒ No, *Continue to 130*

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

131. 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 135*

❒ No, *Continue to 132*

❒ Unknown, *Continue to 135*

132. 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 133*
❒ No, *Continue to 134*

133. Which of the following signs and symptoms has the patient experienced an improvement in from baseline? ***ACTION REQUIRED***: Please attach chart notes or medical record documentation supporting positive clinical response.
❒ Reduced frequency of flare recurrence compared to baseline ***ACTION REQUIRED****: Submit supporting documentation, Continue to 168*

❒ Zero anterior chamber inflammation or reduction in anterior chamber inflammation compared to baseline ***ACTION REQUIRED****: Submit supporting documentation, Continue to 168*
❒ Decreased reliance on topical corticosteroids ***ACTION REQUIRED****: Submit supporting documentation, Continue to 168*

❒ None of the above, *Continue to 134*

134. Is this request for an increase in dosing regimen due to the patient not achieving an adequate clinical response at the current dose?
❒ Yes, *Continue to 168*
❒ No, *Continue to 168*

135. Has the patient ever received or is currently receiving a biologic (e.g., Humira) indicated for the treatment of uveitis (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 168*
❒ No, *Continue to 136*

136. Has the patient had an inadequate response with corticosteroids or immunosuppressive therapy (e.g., azathioprine, cyclosporine, methotrexate, mycophenolate mofetil)? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medication tried, including response to therapy.
❒ Yes, *Continue to 168*
❒ No, *Continue to 137*

137. Does the patient have an intolerance or contraindication to corticosteroids and immunosuppressive therapy (e.g., azathioprine, cyclosporine, methotrexate, mycophenolate mofetil)? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy. If therapy is not advisable, please provide clinical reason to avoid therapy.
❒ Yes, *Continue to 168*
❒ No, *Continue to 168*

138. Is the requested drug being prescribed by or in consultation with a rheumatologist?
❒ Yes, *Continue to 139*
❒ No, *Continue to 139*

139. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 140*
❒ No, *Continue to 143*

140. 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 143*

❒ No, *Continue to 141*

❒ Unknown, *Continue to 143*

141. 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 (e.g., tender joint count, swollen joint count, pain) since starting treatment with the requested drug or a biosimilar of the requested drug? ***ACTION REQUIRED***: If Yes, please attach chart notes or medical record documentation supporting positive clinical response.
❒ Yes, *Continue to 168*
❒ No, *Continue to 142*

142. Is this request for an increase in dosing regimen due to the patient not achieving an adequate clinical response at the current dose?
❒ Yes, *Continue to 168*
❒ No, *Continue to 168*

143. Has the patient ever received or is currently receiving a biologic (e.g., Enbrel) indicated for the treatment of reactive 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 168*
❒ No, *Continue to 144*

144. Has the patient had an inadequate response to methotrexate or 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 168*
❒ No, *Continue to 145*

145. Does the patient have 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 148*
❒ No, *Continue to 146*

146. Does the patient have a contraindication to methotrexate? ***ACTION REQUIRED***: If Yes, please attach documentation of clinical reason to avoid therapy.
❒ Yes, *Continue to 147*
❒ No, *Continue to 148*

147. Please indicate the contraindication to methotrexate.
❒ Clinical diagnosis of alcohol use disorder, alcoholic liver disease, or other chronic liver disease, *Continue to 148*

❒ Drug interaction, *Continue to 148*

❒ Risk of treatment-related toxicity, *Continue to 148*

❒ Pregnancy or currently planning pregnancy, *Continue to 148*

❒ Breastfeeding, *Continue to 148*
❒ Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension), *Continue to 148*

❒ Hypersensitivity, *Continue to 148*

❒ History of intolerance or adverse event, *Continue to 148*

❒ Other, please specify. _____, *Continue to 148*

148. Does the patient have an intolerance to 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 168*
❒ No, *Continue to 149*

149. Does the patient have a contraindication to sulfasalazine (e.g., porphyria, intestinal or urinary obstruction)? ***ACTION REQUIRED***: If Yes, please attach documentation of clinical reason to avoid therapy.
❒ Yes, *Continue to 168*
❒ No, *Continue to 168*

150. Is the requested drug being prescribed by or in consultation with an oncologist or hematologist?
❒ Yes, *Continue to 151*
❒ No, *Continue to 151*

151. Has the patient had 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 168*
❒ No, *Continue to 152*

152. Does the patient have an intolerance to 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 168*
❒ No, *Continue to 153*

153. Does the patient have a contraindication to corticosteroids? ***ACTION REQUIRED***: If Yes, please attach documentation of clinical reason to avoid therapy.
❒ Yes, *Continue to 168*
❒ No, *Continue to 168*

154. Is the requested drug being prescribed by or in consultation with an oncologist, hematologist, or rheumatologist?
❒ Yes, *Continue to 155*
❒ No, *Continue to 155*

155. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 156*
❒ No, *Continue to 159*

156. 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 159*

❒ No, *Continue to 157*

❒ Unknown, *Continue to 159*

157. Has the patient achieved or maintained a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition since starting treatment with the requested drug? ***ACTION REQUIRED***: If Yes, please attach chart notes or medical record documentation supporting positive clinical response.
❒ Yes, *Continue to 168*
❒ No, *Continue to 158*

158. Is this request for an increase in dosing regimen due to the patient not achieving an adequate clinical response at the current dose?
❒ Yes, *Continue to 168*
❒ No, *Continue to 168*

159. Does the patient have severe immunotherapy-related inflammatory arthritis?
❒ Yes, *Continue to 160*
❒ No, *Continue to 160*

160. Has the patient had an inadequate response 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.
❒ Yes, *Continue to 168*
❒ No, *Continue to 161*

161. Has the patient had an inadequate response to a conventional synthetic drug (e.g., methotrexate, sulfasalazine, leflunomide, hydroxychloroquine)? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy.
❒ Yes, *Continue to 168*
❒ No, *Continue to 162*

162. 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 163*
❒ No, *Continue to 163*

163. Does the patient have an intolerance or contraindication to a conventional synthetic drug (e.g., methotrexate, sulfasalazine, leflunomide, hydroxychloroquine)? ***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 168*
❒ No, *Continue to 168*

164. Is the requested drug being prescribed by or in consultation with an oncologist or hematologist?
❒ Yes, *Continue to 165*
❒ No, *Continue to 165*

165. Has the patient had 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 168*
❒ No, *Continue to 166*

166. Does the patient have an intolerance to 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 168*
❒ No, *Continue to 167*

167. Does the patient have contraindication to corticosteroids? ***ACTION REQUIRED***: If Yes, please attach documentation of clinical reason to avoid therapy.
❒ Yes, *Continue to 168*
❒ No, *Continue to 168*

168. What is the diagnosis?

❒ Crohn's disease, *Continue to 169*

❒ Ulcerative colitis, *Continue to 201*

❒ Rheumatoid arthritis, *Continue to 239*

❒ Ankylosing spondylitis, *Continue to 251*

❒ Non-radiographic axial spondyloarthritis, *Continue to 251*

❒ Psoriatic arthritis, *Continue to 263*

❒ Psoriatic arthritis WITH co-existent plaque psoriasis, *Continue to 263*

❒ Plaque psoriasis, *Continue to 263*

❒ Behcet's disease, *Continue to 275*

❒ Hidradenitis suppurativa, *Continue to 275*

❒ Pyoderma gangrenosum, *Continue to 275*

❒ Sarcoidosis, *Continue to 275*

❒ Takayasu's arteritis, *Continue to 275*

❒ Uveitis, *Continue to 280*

❒ Reactive arthritis, *Continue to 275*

❒ Immune checkpoint inhibitor-related toxicity, *Continue to 285*

❒ Immune checkpoint inhibitor-related inflammatory arthritis, *Continue to 275*

❒ Acute graft versus host disease, *Continue to 275*

169. What is the prescribed product?

❒ Avsola, Inflectra, infliximab, Remicade, or Renflexis (intravenous), *Continue to 173*

❒ Zymfentra (subcutaneous), *Continue to 170*

170. What is the patient's age?

❒ Less than 18 years old, *Continue to 171*

❒ 18 years old or older, *Continue to 171*

171. Does the prescribed maintenance dose exceed 120 mg?
❒ Yes, *Continue to 172*
❒ No, *Continue to 172*

172. Is the prescribed frequency for the maintenance dose more frequent than one dose every 2 weeks?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

173. Is the patient currently receiving the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 174*
❒ No, *Continue to 194*

174. What is the patient's age?

❒ Less than 18 years old, *Continue to 175*

❒ 18 years old or older, *Continue to 187*

175. Does the prescribed dose exceed 5 mg per kg?
❒ Yes, *Continue to 178*
❒ No, *Continue to 176*

176. Is the prescribed frequency for the maintenance dose more frequent than one dose every 8 weeks?
❒ Yes, *Continue to 182*
❒ No, *Continue to 177*

177. What is the patient's weight? Indicate units.

❒ 100 kg (220.5 lbs) or less, *No further questions*

❒ Greater than 100 kg (220.5 lbs), *No further questions*

178. Does the prescribed dose exceed 10 mg per kg?
❒ Yes, *Continue to 179*
❒ No, *Continue to 179*

179. Is the prescribed frequency for the maintenance dose more frequent than one dose every 8 weeks?
❒ Yes, *Continue to 182*
❒ No, *Continue to 180*

180. Does the prescriber recognize that a dose above 5 mg per kg every 8 weeks is a higher dose and the prescriber confirms that appropriate monitoring will be done?
❒ Yes, *Continue to 181*
❒ No, *Continue to 181*

181. What is the patient's weight? Indicate units.

❒ 100 kg (220.5 lbs) or less, *No further questions*

❒ Greater than 100 kg (220.5 lbs), *No further questions*

182. Please select the situation that applies to the patient.

❒ Patient is continuing therapy at current dose and/or frequency, *Continue to 184*

❒ Prescriber is increasing dose and/or frequency, *Continue to 183*

❒ Prescriber is decreasing dose and/or frequency, *Continue to 184*

183. Is this a request for an increase in dosing regimen due to the patient not achieving an adequate clinical response at the current dose and/or frequency?
❒ Yes, *Continue to 184*
❒ No, *Continue to 184*

184. Does the prescribed dose and frequency exceed 10 mg per kg every 4 weeks?
❒ Yes, *Continue to 185*
❒ No, *Continue to 185*

185. Does the prescriber recognize that a dose above 5 mg per kg every 8 weeks is a higher dose and the prescriber confirms that appropriate monitoring will be done?
❒ Yes, *Continue to 186*
❒ No, *Continue to 186*

186. What is the patient's weight? Indicate units.

❒ 100 kg (220.5 lbs) or less, *No further questions*

❒ Greater than 100 kg (220.5 lbs), *No further questions*

187. Does the prescribed dose exceed 5 mg per kg?
❒ Yes, *Continue to 190*
❒ No, *Continue to 188*

188. Is the prescribed frequency for the maintenance dose more frequent than one dose every 8 weeks?
❒ Yes, *Continue to 190*
❒ No, *Continue to 189*

189. What is the patient's weight? Indicate units.

❒ 100 kg (220.5 lbs) or less _____, *No further questions*

❒ Greater than 100 kg (220.5 lbs) _____, *No further questions*

190. Please select the situation that applies to the patient.

❒ Patient is continuing therapy at current dose and/or frequency, *Continue to 192*

❒ Prescriber is increasing dose and/or frequency, *Continue to 191*

❒ Prescriber is decreasing dose and/or frequency, *Continue to 192*

191. Is this a request for an increase in dosing regimen due to the patient not achieving an adequate clinical response at the current dose or frequency?
❒ Yes, *Continue to 192*
❒ No, *Continue to 192*

192. Does the prescribed dose and frequency exceed 10 mg per kg every 4 weeks?
❒ Yes, *Continue to 193*
❒ No, *Continue to 193*

193. What is the patient's weight? Indicate units.

❒ 100 kg (220.5 lbs) or less _____, *No further questions*

❒ Greater than 100 kg (220.5 lbs) _____, *No further questions*

194. Is the prescribed frequency for the maintenance dose more frequent than one dose every 8 weeks?
❒ Yes, *Continue to 195*
❒ No, *Continue to 195*

195. Does the prescribed dose exceed an induction dose of 5 mg per kg at week 0, week 2, and week 6, and a maintenance dose of 5 mg per kg thereafter?
❒ Yes, *Continue to 197*
❒ No, *Continue to 196*

196. What is the patient's weight? Indicate units.

❒ 100 kg (220.5 lbs) or less _____, *No further questions*

❒ Greater than 100 kg (220.5 lbs) _____, *No further questions*

197. What is the patient's age?

❒ Less than 18 years old, *Continue to 198*

❒ 18 years of age or older, *Continue to 198*

198. Does the prescriber recognize that a dose above 5 mg per kg every 8 weeks is a higher dose and the prescriber confirms that appropriate monitoring will be done?
❒ Yes, *Continue to 199*
❒ No, *Continue to 199*

199. Does the prescribed dose exceed an induction dose of 10 mg per kg at week 0, week 2, and week 6, and a maintenance dose of 10 mg per kg thereafter?
❒ Yes, *Continue to 200*
❒ No, *Continue to 200*

200. What is the patient's weight? Indicate in units.

❒ 100 kg (220.5 lbs) or less _____, *No further questions*

❒ Greater than 100 kg (220.5 lbs) _____, *No further questions*

201. What is the prescribed product?

❒ Avsola, Inflectra, infliximab, Remicade, or Renflexis (intravenous), *Continue to 205*

❒ Zymfentra (subcutaneous), *Continue to 202*

202. What is the patient's age?

❒ Less than 18 years old, *Continue to 203*

❒ 18 years old or older, *Continue to 203*

203. Does the prescribed maintenance dose exceed 120 mg?
❒ Yes, *Continue to 204*
❒ No, *Continue to 204*

204. Is the prescribed frequency for the maintenance dose more frequent than one dose every 2 weeks?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

205. Is the patient currently receiving the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 206*
❒ No, *Continue to 232*

206. What is the patient's age?

❒ Less than 18 years old, *Continue to 207*

❒ 18 years old or older, *Continue to 219*

207. Does the prescribed dose exceed 5 mg per kg?
❒ Yes, *Continue to 210*
❒ No, *Continue to 208*

208. Is the prescribed frequency for the maintenance dose more frequent than one dose every 8 weeks?
❒ Yes, *Continue to 214*
❒ No, *Continue to 209*

209. What is the patient's weight? Indicate units.

❒ 100 kg (220.5 lbs) or less _____, *No further questions*

❒ Greater than 100 kg (220.5 lbs) _____, *No further questions*

210. Does the prescribed dose exceed 10 mg per kg?
❒ Yes, *Continue to 211*
❒ No, *Continue to 211*

211. Is the prescribed frequency for the maintenance dose more frequent than one dose every 8 weeks?
❒ Yes, *Continue to 214*
❒ No, *Continue to 212*

212. Does the prescriber recognize that a dose above 5 mg per kg every 8 weeks is a higher dose and the prescriber confirms that appropriate monitoring will be done?
❒ Yes, *Continue to 213*
❒ No, *Continue to 213*

213. What is the patient's weight? Indicate in units.

❒ 100 kg (220.5 lbs) or less _____, *No further questions*

❒ Greater than 100 kg (220.5 lbs) _____, *No further questions*

214. Please select the situation that applies to the patient.

❒ Patient is continuing therapy at current dose and/or frequency, *Continue to 216*

❒ Prescriber is increasing dose and/or frequency, *Continue to 215*

❒ Prescriber is decreasing dose and/or frequency, *Continue to 216*

215. Is this a request for an increase in dosing regimen due to the patient not achieving an adequate clinical response at the current dose or frequency?
❒ Yes, *Continue to 216*
❒ No, *Continue to 216*

216. Does the prescribed dose and frequency exceed 10 mg per kg every 4 weeks?
❒ Yes, *Continue to 217*
❒ No, *Continue to 217*

217. Does the prescriber recognize that a dose above 5 mg per kg every 8 weeks is a higher dose and the prescriber confirms that appropriate monitoring will be done?
❒ Yes, *Continue to 218*
❒ No, *Continue to 218*

218. What is the patient's weight? Indicate units.

❒ 100 kg (220.5 lbs) or less, *No further questions*

❒ Greater than 100 kg (220.5 lbs), *No further questions*

219. Does the prescribed dose exceed 5 mg per kg?
❒ Yes, *Continue to 222*
❒ No, *Continue to 220*

220. Is the prescribed frequency for the maintenance dose more frequent than one dose every 8 weeks?
❒ Yes, *Continue to 228*
❒ No, *Continue to 221*

221. What is the patient's weight? Indicate units.

❒ 100 kg (220.5 lbs) or less, *No further questions*

❒ Greater than 100 kg (220.5 lbs), *No further questions*

222. Was the patient on a dose exceeding 5 mg per kg as a pediatric patient and is continuing that dose into adulthood?
❒ Yes, *Continue to 225*
❒ No, *Continue to 223*

223. Please select the situation that applies to the patient.

❒ Patient is continuing therapy at current dose, *Continue to 225*

❒ Prescriber is increasing dose, *Continue to 224*

❒ Prescriber is decreasing dose, *Continue to 225*

224. Is this a request for an increase in dosing regimen due to the patient not achieving an adequate clinical response at the current dose?
❒ Yes, *Continue to 225*
❒ No, *Continue to 225*

225. Does the prescribed dose exceed 10 mg per kg?
❒ Yes, *Continue to 226*
❒ No, *Continue to 226*

226. Is the prescribed frequency for the maintenance dose more frequent than one dose every 8 weeks?
❒ Yes, *Continue to 228*
❒ No, *Continue to 227*

227. What is the patient's weight? Indicate units.

❒ 100 kg (220.5 lbs) or less, *No further questions*

❒ Greater than 100 kg (220.5 lbs), *No further questions*

228. Please select the situation that applies to the patient.

❒ Patient is continuing therapy at current frequency, *Continue to 230*

❒ Prescriber is increasing frequency, *Continue to 229*

❒ Prescriber is decreasing frequency, *Continue to 230*

229. Is this a request for an increase in dosing regimen due to the patient not achieving an adequate clinical response at the current dose or frequency?
❒ Yes, *Continue to 230*
❒ No, *Continue to 230*

230. Is the prescribed frequency for the maintenance dose more frequent than one dose every 4 weeks?
❒ Yes, *Continue to 231*
❒ No, *Continue to 231*

231. What is the patient's weight? Indicate units.

❒ 100 kg (220.5 lbs) or less, *No further questions*

❒ Greater than 100 kg (220.5 lbs), *No further questions*

232. Is the prescribed frequency for the maintenance dose more frequent than one dose every 8 weeks?
❒ Yes, *Continue to 233*
❒ No, *Continue to 233*

233. Does the prescribed dose exceed an induction dose of 5 mg per kg at week 0, week 2, and week 6, and 5 mg per kg thereafter?
❒ Yes, *Continue to 235*
❒ No, *Continue to 234*

234. What is the patient's weight? Indicate units.

❒ 100 kg (220.5 lbs) or less _____, *No further questions*

❒ Greater than 100 kg (220.5 lbs) _____, *No further questions*

235. What is the patient's age?

❒ Less than 18 years old, *Continue to 236*

❒ 18 years of age or older, *Continue to 236*

236. Does the prescriber recognize that a dose above 5 mg per kg every 8 weeks is a higher dose and the prescriber confirms that appropriate monitoring will be done?
❒ Yes, *Continue to 237*
❒ No, *Continue to 237*

237. Does the prescribed dose exceed an induction dose of 10 mg per kg at week 0, week 2, and week 6, and a maintenance dose of 10 mg per kg thereafter?
❒ Yes, *Continue to 238*
❒ No, *Continue to 238*

238. What is the patient's weight? Indicate units.

❒ 100 kg (220.5 lbs) or less _____, *No further questions*

❒ Greater than 100 kg (220.5 lbs) _____, *No further questions*

239. What is the prescribed product?

❒ Avsola, Inflectra, infliximab, Remicade, or Renflexis (intravenous), *Continue to 240*

❒ Zymfentra (subcutaneous), *Continue to 240*

240. Is the patient currently receiving the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 241*
❒ No, *Continue to 248*

241. Does the prescribed dose exceed 3 mg per kg?
❒ Yes, *Continue to 244*
❒ No, *Continue to 242*

242. Is the prescribed frequency for the maintenance dose more frequent than one dose every 8 weeks?
❒ Yes, *Continue to 244*
❒ No, *Continue to 243*

243. What is the patient's weight? Indicate units.

❒ 100 kg (220.5 lbs) or less _____, *No further questions*

❒ Greater than 100 kg (220.5 lbs) _____, *No further questions*

244. Please select the situation that applies to the patient.

❒ Patient is continuing therapy at current dose and/or frequency, *Continue to 246*

❒ Prescriber is increasing dose and/or frequency, *Continue to 245*

❒ Prescriber is decreasing dose and/or frequency, *Continue to 246*

245. Is this a request for an increase in dosing regimen due to the patient not achieving an adequate clinical response at the current dose or frequency?
❒ Yes, *Continue to 246*
❒ No, *Continue to 246*

246. Does the prescribed dose and frequency exceed 10 mg per kg every 4 weeks?
❒ Yes, *Continue to 247*
❒ No, *Continue to 247*

247. What is the patient's weight? Indicate units.

❒ 100 kg (220.5 lbs) or less _____, *No further questions*

❒ Greater than 100 kg (220.5 lbs) _____, *No further questions*

248. Is the prescribed frequency for the maintenance dose more frequent than one dose every 8 weeks?
❒ Yes, *Continue to 249*
❒ No, *Continue to 249*

249. Does the prescribed dose exceed an induction dose of 3 mg per kg at week 0, week 2, and week 6, and a maintenance dose of 3 mg per kg thereafter?
❒ Yes, *Continue to 250*
❒ No, *Continue to 250*

250. What is the patient's weight? Indicate units.

❒ 100 kg (220.5 lbs) or less _____, *No further questions*

❒ Greater than 100 kg (220.5 lbs) _____, *No further questions*

251. What is the prescribed product?

❒ Avsola, Inflectra, infliximab, Remicade, or Renflexis (intravenous), *Continue to 252*

❒ Zymfentra (subcutaneous), *Continue to 252*

252. Is the patient currently receiving the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 253*
❒ No, *Continue to 260*

253. Does the prescribed dose exceed 5 mg per kg?
❒ Yes, *Continue to 256*
❒ No, *Continue to 254*

254. Is the prescribed frequency for the maintenance dose more frequent than one dose every 6 weeks?
❒ Yes, *Continue to 256*
❒ No, *Continue to 255*

255. What is the patient's weight? Indicate units.

❒ 100 kg (220.5 lbs) or less _____, *No further questions*

❒ Greater than 100 kg (220.5 lbs) _____, *No further questions*

256. Please select the situation that applies to the patient.

❒ Patient is continuing therapy at current dose and/or frequency, *Continue to 258*

❒ Prescriber is increasing dose and/or frequency, *Continue to 257*

❒ Prescriber is decreasing dose and/or frequency, *Continue to 258*

257. Is this a request for an increase in dosing regimen due to the patient not achieving an adequate clinical response at the current dose or frequency?
❒ Yes, *Continue to 258*
❒ No, *Continue to 258*

258. Does the prescribed dose and frequency exceed 7.5 mg per kg every 4 weeks?
❒ Yes, *Continue to 259*
❒ No, *Continue to 259*

259. What is the patient's weight? Indicate units.

❒ 100 kg (220.5 lbs) or less, *No further questions*

❒ Greater than 100 kg (220.5 lbs), *No further questions*

260. Is the prescribed frequency for the maintenance dose more frequent than one dose every 6 weeks?
❒ Yes, *Continue to 261*
❒ No, *Continue to 261*

261. Does the prescribed dose exceed an induction dose of 5 mg per kg at week 0, week 2, and week 6, and 5 mg per kg thereafter?
❒ Yes, *Continue to 262*
❒ No, *Continue to 262*

262. What is the patient's weight? Indicate units.

❒ 100 kg (220.5 lbs) or less _____, *No further questions*

❒ Greater than 100 kg (220.5 lbs) _____, *No further questions*

263. What is the prescribed product?

❒ Avsola, Inflectra, infliximab, Remicade, or Renflexis (intravenous), *Continue to 264*

❒ Zymfentra (subcutaneous), *Continue to 264*

264. Is the patient currently receiving the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 265*
❒ No, *Continue to 272*

265. Does the prescribed dose exceed 5 mg per kg?
❒ Yes, *Continue to 268*
❒ No, *Continue to 266*

266. Is the prescribed frequency for the maintenance dose more frequent than one dose every 8 weeks?
❒ Yes, *Continue to 268*
❒ No, *Continue to 267*

267. What is the patient's weight? Indicate units.

❒ 100 kg (220.5 lbs) or less _____, *No further questions*

❒ Greater than 100 kg (220.5 lbs) _____, *No further questions*

268. Please select the situation that applies to the patient.

❒ Patient is continuing therapy at current dose and/or frequency, *Continue to 270*

❒ Prescriber is increasing dose and/or frequency, *Continue to 269*

❒ Prescriber is decreasing dose and/or frequency, *Continue to 270*

269. Is this a request for an increase in dosing regimen due to the patient not achieving an adequate clinical response at the current dose or frequency?
❒ Yes, *Continue to 270*
❒ No, *Continue to 270*

270. Does the prescribed dose and frequency exceed 10 mg per kg every 4 weeks?
❒ Yes, *Continue to 271*
❒ No, *Continue to 271*

271. What is the patient's weight? Indicate units.

❒ 100 kg (220.5 lbs) or less, *No further questions*

❒ Greater than 100 kg (220.5 lbs), *No further questions*

272. Is the prescribed frequency for the maintenance dose more frequent than one dose every 8 weeks?
❒ Yes, *Continue to 273*
❒ No, *Continue to 273*

273. Does the prescribed dose exceed an induction dose of 5 mg per kg at week 0, week 2, and week 6, and 5 mg per kg thereafter?
❒ Yes, *Continue to 274*
❒ No, *Continue to 274*

274. What is the patient's weight? Indicate units.

❒ 100 kg (220.5 lbs) or less _____, *No further questions*

❒ Greater than 100 kg (220.5 lbs) _____, *No further questions*

275. What is the prescribed product?

❒ Avsola, Inflectra, infliximab, Remicade, or Renflexis (intravenous), *Continue to 276*

❒ Zymfentra (subcutaneous), *Continue to 276*

276. 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 277*
❒ No, *Continue to 277*

277. Is the patient currently receiving the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 278*
❒ No, *Continue to 279*

278. What is the patient's weight? Indicate units.

❒ 100 kg (220.5 lbs) or less _____, *No further questions*

❒ Greater than 100 kg (220.5 lbs) _____, *No further questions*

279. What is the patient's weight? Indicate units.

❒ 100 kg (220.5 lbs) or less _____, *No further questions*

❒ Greater than 100 kg (220.5 lbs), *No further questions*

280. What is the prescribed product?

❒ Avsola, Inflectra, infliximab, Remicade, or Renflexis (intravenous), *Continue to 281*

❒ Zymfentra (subcutaneous), *Continue to 281*

281. 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 282*
❒ No, *Continue to 282*

282. Is the patient currently receiving the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 283*
❒ No, *Continue to 284*

283. What is the patient's weight? Indicate units.

❒ 100 kg (220.5 lbs) or less _____, *No further questions*

❒ Greater than 100 kg (220.5 lbs) _____, *No further questions*

284. What is the patient's weight? Indicate units.

❒ 100 kg (220.5 lbs) or less _____, *No further questions*

❒ Greater than 100 kg (220.5 lbs) _____, *No further questions*

285. What is the prescribed product?

❒ Avsola, Inflectra, infliximab, Remicade, or Renflexis (intravenous), *Continue to 286*

❒ Zymfentra (subcutaneous), *Continue to 286*

286. 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 287*
❒ No, *Continue to 287*

287. Is the patient currently receiving the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 288*
❒ No, *Continue to 289*

288. What is the patient's weight? Indicate units.

❒ 100 kg (220.5 lbs) or less _____, *No further questions*

❒ Greater than 100 kg (220.5 lbs) _____, *No further questions*

289. What is the patient's weight? Indicate units.

❒ 100 kg (220.5 lbs) or less _____, *No further questions*

❒ Greater than 100 kg (220.5 lbs) _____, *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