



Stelara 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.

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Patient's Name: _____ **Date:** _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ☐ Same as Requesting Provider

Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ☐ Same as Referring Provider ☐ Same as Requesting Provider

Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____ *kg*

Patient Height: _____ *cm*

Please indicate the place of service for the requested drug:

- | | | |
|--|---------------------------------|---|
| ☐ Ambulatory Surgical | ☐ Home | ☐ Off Campus Outpatient Hospital |
| ☐ On Campus Outpatient Hospital | ☐ Office | ☐ Pharmacy |

What is the ICD-10 code? _____

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

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What product is being requested?

- ☐ Stelara IV ☐ Ustekinumab (unbranded Stelara) IV ☐ Stelara SC ☐ Ustekinumab (unbranded Stelara) SC
☐ Imuldosa IV ☐ Ustekinumab (unbranded Imuldosa) IV ☐ Imuldosa SC ☐ Ustekinumab (unbranded Imuldosa) SC
☐ Otulfi IV ☐ Ustekinumab-aauz (unbranded Otulfi) IV ☐ Otulfi SC ☐ Ustekinumab-aauz (unbranded Otulfi) SC
☐ Pyzchiva IV ☐ Ustekinumab-ttwe (unbranded Pyzchiva) IV
☐ Pyzchiva SC ☐ Ustekinumab ttwe (unbranded Pyzchiva) SC
☐ Selarsdi IV ☐ Ustekinumab-aekn (unbranded Selarsdi) IV
☐ Selarsdi SC ☐ Ustekinumab-aekn (unbranded Selarsdi) SC
☐ Steqeyma IV ☐ Ustekinumab-stba (unbranded Steqeyma) IV
☐ Steqeyma SC ☐ Ustekinumab-stba (unbranded Steqeyma) SC
☐ Wezlana IV ☐ Ustekinumab-auub (unbranded Wezlana) IV
☐ Wezlana SC ☐ Ustekinumab-auub (unbranded Wezlana) SC
☐ Starjemza IV ☐ Starjemza SC ☐ Yesintek IV ☐ Yesintek SC

Exception Criteria Questions:

1. For MD-risk LOB only: Is the requested drug being prescribed to treat a patient with stage IV advanced, metastatic cancer with its use being consistent for an FDA-approved indication, the NCCN Drugs Biologics Compendium indication for the treatment of stage IV advanced, metastatic cancer, and/or supported by peer-reviewed medical literature?

- ☐ Yes, *skip to Clinical Criteria Questions*
☐ No, *Continue to Question 2*

2. What is the prescribed product?

- ☐ Pyzchiva, *skip to Psoriasis Enhanced SGM 4179-A Criteria Questions*
☐ Yesintek, *skip to Psoriasis Enhanced SGM 4179-A Criteria Questions*
☐ Imuldosa, *Continue to Question 3*
☐ Otulfi, *Continue to Question 3*
☐ Selarsdi, *Continue to Question 3*
☐ Starjemza, *Continue to Question 3*
☐ Stelara, *Continue to Question 3*
☐ Steqeyma, *Continue to Question 3*
☐ Wezlana, *Continue to Question 3*

3. The preferred products for your patient's health plan are Pyzchiva and Yesintek

Can the patient's treatment be switched to one of the preferred products?

- ☐ Yes, Pyzchiva, *skip to Psoriasis Enhanced SGM 4179-A Criteria Questions*
☐ Yes, Yesintek, *skip to Psoriasis Enhanced SGM 4179-A Criteria Questions*
☐ No, *Continue to Question 4*

4. Does the patient have a documented intolerable adverse event to all of the preferred products (Pyzchiva and Yesintek)? **Action Required:** If 'Yes', attach supporting chart note(s)

- ☐ Yes, *Continue to Question 5*
☐ No, *Continue to Question 6*

5. 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 6*
☐ No, *skip to Psoriasis Enhanced SGM 4179-A Criteria Questions*

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6. Does the patient have a documented inadequate response to all of the preferred products (Pyzchiva and Yesintek)?

Action Required: If 'Yes', attach supporting chart note(s)

☐ Yes, skip to Psoriasis Enhanced SGM 4179-A Criteria Questions

☐ No, Continue to Question 7

7. Does the patient have a contraindication to all of the preferred products (Pyzchiva and Yesintek)? **Action Required:** If 'Yes', attach supporting chart note(s)

☐ Yes, Continue to Psoriasis Enhanced SGM 4179-A Criteria Questions

☐ No, Continue to Psoriasis Enhanced SGM 4179-A Criteria Questions

Psoriasis Enhanced SGM 4179-A Criteria Questions:

1. What is the patient's age?

☐ 18 years of age or older _____, Continue to 2

☐ Less than 18 years of age _____, Skip to Stelara and Biosimilars SGM 2010-A Criteria

2. What is the diagnosis?

☐ Plaque psoriasis, Continue to 3

☐ Plaque psoriasis with co-existent psoriatic arthritis, Skip to Stelara and Biosimilars SGM 2010-A Criteria

☐ Other, please specify _____, Skip to Stelara and Biosimilars SGM 2010-A Criteria

3. Is the request for Sotyktu?

☐ Yes, Continue to 4

☐ No, Continue to 5

4. Will the requested drug be used in combination with any other biologic (e.g., Humira) or targeted synthetic drug (e.g., Otezla)?

☐ Yes, Continue to 7

☐ No, Continue to 7

5. Will the requested drug be used in combination with any other biologic (e.g., Humira) or targeted synthetic drug (e.g., Otezla, Sotyktu) for the same indication?

☐ Yes, Continue to 6

☐ No, Continue to 6

6. What is the requested medication?

☐ Icotyde, Continue to 10

☐ Otezla/Otezla XR, Continue to 9

☐ Other, please specify _____, Continue to 7

7. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic drug (e.g., Olumiant, Xeljanz) associated with an increased risk of tuberculosis?

☐ Yes, Continue to 10

☐ No, Continue to 8

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8. Has the patient been evaluated for tuberculosis (TB) infection prior to initiation of treatment with the requested drug?

☐ Yes, *Continue to 10*

☐ No, *Continue to 10*

9. What is the severity of the disease?

☐ Mild plaque psoriasis, *Skip to Stelara and Biosimilars SGM 2010-A*

☐ Moderate plaque psoriasis, *Continue to 11*

☐ Severe plaque psoriasis, *Continue to 11*

10. Has the patient been diagnosed with moderate to severe plaque psoriasis?

☐ Yes, *Continue to 11*

☐ No, *Continue to 11*

11. Is the requested drug prescribed by or in consultation with a dermatologist?

☐ 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 (if applicable)?

☐ Yes, *Continue to 13*

☐ No, *Continue to 19*

13. Is the patient currently receiving the requested drug or a biosimilar of the requested drug (if applicable) through samples or a manufacturer's patient assistance program?

☐ Yes, *Continue to 19*

☐ No, *Continue to 14*

☐ Unknown, *Continue to 19*

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 15*

15. What is the patient's current psoriasis involvement in body surface area (BSA) percent? Indicate in percentage.

ACTION REQUIRED: Attach supporting chart note(s) or medical record documentation for current psoriasis involvement of BSA percent.

☐ Less than or equal to 3% _____, *Skip to Stelara and Biosimilars SGM 2010-A Criteria Question 58*

☐ Greater than 3% _____, *Continue to 16*

16. What is the patient's percent improvement in body surface area (BSA) from baseline? Indicate in percentage.

ACTION REQUIRED: Attach supporting chart note(s) or medical record documentation for percent improvement of BSA from baseline.

☐ Less than 75% BSA improvement _____, *Continue to 17*

☐ Greater than or equal to 75% BSA improvement _____, *Skip to Stelara and Biosimilars SGM 2010-A Criteria Question 58*

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17. What is the patient's percent reduction in the Psoriasis Area Severity Index (PASI) score from baseline? Indicate score reduction in percentage. **ACTION REQUIRED:** Attach supporting chart note(s) or medical record documentation for percent reduction of PASI score from baseline.

☐ Greater than or equal to 75% reduction _____, *Skip to Stelara and Biosimilars SGM 2010-A Criteria Question 58*

☐ Greater than or equal to 50% and less than 75% reduction _____, *Continue to 18*

☐ Less than 50% reduction _____, *Continue to 18*

18. What is the patient's Dermatology Life Quality Index (DLQI) score? Indicate patient's DLQI score. **ACTION REQUIRED:** Attach supporting chart note(s) or medical record documentation for Dermatology Life Quality Index (DLQI) score.

☐ Less than or equal to 5 _____, *Skip to Stelara and Biosimilars SGM 2010-A Criteria Question 58*

☐ Greater than 5 _____, *No further questions*

19. Has the patient received or is currently receiving a biologic (e.g., Humira) or targeted synthetic drug (e.g., Sotyktu, Otezla) within the past 120 days indicated for the treatment of moderate to severe plaque psoriasis (excluding receiving the drug via samples or a manufacturer's patient assistance program)? **ACTION REQUIRED:** If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried.

☐ Yes, *Skip to Stelara and Biosimilars SGM 2010-A Criteria Question 58*

☐ No, *Continue to 20*

20. Is the percentage of body surface area (BSA) affected (prior to starting the requested medication) less than 3%?

☐ Yes, *Continue to 23*

☐ No, *Continue to 21*

21. What is the percentage of body surface area (BSA) affected (prior to starting the requested medication)? Indicate in percentage. **ACTION REQUIRED:** Attach supporting chart notes or medical record documentation of body surface area (BSA) affected.

☐ Greater than or equal to 3% but less than 10% _____, *Continue to 22*

☐ Greater than or equal to 10% _____, *Continue to 31*

22. What is the patient's Psoriasis Area Severity Index (PASI) score? Indicate patient's PASI score. **ACTION REQUIRED:** Attach supporting chart note(s) or medical record documentation of Psoriasis Area Severity Index (PASI) score.

☐ Greater than or equal to 10 _____, *Continue to 24*

☐ Less than 10 _____, *Continue to 23*

23. Is the affected area severe at localized sites and associated with significant functional impairment and/or high levels of distress (e.g., nail disease or involvement of high-impact and difficult-to-treat sites such as face, scalp, palms, soles, flexures and genitals)? **ACTION REQUIRED:** If Yes, please attach supporting chart notes or medical record documentation of affected area(s) with significant functional impairment and/or high levels of distress.

☐ Yes, *Continue to 31*

☐ No, *Continue to 31*

24. Has the patient had an inadequate response at the maximum tolerated dose to a medium to super-high potency topical corticosteroid therapy for a duration of at least 4 weeks? **ACTION REQUIRED:** If Yes, please attach supporting chart notes, medical record documentation, or claims history of all prior and current use of treatment regimens for topical corticosteroid therapy, including dosage, duration, and response to therapy.

☐ Yes, *Continue to 31*

☐ No, *Continue to 25*

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25. Has the patient had an inadequate response at the maximum tolerated dose to a topical calcineurin inhibitor therapy for a duration of at least 8 weeks? **ACTION REQUIRED:** If Yes, please attach supporting chart note(s), medical record documentation, or claims history of all prior and current use of treatment regimens for topical calcineurin inhibitor therapy, including dosage, duration, and response to therapy.

☐ Yes, *Continue to 31*

☐ No, *Continue to 26*

26. Has the patient had an inadequate response at the maximum tolerated dose to a topical vitamin D analog therapy for a duration of at least 12 weeks? **ACTION REQUIRED:** If Yes, please attach supporting chart note(s), medical record documentation, or claims history of all prior and current use of treatment regimens for topical vitamin D analog therapy, including dosage, duration, and response to therapy.

☐ Yes, *Continue to 31*

☐ No, *Continue to 27*

27. Has the patient had an inadequate response at the maximum tolerated dose to a topical retinoid therapy for a duration of at least 12 weeks? **ACTION REQUIRED:** If Yes, please attach supporting chart note(s), medical record documentation, or claims history of all prior and current use of treatment regimens for topical retinoid therapy, including dosage, duration, and response to therapy.

☐ Yes, *Continue to 31*

☐ No, *Continue to 28*

28. Has the patient had an inadequate response at the maximum tolerated dose to a topical aryl hydrocarbon receptor agonist therapy for a duration of at least 12 weeks? **ACTION REQUIRED:** If Yes, please attach supporting chart note(s), medical record documentation, or claims history of all prior and current use of treatment regimens for topical aryl hydrocarbon receptor agonist therapy, including dosage, duration, and response to therapy.

☐ Yes, *Continue to 31*

☐ No, *Continue to 29*

29. Has the patient had an inadequate response at the maximum tolerated dose to a topical phosphodiesterase 4 inhibitor therapy for a duration of at least 8 weeks? **ACTION REQUIRED:** If Yes, please attach supporting chart note(s), medical record documentation, or claims history of all prior and current use of treatment regimens for topical phosphodiesterase 4 inhibitor therapy, including dosage, duration, and response to therapy.

☐ Yes, *Continue to 31*

☐ No, *Continue to 30*

30. Are high impact site (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 31*

☐ No, *Continue to 31*

31. Has the patient had a trial of phototherapy (e.g., UVB, PUVA) for a duration of at least 3 months? **ACTION REQUIRED:** If Yes, please attach supporting chart note(s) or medical record documentation for phototherapy, including duration and response to therapy.

☐ Yes, *Continue to 33*

☐ No, *Continue to 32*

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32. Does the patient meet any of the following criteria: a) the patient has experienced an intolerable adverse event with phototherapy, b) the patient has a clinical reason to avoid phototherapy, or c) the patient does not have access to phototherapy?

ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation supporting previous treatments tried (if applicable), including duration and response to therapy. If therapy is not advisable, please attach documentation of clinical reason to avoid therapy.

- ☐ Yes, intolerable adverse event to phototherapy, *Continue to 33*
- ☐ Yes, clinical reason to avoid phototherapy, *Continue to 33*
- ☐ Yes, does not have access to phototherapy, *Continue to 33*
- ☐ None of the above, *Continue to 33*

33. Has the patient had a trial of methotrexate at a dose of at least 25 mg/week or at the maximum tolerated dose for a duration of at least 3 months? **ACTION REQUIRED:** If Yes, please attach supporting chart note(s), medical record documentation, or claims history of all prior and current use of treatment regimens for methotrexate, including dosage, duration, and response to therapy.

- ☐ Yes, *Skip to Stelara and Biosimilars SGM 2010-A Criteria Question 58*
- ☐ No, *Continue to 34*

34. Has the patient had a trial of cyclosporine at a dose of at least 5 mg/kg/day or at the maximum tolerated dose for a duration of at least 6 weeks? **ACTION REQUIRED:** If Yes, please attach supporting chart note(s), medical record documentation, or claims history of all prior and current use of treatment regimens for cyclosporine, including dosage, duration, and response to therapy.

- ☐ Yes, *Skip to Stelara and Biosimilars SGM 2010-A Criteria Question 58*
- ☐ No, *Continue to 35*

35. Has the patient had a trial of acitretin at a dose of at least 50 mg/day or at the maximum tolerated dose for a duration of at least 3 months? **ACTION REQUIRED:** If Yes, please attach supporting chart note(s), medical record documentation, or claims history of all prior and current use of treatment regimens for acitretin, including dosage, duration, and response to therapy.

- ☐ Yes, *Skip to Stelara and Biosimilars SGM 2010-A Criteria Question 58*
- ☐ No, *Continue to 36*

36. Does the patient have a clinical reason to avoid systemic pharmacologic treatment with methotrexate, cyclosporine, and acitretin? **ACTION REQUIRED:** Please attach documentation of clinical reason to avoid therapy.

- ☐ Yes, *Continue to 37*
- ☐ No, *Continue to 37*

37. Please indicate the clinical reason to avoid pharmacologic treatment with methotrexate, cyclosporine, and acitretin.
☐ Clinical diagnosis of alcohol use disorder, alcoholic liver disease, or other chronic liver disease, *Skip to Stelara and Biosimilars SGM 2010-A Criteria Question 58*

- ☐ Drug interaction, *Skip to Stelara and Biosimilars SGM 2010-A Criteria Question 58*
- ☐ Risk of treatment-related toxicity, *Skip to Stelara and Biosimilars SGM 2010-A Criteria Question 58*
- ☐ Pregnancy or currently planning pregnancy, *Skip to Stelara and Biosimilars SGM 2010-A Criteria Question 58*
- ☐ Breastfeeding, *Skip to Stelara and Biosimilars SGM 2010-A Criteria Question 58*
- ☐ Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension), *Skip to Stelara and Biosimilars SGM 2010-A Criteria Question 58*
- ☐ Hypersensitivity, *Skip to Stelara and Biosimilars SGM 2010-A Criteria Question 58*
- ☐ History of intolerance or adverse event, *Skip to Stelara and Biosimilars SGM 2010-A Criteria Question 58*
- ☐ Other, please specify _____, *No further questions*

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Criteria Questions:

1. Will the requested drug or a biosimilar of the requested drug be used in combination with any other biologic (e.g., Humira) or targeted synthetic drug (e.g., Otezla, Xeljanz) for the same indication?
☐ Yes, *Continue to 2*
☐ No, *Continue to 2*
2. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic drug (e.g., Olumiant, Xeljanz) associated with an increased risk of tuberculosis?
☐ Yes, *Continue to 4*
☐ No, *Continue to 3*
3. Has the patient been evaluated for tuberculosis (TB) infection prior to initiation of treatment with the requested drug?
☐ Yes, *Continue to 4*
☐ No, *Continue to 4*
4. What is the diagnosis?
☐ Plaque psoriasis, *Continue to 8*
☐ Psoriatic arthritis WITH co-existent plaque psoriasis, *Continue to 5*
☐ Psoriatic arthritis, *Continue to 23*
☐ Crohn's disease, *Continue to 38*
☐ Ulcerative colitis, *Continue to 44*
☐ Immune checkpoint inhibitor-related diarrhea or colitis, *Continue to 50*
☐ Other, please specify. _____, *No further questions*
5. Is the patient 6 years of age or older?
☐ Yes, *Continue to 6*
☐ No, *Continue to 6*
6. Is the requested drug or a biosimilar of the requested drug being prescribed by or in consultation with a rheumatologist or dermatologist?
☐ Yes, *Continue to 7*
☐ No, *Continue to 7*
7. What is the primary diagnosis being treated?
☐ Psoriatic arthritis, *Continue to 25*
☐ Plaque psoriasis, *Continue to 10*
8. Is the patient 6 years of age or older?
☐ Yes, *Continue to 9*
☐ No, *Continue to 9*
9. Is the requested drug or a biosimilar of the requested drug being prescribed by or in consultation with a dermatologist?
☐ Yes, *Continue to 10*
☐ No, *Continue to 10*
10. Has the patient been diagnosed with moderate to severe plaque psoriasis?
☐ Yes, *Continue to 11*
☐ No, *Continue to 11*

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11. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug?

☐ Yes, *Continue to 12*

☐ No, *Continue to 16*

12. 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 16*

☐ No, *Continue to 13*

☐ Unknown, *Continue to 16*

13. 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 14*

☐ No, *Continue to 14*

14. 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 55*

☐ No, *Continue to 15*

15. 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 55*

☐ No, *Continue to 55*

16. Has the patient ever received or is currently receiving a biologic (e.g., Humira) or targeted synthetic drug (e.g., Sotyktu, Otezla) indicated for 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 55*

☐ No, *Continue to 17*

17. 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 55*

☐ No, *Continue to 18*

18. Is the percentage of body surface area (BSA) affected (prior to starting the requested medication) less than 3%?

☐ Yes, *Continue to 19*

☐ No, *Continue to 19*

19. What is the percentage of body surface area (BSA) affected (prior to starting the requested drug or a biosimilar of the requested drug)? Indicate percentage. **ACTION REQUIRED:** Please attach chart notes or medical record documentation of body surface area affected.

☐ Greater than or equal to 3% to less than 10% of BSA _____, *Continue to 20*

☐ Greater than or equal to 10% of BSA _____, *Continue to 55*

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20. Has the patient had 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 55*

☐ No, *Continue to 21*

21. Does the patient have a clinical reason to avoid pharmacologic treatment with methotrexate, cyclosporine, and acitretin? **ACTION REQUIRED:** If Yes, please attach documentation of clinical reason to avoid each therapy.

☐ Yes, *Continue to 22*

☐ No, *Continue to 22*

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

☐ Clinical diagnosis of alcohol use disorder, alcoholic liver disease, or other chronic liver disease, *Continue to 55*

☐ Drug interaction, *Continue to 55*

☐ Risk of treatment-related toxicity, *Continue to 55*

☐ Pregnancy or currently planning pregnancy, *Continue to 55*

☐ Breastfeeding, *Continue to 55*

☐ Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension), *Continue to 55*

☐ Hypersensitivity, *Continue to 55*

☐ History of intolerance or adverse event, *Continue to 55*

☐ Other, please specify _____, *Continue to 55*

23. Is the patient 6 years of age or older?

☐ Yes, *Continue to 24*

☐ No, *Continue to 24*

24. Is the requested drug or a biosimilar of the requested drug being prescribed by or in consultation with a rheumatologist or dermatologist?

☐ Yes, *Continue to 25*

☐ No, *Continue to 25*

25. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug?

☐ Yes, *Continue to 26*

☐ No, *Continue to 29*

26. 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 29*

☐ No, *Continue to 27*

☐ Unknown, *Continue to 29*

27. 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 28*

☐ No, *Continue to 28*

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28. 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, *Continue to 55*
- ☐ Number of tender joints, *Continue to 55*
- ☐ Dactylitis, *Continue to 55*
- ☐ Enthesitis, *Continue to 55*
- ☐ Skin and/or nail involvement, *Continue to 55*
- ☐ Functional status, *Continue to 55*
- ☐ C-reactive protein (CRP), *Continue to 55*
- ☐ None of the above, *Continue to 55*

29. Has the patient been diagnosed with active psoriatic arthritis (PsA)?

- ☐ Yes, *Continue to 30*
- ☐ No, *Continue to 30*

30. 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 55*
- ☐ No, *Continue to 31*

31. What is the patient's disease severity?

- ☐ Mild to moderate, *Continue to 32*
- ☐ Severe, *Continue to 55*

32. Does the patient have enthesitis?

- ☐ Yes, *Continue to 55*
- ☐ No, *Continue to 33*

33. 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 55*
- ☐ No, *Continue to 34*

34. 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 55*
- ☐ 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 37*

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36. Please indicate the contraindication to methotrexate or leflunomide.

- ☐ Clinical diagnosis of alcohol use disorder, alcoholic liver disease, or other chronic liver disease, *Continue to 55*
- ☐ Drug interaction, *Continue to 55*
- ☐ Risk of treatment-related toxicity, *Continue to 55*
- ☐ Pregnancy or currently planning pregnancy, *Continue to 55*
- ☐ Breastfeeding, *Continue to 55*
- ☐ Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension), *Continue to 55*
- ☐ Hypersensitivity, *Continue to 55*
- ☐ History of intolerance or adverse event, *Continue to 55*
- ☐ Other, please specify. _____, *Continue to 55*

37. 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 55*
- ☐ No, *Continue to 55*

38. Has the patient been diagnosed with moderately to severely active Crohn's disease (CD)?

- ☐ Yes, *Continue to 39*
- ☐ No, *Continue to 39*

39. Is the requested drug or a biosimilar of the requested drug being prescribed by or in consultation with a gastroenterologist?

- ☐ Yes, *Continue to 40*
- ☐ No, *Continue to 40*

40. Which of the following applies to this request for the requested drug or a biosimilar of the requested drug?

- ☐ Initiation of the intravenous (IV) loading dose, *Continue to 55*
- ☐ Initiation of the subcutaneous (SQ) maintenance dose, *Continue to 55*
- ☐ Continuation of the subcutaneous (SQ) maintenance dose, *Continue to 41*

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

- ☐ Yes, achieved or maintained remission, *Continue to 55*
- ☐ Yes, achieved or maintained a positive clinical response, *Continue to 42*
- ☐ No or none of the above, *Continue to 43*

42. 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, *Continue to 55*
- ☐ Diarrhea, *Continue to 55*
- ☐ Body weight, *Continue to 55*
- ☐ Abdominal mass, *Continue to 55*
- ☐ Hematocrit, *Continue to 55*
- ☐ Appearance of the mucosa on endoscopy, computed tomography enterography (CTE), magnetic resonance enterography (MRE), or intestinal ultrasound, *Continue to 55*
- ☐ Improvement on a disease activity scoring tool (e.g., Crohn's Disease Activity Index [CDAI] score), *Continue to 55*
- ☐ None of the above, *Continue to 43*

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43. Is this a request for an increase in dosing frequency due to the patient not achieving an adequate clinical response at the current frequency?

☐ Yes, *Continue to 55*

☐ No, *Continue to 55*

44. Has the patient been diagnosed with moderately to severely active ulcerative colitis (UC)?

☐ Yes, *Continue to 45*

☐ No, *Continue to 45*

45. Is the requested drug or a biosimilar of the requested drug being prescribed by or in consultation with a gastroenterologist?

☐ Yes, *Continue to 46*

☐ No, *Continue to 46*

46. Which of the following applies to this request for the requested drug or a biosimilar of the requested drug?

☐ Initiation of the intravenous (IV) loading dose, *Continue to 55*

☐ Initiation of the subcutaneous (SQ) maintenance dose, *Continue to 55*

☐ Continuation of the subcutaneous (SQ) maintenance dose, *Continue to 47*

47. Has the patient achieved or maintained remission OR achieved or maintained a positive clinical response to treatment as evidenced by low disease activity or improvement in signs and symptoms of the condition since starting treatment with the requested drug or a biosimilar of the requested drug? **ACTION REQUIRED:** If Yes, please attach chart notes or medical record documentation of remission.

☐ Yes, achieved or maintained remission, *Continue to 55*

☐ Yes, achieved or maintained a positive clinical response, *Continue to 48*

☐ No or none of the above, *Continue to 49*

48. 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, *Continue to 55*

☐ Rectal bleeding, *Continue to 55*

☐ Urgency of defecation, *Continue to 55*

☐ C-reactive protein (CRP), *Continue to 55*

☐ Fecal calprotectin (FC), *Continue to 55*

☐ Appearance of the mucosa on endoscopy, computed tomography enterography (CTE), magnetic resonance enterography (MRE), or intestinal ultrasound, *Continue to 55*

☐ Improvement on a disease activity scoring tool (e.g., Ulcerative Colitis Endoscopic Index of Severity [UCEIS], Mayo Score), *Continue to 55*

☐ None of the above, *Continue to 49*

49. Is this a request for an increase in dosing frequency due to the patient not achieving an adequate clinical response at the current frequency?

☐ Yes, *Continue to 55*

☐ No, *Continue to 55*

50. Is the requested drug or a biosimilar of the requested drug being prescribed by or in consultation with a gastroenterologist, hematologist, or oncologist?

☐ Yes, *Continue to 51*

☐ No, *Continue to 51*

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51. Has the patient experienced an inadequate response to infliximab or vedolizumab? **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 54*

☐ No, *Continue to 52*

52. Has the patient experienced an intolerance to infliximab or vedolizumab? **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 54*

☐ No, *Continue to 53*

53. Does the patient have a contraindication to infliximab or vedolizumab? **ACTION REQUIRED:** If Yes, please attach documentation of clinical reason to avoid therapy.

☐ Yes, *Continue to 54*

☐ No, *Continue to 54*

54. 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, *No Further Questions*

☐ No, *No Further Questions*

55. What is the diagnosis?

☐ Plaque psoriasis, *Continue to 56*

☐ Psoriatic arthritis WITH co-existent plaque psoriasis, *Continue to 56*

☐ Psoriatic arthritis, *Continue to 72*

☐ Crohn's disease, *Continue to 80*

☐ Ulcerative colitis, *Continue to 80*

56. What is the requested formulation?

☐ Subcutaneous injection, *Continue to 57*

☐ Intravenous infusion, *Continue to 57*

57. Is the patient currently receiving the requested drug or a biosimilar of the requested drug?

☐ Yes, *Continue to 58*

☐ No, *Continue to 65*

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

☐ Less than or equal to 100 kg _____ kg, *Continue to 59*

☐ Greater than 100 kg _____ kg, *Continue to 62*

59. Does the prescribed maintenance dose exceed 45 mg?

☐ Yes, *Continue to 60*

☐ No, *Continue to 60*

60. Is the prescribed frequency for the maintenance dose more frequent than one dose every 12 weeks?

☐ Yes, *Continue to 61*

☐ No, *Continue to 61*

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61. What is the requested product?

- ☐ Stelara, *No further questions*
- ☐ Imuldosa, *No further questions*
- ☐ Otulfi, *No further questions*
- ☐ Pyzchiva, *No further questions*
- ☐ Selarsdi, *No further questions*
- ☐ Starjemza, *No further questions*
- ☐ Steqeyma, *No further questions*
- ☐ ustekinumab, *No further questions*
- ☐ ustekinumab-aauz, *No further questions*
- ☐ ustekinumab-aekn, *No further questions*
- ☐ ustekinumab-auub, *No further questions*
- ☐ ustekinumab-srlf, *No further questions*
- ☐ ustekinumab-stba, *No further questions*
- ☐ ustekinumab-ttwe, *No further questions*
- ☐ Wezlana, *No further questions*
- ☐ Yesintek, *No further questions*

62. Does the prescribed maintenance dose exceed 90 mg?

- ☐ Yes, *Continue to 63*
- ☐ No, *Continue to 63*

63. Is the prescribed frequency for the maintenance dose more frequent than one dose every 12 weeks?

- ☐ Yes, *Continue to 64*
- ☐ No, *Continue to 64*

64. What is the requested product?

- ☐ Stelara, *No further questions*
- ☐ Imuldosa, *No further questions*
- ☐ Otulfi, *No further questions*
- ☐ Pyzchiva, *No further questions*
- ☐ Selarsdi, *No further questions*
- ☐ Starjemza, *No further questions*
- ☐ Steqeyma, *No further questions*
- ☐ ustekinumab, *No further questions*
- ☐ ustekinumab-aauz, *No further questions*
- ☐ ustekinumab-aekn, *No further questions*
- ☐ ustekinumab-auub, *No further questions*
- ☐ ustekinumab-srlf, *No further questions*
- ☐ ustekinumab-stba, *No further questions*
- ☐ ustekinumab-ttwe, *No further questions*
- ☐ Wezlana, *No further questions*
- ☐ Yesintek, *No further questions*

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

- ☐ Less than or equal to 100 kg _____ kg, *Continue to 66*
- ☐ Greater than 100 kg _____ kg, *Continue to 69*

66. Does the prescribed dose exceed a loading dose of 45 mg at weeks 0 and 4, and a maintenance dose of 45 mg thereafter?

- ☐ Yes, *Continue to 67*
- ☐ No, *Continue to 67*

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67. Is the prescribed frequency for the maintenance dose more frequent than one dose every 12 weeks?

☐ Yes, *Continue to 68*

☐ No, *Continue to 68*

68. What is the requested product?

☐ Stelara, *No further questions*

☐ Imuldosa, *No further questions*

☐ Otulfi, *No further questions*

☐ Pyzchiva, *No further questions*

☐ Selarsdi, *No further questions*

☐ Starjemza, *No further questions*

☐ Steqeyma, *No further questions*

☐ ustekinumab, *No further questions*

☐ ustekinumab-aaaz, *No further questions*

☐ ustekinumab-aekn, *No further questions*

☐ ustekinumab-auub, *No further questions*

☐ ustekinumab-srlf, *No further questions*

☐ ustekinumab-stba, *No further questions*

☐ ustekinumab-ttwe, *No further questions*

☐ Wezlana, *No further questions*

☐ Yesintek, *No further questions*

69. Does the prescribed dose exceed a loading dose of 90 mg at weeks 0 and 4, and a maintenance dose of 90 mg thereafter?

☐ Yes, *Continue to 70*

☐ No, *Continue to 70*

70. Is the prescribed frequency for the maintenance dose more frequent than one dose every 12 weeks?

☐ Yes, *Continue to 71*

☐ No, *Continue to 71*

71. What is the requested product?

☐ Stelara, *No further questions*

☐ Imuldosa, *No further questions*

☐ Otulfi, *No further questions*

☐ Pyzchiva, *No further questions*

☐ Selarsdi, *No further questions*

☐ Starjemza, *No further questions*

☐ Steqeyma, *No further questions*

☐ ustekinumab, *No further questions*

☐ ustekinumab-aaaz, *No further questions*

☐ ustekinumab-aekn, *No further questions*

☐ ustekinumab-auub, *No further questions*

☐ ustekinumab-srlf, *No further questions*

☐ ustekinumab-stba, *No further questions*

☐ ustekinumab-ttwe, *No further questions*

☐ Wezlana, *No further questions*

☐ Yesintek, *No further questions*

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72. What is the requested formulation?

- ☐ Subcutaneous injection, *Continue to 73*
- ☐ Intravenous infusion, *Continue to 73*

73. Is the patient currently receiving the requested drug or a biosimilar of the requested drug?

- ☐ Yes, *Continue to 74*
- ☐ No, *Continue to 77*

74. Does the prescribed maintenance dose exceed 45 mg?

- ☐ Yes, *Continue to 75*
- ☐ No, *Continue to 75*

75. Is the prescribed frequency for the maintenance dose more frequent than one dose every 12 weeks?

- ☐ Yes, *Continue to 76*
- ☐ No, *Continue to 76*

76. What is the requested product?

- ☐ Stelara, *No further questions*
- ☐ Imuldosa, *No further questions*
- ☐ Otulfi, *No further questions*
- ☐ Pyzchiva, *No further questions*
- ☐ Selarsdi, *No further questions*
- ☐ Starjemza, *No further questions*
- ☐ Steqeyma, *No further questions*
- ☐ ustekinumab, *No further questions*
- ☐ ustekinumab-aauz, *No further questions*
- ☐ ustekinumab-aekn, *No further questions*
- ☐ ustekinumab-auub, *No further questions*
- ☐ ustekinumab-srlf, *No further questions*
- ☐ ustekinumab-stba, *No further questions*
- ☐ ustekinumab-ttwe, *No further questions*
- ☐ Wezlana, *No further questions*
- ☐ Yesintek, *No further questions*

77. Does the prescribed dose exceed a loading dose of 45 mg at weeks 0 and 4, and a maintenance dose of 45 mg thereafter?

- ☐ Yes, *Continue to 78*
- ☐ No, *Continue to 78*

78. Is the prescribed frequency for the maintenance dose more frequent than one dose every 12 weeks?

- ☐ Yes, *Continue to 79*
- ☐ No, *Continue to 79*

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79. What is the requested product?

- ☐ Stelara, *No further questions*
- ☐ Imuldosa, *No further questions*
- ☐ Otulfi, *No further questions*
- ☐ Pyzchiva, *No further questions*
- ☐ Selarsdi, *No further questions*
- ☐ Starjemza, *No further questions*
- ☐ Steqeyma, *No further questions*
- ☐ ustekinumab, *No further questions*
- ☐ ustekinumab-aaaz, *No further questions*
- ☐ ustekinumab-aekn, *No further questions*
- ☐ ustekinumab-auub, *No further questions*
- ☐ ustekinumab-srlf, *No further questions*
- ☐ ustekinumab-stba, *No further questions*
- ☐ ustekinumab-ttwe, *No further questions*
- ☐ Wezlana, *No further questions*
- ☐ Yesintek, *No further questions*

80. Which of the following applies to this request for the requested drug or a biosimilar of the requested drug?

- ☐ Initiation of the intravenous (IV) loading dose, *Continue to 90*
- ☐ Initiation of the subcutaneous (SQ) maintenance dose, *Continue to 81*
- ☐ Continuation of the subcutaneous (SQ) maintenance dose, *Continue to 83*

81. Does the prescribed maintenance dose exceed 90 mg?

- ☐ Yes, *Continue to 82*
- ☐ No, *Continue to 82*

82. Is the prescribed frequency for the maintenance dose more frequent than one dose every 8 weeks?

- ☐ Yes, *Continue to 89*
- ☐ No, *Continue to 89*

83. Does the prescribed maintenance dose exceed 90 mg?

- ☐ Yes, *Continue to 84*
- ☐ No, *Continue to 84*

84. Is the prescribed frequency for the maintenance dose more frequent than one dose every 8 weeks?

- ☐ Yes, *Continue to 85*
- ☐ No, *Continue to 89*

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

- ☐ Patient is continuing therapy at current frequency, *Continue to 87*
- ☐ Prescriber is increasing frequency, *Continue to 86*

86. Does the patient require an increase in dosing frequency due to lack of clinical response at the current dose?

- ☐ Yes, *Continue to 87*
- ☐ No, *Continue to 88*

87. Is the prescribed frequency for the maintenance dose more frequent than one dose every 4 weeks?

- ☐ Yes, *Continue to 88*
- ☐ No, *Continue to 88*

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88. What is the requested product?

- ☐ Stelara, *No further questions*
- ☐ Imuldosa, *No further questions*
- ☐ Otulfi, *No further questions*
- ☐ Pyzchiva, *No further questions*
- ☐ Selarsdi, *No further questions*
- ☐ Starjemza, *No further questions*
- ☐ Steqeyma, *No further questions*
- ☐ ustekinumab, *No further questions*
- ☐ ustekinumab-aaaz, *No further questions*
- ☐ ustekinumab-aekn, *No further questions*
- ☐ ustekinumab-auub, *No further questions*
- ☐ ustekinumab-srlf, *No further questions*
- ☐ ustekinumab-stba, *No further questions*
- ☐ ustekinumab-ttwe, *No further questions*
- ☐ Wezlana, *No further questions*
- ☐ Yesintek, *No further questions*

89. What is the requested product?

- ☐ Stelara, *No further questions*
- ☐ Imuldosa, *No further questions*
- ☐ Otulfi, *No further questions*
- ☐ Pyzchiva, *No further questions*
- ☐ Selarsdi, *No further questions*
- ☐ Starjemza, *No further questions*
- ☐ Steqeyma, *No further questions*
- ☐ ustekinumab, *No further questions*
- ☐ ustekinumab-aaaz, *No further questions*
- ☐ ustekinumab-aekn, *No further questions*
- ☐ ustekinumab-auub, *No further questions*
- ☐ ustekinumab-srlf, *No further questions*
- ☐ ustekinumab-stba, *No further questions*
- ☐ ustekinumab-ttwe, *No further questions*
- ☐ Wezlana, *No further questions*
- ☐ Yesintek, *No further questions*

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

- ☐ Less than or equal to 55 kg _____ kg, *Continue to 91*
- ☐ Greater than 55 kg to less than or equal to 85 kg _____ kg, *Continue to 94*
- ☐ Greater than 85 kg _____ kg, *Continue to 97*

91. Does the prescribed dose exceed a one-time loading dose of 260 mg and a maintenance dose of 90 mg thereafter?

- ☐ Yes, *Continue to 92*
- ☐ No, *Continue to 92*

92. Is the prescribed frequency for the maintenance dose more frequent than one dose every 8 weeks?

- ☐ Yes, *Continue to 93*
- ☐ No, *Continue to 93*

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93. What is the requested product?

- ☐ Stelara, *No further questions*
- ☐ Imuldosa, *No further questions*
- ☐ Otulfi, *No further questions*
- ☐ Pyzchiva, *No further questions*
- ☐ Selarsdi, *No further questions*
- ☐ Starjemza, *No further questions*
- ☐ Steqeyma, *No further questions*
- ☐ ustekinumab, *No further questions*
- ☐ ustekinumab-aaaz, *No further questions*
- ☐ ustekinumab-aekn, *No further questions*
- ☐ ustekinumab-auub, *No further questions*
- ☐ ustekinumab-srlf, *No further questions*
- ☐ ustekinumab-stba, *No further questions*
- ☐ ustekinumab-ttwe, *No further questions*
- ☐ Wezlana, *No further questions*
- ☐ Yesintek, *No further questions*

94. Does the prescribed dose exceed a one-time loading dose of 390 mg and a maintenance dose of 90 mg thereafter?

- ☐ Yes, *Continue to 95*
- ☐ No, *Continue to 95*

95. Is the prescribed frequency for the maintenance dose more frequent than one dose every 8 weeks?

- ☐ Yes, *Continue to 96*
- ☐ No, *Continue to 96*

96. What is the requested product?

- ☐ Stelara, *No further questions*
- ☐ Imuldosa, *No further questions*
- ☐ Otulfi, *No further questions*
- ☐ Pyzchiva, *No further questions*
- ☐ Selarsdi, *No further questions*
- ☐ Starjemza, *No further questions*
- ☐ Steqeyma, *No further questions*
- ☐ ustekinumab, *No further questions*
- ☐ ustekinumab-aaaz, *No further questions*
- ☐ ustekinumab-aekn, *No further questions*
- ☐ ustekinumab-auub, *No further questions*
- ☐ ustekinumab-srlf, *No further questions*
- ☐ ustekinumab-stba, *No further questions*
- ☐ ustekinumab-ttwe, *No further questions*
- ☐ Wezlana, *No further questions*
- ☐ Yesintek, *No further questions*

97. Does the prescribed dose exceed a one-time loading dose of 520 mg and a maintenance dose of 90 mg thereafter?

- ☐ Yes, *Continue to 98*
- ☐ No, *Continue to 98*

98. Is the prescribed frequency for the maintenance dose more frequent than one dose every 8 weeks?

- ☐ Yes, *Continue to 99*
- ☐ No, *Continue to 99*

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99. What is the requested product?

- ☐ Stelara, *No further questions*
- ☐ Imuldosa, *No further questions*
- ☐ Otulfi, *No further questions*
- ☐ Pyzchiva, *No further questions*
- ☐ Selarsdi, *No further questions*
- ☐ Starjemza, *No further questions*
- ☐ Steqeyma, *No further questions*
- ☐ ustekinumab, *No further questions*
- ☐ ustekinumab-aauz, *No further questions*
- ☐ ustekinumab-aekn, *No further questions*
- ☐ ustekinumab-auub, *No further questions*
- ☐ ustekinumab-srlf, *No further questions*
- ☐ ustekinumab-stba, *No further questions*
- ☐ ustekinumab-ttwe, *No further questions*
- ☐ Wezlana, *No further questions*
- ☐ Yesintek, *No further questions*

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X

Prescriber or Authorized Signature

Date (mm/dd/yy)

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