PA Request Criteria

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This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at . Please contact CVS/Caremark at 1-888-413-2723 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of the medication.

Patient Name: _____ **Date:** 6/13/2025
Patient ID: _____ **Patient Date Of Birth:** _____
Patient Group No: _____ **Patient Phone:** _____ **Physician Name:**
_____ **NPI#:** **Specialty:**
Physician Office Address: _____ **Physician Office Telephone:**
_

Drug Name (specify drug) _____

Quantity: _____ **Frequency:** _____ **Strength:** _____

Route of Administration: _____ **Expected Length of Therapy:** _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____
_____
_____

Please check the appropriate answer for each applicable question.

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)? **Y** ☐ **N** ☐

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? **Y** ☐ **N** ☐

3. Has the patient had a tuberculosis (TB) test (e.g., tuberculosis skin test [TST], interferon-release assay [IGRA]) within 12 months of initiating therapy? **Y** ☐ **N** ☐

4. What were the results of the tuberculosis (TB) test?
   - Positive for TB (If checked, go to 5) ☐
   - Negative for TB (If checked, go to 6) ☐
   - Unknown (If checked, no further questions) ☐

5. Which of the following applies to the patient?
   - Patient has latent TB and treatment for latent TB has been initiated (If checked, go to 6) ☐
   - Patient has latent TB and treatment for latent TB has been completed (If checked, go to 6) ☐
   - Patient has latent TB and treatment for latent TB has not been initiated (If checked, no further questions) ☐
   - Patient has active TB (If checked, no further questions) ☐

6. What is the diagnosis?
   - Cryopyrin-Associated Periodic Syndromes (CAPS), including Familial Cold Autoinflammatory Syndrome (FCAS) and Muckle-Wells Syndrome (MWS) (If checked, go to 7) ☐
   - Deficiency of interleukin-1 receptor antagonist (DIRA) (If checked, go to 16) ☐
   - Recurrent pericarditis (RP) (If checked, go to 23) ☐
   - Other, please specify. (If checked, no further questions) ☐

   _____

7. Is the patient 12 years of age or older? **Y** ☐ **N** ☐

8. Is the requested drug being prescribed by or in consultation with a rheumatologist or immunologist? **Y** ☐ **N** ☐

9. Is this request for continuation of therapy with the requested drug? **Y** ☐ **N** ☐

10. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program?
    - Yes (If checked, go to 12) ☐
    - No (If checked, go to 11) ☐
    - Unknown (If checked, go to 12) ☐

11. 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? **Y** ☐ **N** ☐

12. Which is the patient's diagnosis?
    - Familial cold autoinflammatory syndrome (FCAS) (If checked, go to 13) ☐
    - Muckle-Wells syndrome (MWS) (If checked, go to 14) ☐
    - Other, please specify. (If checked, no further questions) ☐

    _____

13. Does the patient have classic signs and symptoms of familial cold autoinflammatory syndrome (FCAS) (i.e., recurrent, intermittent fever and rash that were often exacerbated by exposure to generalized cool ambient temperature)? **Y** ☐ **N** ☐

14. Does the patient have classic signs and symptoms of Muckle-Wells syndrome (MWS) (i.e., chronic fever and rash of waxing and waning intensity, sometimes exacerbated by exposure to generalized cool ambient temperature)? **Y** ☐ **N** ☐

15. Does the patient have functional impairment limiting the activities of daily living? **Y** ☐ **N** ☐

16. Does the patient weigh 10 kilograms (kg) or more? **Y** ☐ **N** ☐

17. Is the requested drug being prescribed by or in consultation with a rheumatologist or immunologist? **Y** ☐ **N** ☐

18. Is this request for continuation of therapy with the requested drug? **Y** ☐ **N** ☐

19. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program?
    - Yes (If checked, go to 21) ☐
    - No (If checked, go to 20) ☐
    - Unknown (If checked, go to 21) ☐

20. 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? **Y** ☐ **N** ☐

21. Does the patient have IL1RN gene variants? ACTION REQUIRED: If Yes, please attach documentation of IL1RN gene variant status.
    ACTION REQUIRED: Submit supporting documentation **Y** ☐ **N** ☐

22. Will the requested drug be used for maintenance of remission following treatment with Kineret (anakinra)? **Y** ☐ **N** ☐

23. Is the patient 12 years of age or older? **Y** ☐ **N** ☐

24. Is the requested drug being prescribed by or in consultation with a cardiologist, rheumatologist, or immunologist? **Y** ☐ **N** ☐

25. Is this request for continuation of therapy with the requested drug? **Y** ☐ **N** ☐

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

- Yes (If checked, go to 30) ☐
- No (If checked, go to 27) ☐
- Unknown (If checked, go to 30) ☐

27. Has the patient achieved or maintained a positive clinical response as evidenced by decreased recurrence of pericarditis? ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation supporting positive clinical response. **Y** ☐ **N** ☐
    ACTION REQUIRED: Submit supporting documentation

28. Has the patient achieved or maintained a positive clinical response as evidenced by improvement in signs and symptoms of the condition since starting treatment with the requested drug? **Y** ☐ **N** ☐

29. 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.

- Pericarditic or pleuritic chest pain (If checked, no further questions) ☐
- Pericardial or pleural rubs (If checked, no further questions) ☐
- Electrocardiogram (ECG) (If checked, no further questions) ☐
- Pericardial effusion (If checked, no further questions) ☐
- C-reactive protein (CRP) (If checked, no further questions) ☐
- None of the above (If checked, no further questions) ☐

ACTION REQUIRED: Submit supporting documentation

30. Has the patient had at least two episodes of pericarditis? **Y** ☐ **N** ☐

31. Has the patient failed at least two agents of standard therapy (e.g., colchicine, non-steroidal anti-inflammatory drugs [NSAIDs], corticosteroids)? ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy. **Y** ☐ **N** ☐
    ACTION REQUIRED: Submit supporting documentation

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

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Prescriber (Or Authorized) Signature and Date