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:** 8/12/2024
Patient ID: _____ **Patient Date Of Birth:**
Patient Group No: _____ **Patient Phone:** _____ **Physician Name:**
NPI#: **Specialty:**
_____ **Physician Office Telephone:**
Physician Office Address: _____
_
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. What is the patient's diagnosis?
   - Active systemic lupus erythematosus (SLE) (If checked, go to 2) ☐
   - Active lupus nephritis (If checked, go to 2) ☐
   - Other, please specify. (If checked, no further questions) ☐

   _____

2. Is the patient currently receiving treatment with the requested medication? **Y** ☐ **N** ☐

3. 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? ACTION REQUIRED: If Yes, attach medical records (e.g., chart notes, lab reports) documenting disease stability or improvement. **Y** ☐ **N** ☐
   ACTION REQUIRED: Submit supporting documentation

4. Will the patient be using the requested drug in combination with other biologics? **Y** ☐ **N** ☐

5. Does the patient have severe active central nervous system (CNS) lupus [including seizures that are attributed to CNS lupus, psychosis, organic brain syndrome, cerebritis, or CNS vasculitis requiring therapeutic intervention before initiation of the requested drug]? **Y** ☐ **N** ☐

6. Will the patient be using the requested drug in combination with other biologics? **Y** ☐ **N** ☐

7. What is the patient's diagnosis?
   - Active systemic lupus erythematosus (SLE) (If checked, go to 8) ☐
   - Active lupus nephritis (If checked, go to 10) ☐

8. Prior to initiating therapy, is the patient positive for autoantibodies relevant to systemic lupus erythematosus (SLE) (e.g., ANA, anti-ds DNA, anti-Sm, antiphospholipid antibodies, complement proteins)? ACTION REQUIRED: If Yes, attach medical records (e.g., chart notes, lab reports) documenting the presence of autoantibodies relevant to SLE (e.g., ANA, anti-ds DNA, anti-Sm, antiphospholipid antibodies, complement proteins).
   - Yes (If checked, go to 9) ☐
   - No (If checked, no further questions) ☐
   - Unknown (If checked, no further questions) ☐

   ACTION REQUIRED: Submit supporting documentation

9. Is the patient currently receiving a stable standard treatment regimen for systemic lupus erythematosus (SLE) with any of the following (alone or in combination)?

- ☐ Yes, glucocorticoids (e.g., prednisone, methylprednisolone, dexamethasone) (If checked, no further questions)
- ☐ Yes, antimalarials (e.g., hydroxychloroquine) (If checked, no further questions)
- ☐ Yes, immunosuppressives (e.g., azathioprine, methotrexate, mycophenolate, cyclosporine, cyclophosphamide) (If checked, no further questions)
- ☐ Yes, nonsteroidal anti-inflammatory drugs (NSAIDs, e.g., ibuprofen, naproxen) (If checked, no further questions)
- ☐ No (If checked, no further questions)

10. Prior to initiating therapy, is the patient positive for autoantibodies relevant to systemic lupus erythematosus (SLE) (e.g., ANA, anti-ds DNA, anti-Sm, antiphospholipid antibodies, complement proteins) or was lupus nephritis confirmed on kidney biopsy? ACTION REQUIRED: If Yes, attach medical records (e.g., chart notes, lab reports) documenting the presence of autoantibodies relevant to SLE (e.g., ANA, anti-ds DNA, anti-Sm, antiphospholipid antibodies, complement proteins) or kidney biopsy confirming diagnosis.

- ☐ Yes (If checked, go to 11)
- ☐ No (If checked, no further questions)
- ☐ Unknown (If checked, no further questions)

ACTION REQUIRED: Submit supporting documentation

11. Is the patient currently receiving a stable standard therapy regimen for lupus nephritis (e.g., cyclophosphamide, mycophenolate mofetil, azathioprine, glucocorticoids)? **Y** ☐ **N** ☐

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