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.

1. Will the requested drug be used in combination with any other biologic (e.g., Adbry, Dupixent, Humira), targeted synthetic drug (e.g., Olumiant, Opzelura, Otezla, Rinvoq, Xeljanz), or potent immunosuppressant such as azathioprine or cyclosporine? **Y** ☐ **N** ☐
2. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic drug (e.g., Olumiant, Rinvoq, 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], interferonrelease assay [IGRA]) within 6 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?
   - Atopic dermatitis, moderate-to-severe (If checked, go to 7) ☐
   - 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 dermatologist or allergist/immunologist? **Y** ☐ **N** ☐

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

Patient Name: _____ **Date:** 5/13/2025
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.

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 (i.e., clear or almost clear skin) or improvement in signs and symptoms of atopic dermatitis (e.g., redness, itching, oozing/crusting) since starting treatment with the requested drug? ACTION REQUIRED: If Yes, please attach chart note(s) or medical record documentation supporting positive clinical response. Y ☐ N ☐
    ACTION REQUIRED: Submit supporting documentation
12. Has the patient experienced in the past year an inadequate response or intolerance to at least one biologic (e.g., Dupixent, Adbry) or targeted synthetic drug (e.g., Rinvoq) indicated for moderate-to-severe atopic dermatitis (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, including response to therapy. Y ☐ N
    ACTION REQUIRED: Submit supporting documentation
13. What is the percentage of body surface area (BSA) affected prior to initiation of the requested drug? Please indicate BSA percentage. ACTION REQUIRED: Please attach chart note(s) or medical record documentation of body surface area affected.
    Less than 10% of BSA (If checked, go to 14) ☐
    _____
    Greater than or equal to 10% of BSA (If checked, go to 15) ☐
    _____
    ACTION REQUIRED: Submit supporting documentation
14. Are crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) affected? ACTION REQUIRED: If Yes, please attach chart note(s) or medical record documentation of affected area(s). Y ☐ N
    ACTION REQUIRED: Submit supporting documentation
15. Has the patient had an inadequate treatment response with a medium potency to superhigh potency topical corticosteroid in the past year? Y ☐ N
16. Has the patient had an inadequate treatment response with a topical calcineurin inhibitor in the past year? ACTION REQUIRED: If Yes, please attach chart note(s), medical record, or claims history supporting prerequisite therapies, including response to therapy. ACTION REQUIRED: Submit supporting documentation Y ☐ N
17. Is the use of medium potency to super-high potency topical corticosteroids not advisable for the patient (e.g., due to contraindications, prior intolerances)? ACTION REQUIRED: If Yes, please attach chart note(s) or medical record documentation of clinical reason to avoid therapy. Y ☐ N
    ACTION REQUIRED: Submit supporting documentation
18. Is the information on the active ingredient, strength, and dosage form of the medium potency to super-high potency topical steroid the patient had an inadequate treatment response to in the past year provided? ACTION REQUIRED: Please attach chart note(s), medical record, or claims history supporting prerequisite therapies including drug name, dosage form, strength, and response to therapy.
    Yes, information is included (If checked, go to 20) ☐
    _____
    No, information is not included (If checked, no further questions) ☐
    ACTION REQUIRED: Submit supporting documentation
19. Is the use of topical calcineurin inhibitors not advisable for the patient (e.g., due to contraindications, prior intolerances)? ACTION REQUIRED: If Yes, please attach chart note(s) or medical record documentation of clinical reason to avoid therapy. ACTION REQUIRED: Submit supporting documentation Y ☐ N
20. Has the patient had an inadequate response to treatment with a systemic drug product (e.g., oral cyclosporine, azathioprine, methotrexate, mycophenolate mofetil) indicated for treatment of atopic dermatitis? ACTION REQUIRED: If Yes, please attach chart note(s), medical record, or claims history supporting prerequisite therapies, including response to therapy. Y ☐ N
    ACTION REQUIRED: Submit supporting documentation
21. Is the use of other systemic drug products (e.g., oral cyclosporine, azathioprine, methotrexate, mycophenolate mofetil) not advisable for the patient? ACTION REQUIRED: If Yes, please attach documentation of clinical reason to avoid therapies.
    Yes - indicate clinical reason to avoid therapies (If checked, no further questions) ☐
    _____

No (If checked, no further questions) ☐

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