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:** 7/25/2025
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., 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], 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?
   - 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** ☐

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

- ☐ Yes (If checked, go to 13)
- ☐ No (If checked, go to 11)
- ☐ Unknown (If checked, go to 13)

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. Is this a request for an increase in dosing regimen due to the patient not achieving an adequate clinical response at the current dose? **Y** ☐ **N** ☐

13. Has the patient had an inadequate response or intolerance to at least one biologic (e.g., Adbry, Dupixent, Ebglyss, Nemluvio) or systemic targeted synthetic drug (e.g., Rinvoq) within the past 180 days indicated for the treatment of 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

14. 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 15)

_____

- ☐ Greater than or equal to 10% of BSA (If checked, go to 16)

_____

ACTION REQUIRED: Submit supporting documentation

15. 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

16. Has the patient had an inadequate treatment response with a high potency or super-high potency topical corticosteroid in the past 180 days? **Y** ☐ **N** ☐

17. Is information on the active ingredient, strength, and dosage form of the high or super-high potency topical steroid the patient had an inadequate treatment response to in the past 180 days provided? Indicate drug strength in percentage. ACTION REQUIRED: Please attach chart note(s), medical record documentation, or claims history supporting previous medications tried including drug name, dosage form, strength, and response to therapy.

- ☐ Yes, information is included (If checked, go to 25)

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- ☐ No, information is not included (If checked, go to 18)

ACTION REQUIRED: Submit supporting documentation

18. Has the patient had an inadequate treatment response with a topical calcineurin inhibitor in the past 180 days? ACTION REQUIRED: If Yes, please attach chart note(s), medical record documentation, or claims history supporting previous medications tried including drug name, dosage form, strength, and response to therapy. **Y** ☐ **N** ☐
    ACTION REQUIRED: Submit supporting documentation

19. Has the patient had an inadequate treatment response with a topical Janus kinase (JAK) inhibitor in the past 180 days? ACTION REQUIRED: If Yes, please attach chart note(s), medical record documentation, or claims history supporting previous medications tried including drug name, dosage form, strength, and response to therapy. **Y** ☐ **N** ☐
    ACTION REQUIRED: Submit supporting documentation

20. Has the patient had an inadequate treatment response with a topical phosphodiesterase-4 (PDE-4) inhibitor in the past 180 days? ACTION REQUIRED: If Yes, please attach chart note(s), medical record documentation, or claims history supporting previous medications tried including drug name, dosage form, strength, and response to therapy. **Y** ☐ **N** ☐
    ACTION REQUIRED: Submit supporting documentation

21. Is the use of high potency or super-high potency topical corticosteroids not advisable for the patient (e.g., due to contraindications, prior intolerances, potency not appropriate for member's age)? ACTION REQUIRED: If Yes, please attach chart note(s) or medical record documentation of clinical reason to avoid therapy.
    Note: Submit supporting documentation — Y ☐ N ☐

22. 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 ☐

23. Is the use of topical Janus kinase (JAK) inhibitors not advisable for the patient (e.g., due to contraindications or prior intolerances)? ACTION REQUIRED: Please attach chart note(s) or medical record documentation of clinical reason to avoid therapy.
    ACTION REQUIRED: Submit supporting documentation — Y ☐ N ☐

24. Is the use of topical phosphodiesterase-4 (PDE-4) inhibitors not advisable for the patient (e.g., due to contraindications or prior intolerances)? ACTION REQUIRED: Please attach chart note(s) or medical record documentation of clinical reason to avoid therapy.
    ACTION REQUIRED: Submit supporting documentation — Y ☐ N ☐

25. Has the patient had an inadequate response or intolerance to treatment with a biologic (e.g., Adbry, Dupixent, Ebglyss, Nemluvio) or systemic targeted synthetic drug (e.g., Rinvoq) indicated for the treatment of atopic dermatitis? ACTION REQUIRED: If Yes, please attach chart note(s), medical record, or claims history supporting previous medications tried, including response to therapy.
    ACTION REQUIRED: Submit supporting documentation — Y ☐ N ☐

26. Is the patient currently receiving the requested drug? — Y ☐ N ☐

27. Does the prescribed dose exceed 100 mg? — Y ☐ N ☐

28. Does the prescribed dose exceed 200 mg? — Y ☐ N ☐

29. Is this a request for an increase in dosing regimen? — Y ☐ N ☐

30. Is this request for an increase in dosing regimen due to the patient not having achieved an adequate response at the 100 mg dose? — Y ☐ N ☐

31. Is the prescribed frequency more frequent than one dose once daily? — Y ☐ N ☐

32. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program?
    - Yes (If checked, no further questions) ☐
    - No (If checked, no further questions) ☐
    - Unknown (If checked, no further questions) ☐

33. Does the prescribed frequency exceed one dose once daily? — Y ☐ N ☐

34. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program?
    - Yes (If checked, no further questions) ☐
    - No (If checked, no further questions) ☐
    - Unknown (If checked, no further questions) ☐

35. Does the prescribed dose exceed 100 mg? — Y ☐ N ☐

36. Is the prescribed frequency more frequent than one dose once daily? — 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

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