CAREFIRST COMMERCIAL - NON-RISK - SPC

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Patient Information

Patient Name:

Patient Phone: - -

Patient ID:

Patient Group:

Patient DOB: / /

Physician Information

Physician Name

Physician Phone: - -

Physician Fax: - -

Physician Addr.:

City, St, Zip:

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) for the same indication? **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 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?

- Rheumatoid arthritis (If checked, go to 9) ☐
- Plaque psoriasis (If checked, go to 60) ☐
- Psoriatic arthritis (If checked, go to 36) ☐
- Psoriatic arthritis WITH co-existent plaque psoriasis (If checked, go to 7) ☐
- Ankylosing spondylitis (If checked, go to 51) ☐
- Non-radiographic axial spondyloarthritis (If checked, go to 51) ☐
- Polyarticular juvenile idiopathic arthritis (If checked, go to 23) ☐
- Oligoarticular juvenile idiopathic arthritis (If checked, go to 23) ☐
- Reactive arthritis (If checked, go to 75) ☐
- Systemic juvenile idiopathic arthritis (If checked, no further questions) ☐
- Hidradenitis suppurativa (If checked, go to 87) ☐
- Behcet's disease (If checked, go to 101) ☐
- Graft versus host disease (If checked, go to 97) ☐
- Immune checkpoint inhibitor-related toxicity (If checked, go to 107) ☐
- Immune checkpoint inhibitor-related inflammatory arthritis (If checked, go to 109) ☐
- Other, please specify (If checked, no further questions) _____

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

8. What is the primary diagnosis being treated?

- Psoriatic arthritis (If checked, go to 37) ☐
- Plaque psoriasis (If checked, go to 61) ☐

9. Has the patient been diagnosed with moderately to severely active rheumatoid arthritis? **Y** ☐ **N** ☐

10. Is the patient an adult (18 years of age or older)? **Y** ☐ **N** ☐

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

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

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

- Yes (If checked, go to 16) ☐
- No (If checked, go to 14) ☐
- Unknown (If checked, go to 16) ☐

14. Has the patient achieved or maintained a positive clinical response since starting treatment with the requested drug? **Y** ☐ **N** ☐

15. Has the patient experienced substantial disease activity improvement (e.g., at least 20% from baseline) in tender joint count, swollen joint count, pain, or disability? ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation supporting positive clinical response and substantial disease activity improvement. **Y** ☐ **N** ☐

16. Has the patient ever received or is currently receiving a biologic (e.g., Humira) or targeted synthetic drug (e.g., Rinvoq, Xeljanz) indicated for treatment of moderately to severely active rheumatoid 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. **Y** ☐ **N** ☐

17. Does the patient meet either of the following: a) the patient was tested for the rheumatoid factor (RF) biomarker and the RF biomarker test was positive, or b) the patient was tested for the anti-cyclic citrullinated peptide (anti-CCP) biomarker and the anti-CCP biomarker test was positive? ACTION REQUIRED: If Yes, please attach laboratory results, chart notes, or medical record documentation of biomarker testing. **Y** ☐ **N** ☐

18. Has the patient been tested for all of the following biomarkers: a) rheumatoid factor (RF), b) anti-cyclic citrullinated peptide (anti-CCP), and c) C-reactive protein (CRP) and/or erythrocyte sedimentation rate (ESR)? ACTION REQUIRED: If Yes, please attach laboratory results, chart notes, or medical record documentation of biomarker testing. **Y** ☐ **N** ☐

19. Has the patient experienced an inadequate response after at least 3 months of treatment with methotrexate at a dose greater than or equal to 15 mg per week? ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy. **Y** ☐ **N** ☐

20. Has the patient experienced an intolerance to methotrexate? ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy. **Y** ☐ **N** ☐

21. Does the patient have a contraindication to methotrexate? ACTION REQUIRED: If Yes, please attach documentation of clinical reason to avoid therapy. **Y** ☐ **N** ☐

22. Please indicate the contraindication to methotrexate.

- Clinical diagnosis of alcohol use disorder, alcoholic liver disease, or other chronic liver disease (If checked, go to 118) ☐
- Drug interaction (If checked, go to 118) ☐
- Risk of treatment-related toxicity (If checked, go to 118) ☐
- Pregnancy or currently planning pregnancy (If checked, go to 118) ☐
- Breastfeeding (If checked, go to 118) ☐
- Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension) (If checked, go to 118) ☐
- Hypersensitivity (If checked, go to 118) ☐
- History of intolerance or adverse event (If checked, go to 118) ☐
- Other, please specify. (If checked, no further questions) _____

23. Has the patient been diagnosed with moderately to severely active articular juvenile idiopathic arthritis? **Y** ☐ **N** ☐

24. Is the patient 2 years of age or older? **Y** ☐ **N** ☐

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

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

27. 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 28) ☐
- Unknown (If checked, go to 30) ☐

28. 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** ☐

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.

- Number of joints with active arthritis (e.g., swelling, pain, limitation of motion) (If checked, go to 118) ☐
- Number of joints with limitation of movement (If checked, go to 118) ☐
- Functional ability (If checked, go to 118) ☐
- None of the above (If checked, no further questions) ☐

30. Has the patient ever received or is currently receiving a biologic (e.g., Humira) or targeted synthetic drug (e.g., Xeljanz) indicated for the treatment of active articular juvenile idiopathic 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. **Y** ☐ **N** ☐

31. Has the patient had an inadequate response to methotrexate or another conventional synthetic drug (e.g., leflunomide, sulfasalazine, hydroxychloroquine) 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. **Y** ☐ **N** ☐

32. Has the patient had an inadequate response to a trial of scheduled non-steroidal anti-inflammatory drugs (NSAIDs) and/or intra-articular glucocorticoids (e.g., triamcinolone hexacetonide)? ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy. **Y** ☐ **N** ☐

33. Does the patient have one of the following risk factors for poor outcome: a) involvement of ankle, wrist, hip, sacroiliac joint, and/or temporomandibular joint (TMJ), b) presence of erosive disease or enthesitis, c) delay in diagnosis, d) elevated levels of inflammation markers, or e) symmetric disease? **Y** ☐ **N** ☐

34. Does the patient have any of the following risk factors for disease severity and potentially a more refractory disease course: a) positive rheumatoid factor, b) positive anti-cyclic citrullinated peptide antibodies, or c) pre-existing joint damage? **Y** ☐ **N** ☐

35. Does the patient meet any of the following: a) high-risk joints are involved (e.g., cervical spine, wrist, or hip), b) high disease activity, or c) high risk for disabling joint disease? **Y** ☐ **N** ☐

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

37. Is the patient 2 years of age or older? **Y** ☐ **N** ☐

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

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

- Yes (If checked, go to 42) ☐
- No (If checked, go to 40) ☐
- Unknown (If checked, go to 42) ☐

40. 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** ☐

41. 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 (If checked, go to 118) ☐
- Number of tender joints (If checked, go to 118) ☐
- Dactylitis (If checked, go to 118) ☐
- Enthesitis (If checked, go to 118) ☐
- Axial disease (If checked, go to 118) ☐
- Skin and/or nail involvement (If checked, go to 118) ☐
- Functional status (If checked, go to 118) ☐
- C-reactive protein (CRP) (If checked, go to 118) ☐
- None of the above (If checked, no further questions) ☐

42. Has the patient been diagnosed with active psoriatic arthritis (PsA)? **Y** ☐ **N** ☐

43. Has the patient ever received or is currently receiving a biologic (e.g., Humira) or targeted synthetic drug (e.g., Rinvoq, Otezla) indicated for treatment of 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. **Y** ☐ **N** ☐

44. What is the patient's disease severity?

- Mild to moderate (If checked, go to 45) ☐
- Severe (If checked, go to 118) ☐

45. Does the patient have enthesitis or predominantly axial disease? **Y** ☐ **N** ☐

46. 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. **Y** ☐ **N** ☐

47. 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. **Y** ☐ **N** ☐

48. Does the patient have a contraindication to methotrexate or leflunomide? ACTION REQUIRED: If Yes, please attach documentation of clinical reason to avoid therapy. **Y** ☐ **N** ☐

49. Please indicate the contraindication to methotrexate or leflunomide.

- Clinical diagnosis of alcohol use disorder, alcoholic liver disease, or other chronic liver disease (If checked, go to 118) ☐
- Drug interaction (If checked, go to 118) ☐
- Risk of treatment-related toxicity (If checked, go to 118) ☐
- Pregnancy or currently planning pregnancy (If checked, go to 118) ☐
- Breastfeeding (If checked, go to 118) ☐
- Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension) (If checked, go to 118) ☐
- Hypersensitivity (If checked, go to 118) ☐
- History of intolerance or adverse event (If checked, go to 118) ☐
- Other, please specify. (If checked, no further questions) _____

50. 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. **Y** ☐ **N** ☐

51. Is the patient an adult (18 years of age or older)? **Y** ☐ **N** ☐

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

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

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

- Yes (If checked, go to 57) ☐
- No (If checked, go to 55) ☐
- Unknown (If checked, go to 57) ☐

55. 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** ☐

56. 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.

- Functional status (If checked, go to 118) ☐
- Total spinal pain (If checked, go to 118) ☐
- Inflammation (e.g., morning stiffness) (If checked, go to 118) ☐
- Swollen joints (If checked, go to 118) ☐
- Tender joints (If checked, go to 118) ☐
- C-reactive protein (CRP) (If checked, go to 118) ☐
- None of the above (If checked, no further questions) ☐

57. Has the patient been diagnosed with active ankylosing spondylitis (AS) or active non-radiographic axial spondyloarthritis (nr-axSpA)?

- Yes - Active ankylosing spondylitis (If checked, go to 58) ☐
- Yes - Active non-radiographic axial spondyloarthritis (If checked, go to 58) ☐

No (If checked, no further questions) ☐

58. Has the patient ever received or is currently receiving a biologic (e.g., Humira) or targeted synthetic drug (e.g., Rinvoq, Xeljanz) indicated for treatment of active ankylosing spondylitis or active non-radiographic axial spondyloarthritis (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. **Y** ☐ **N** ☐

59. Has the patient experienced an inadequate response with at least TWO nonsteroidal anti-inflammatory drugs (NSAIDs), or has an intolerance or contraindication to at least two NSAIDs? ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy. If therapy is not advisable, please attach documentation of clinical reason to avoid therapy. **Y** ☐ **N** ☐

60. Is the requested drug being prescribed by or in consultation with a dermatologist? **Y** ☐ **N** ☐

61. Has the patient been diagnosed with moderate to severe plaque psoriasis? **Y** ☐ **N** ☐

62. Is the patient 4 years of age or older? **Y** ☐ **N** ☐

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

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

Yes (If checked, go to 68) ☐

No (If checked, go to 65) ☐

Unknown (If checked, go to 68) ☐

65. 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** ☐

66. 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. **Y** ☐ **N** ☐

67. 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. **Y** ☐ **N** ☐

68. 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. **Y** ☐ **N** ☐

69. 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. **Y** ☐ **N** ☐

70. Is the percentage of body surface area (BSA) affected (prior to starting the requested medication) less than 3%? **Y** ☐ **N** ☐

71. What is the percentage of body surface area (BSA) affected (prior to starting the requested medication)? 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 (If checked, go to 72) _____

Greater than or equal to 10% of BSA (If checked, go to 118) _____

72. Has the patient experienced 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. **Y** ☐ **N** ☐

73. 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 therapy. **Y** ☐ **N** ☐

74. 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 (If checked, go to 118) ☐
- Drug interaction (If checked, go to 118) ☐
- Risk of treatment-related toxicity (If checked, go to 118) ☐
- Pregnancy or currently planning pregnancy (If checked, go to 118) ☐
- Breastfeeding (If checked, go to 118) ☐
- Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension) (If checked, go to 118) ☐
- Hypersensitivity (If checked, go to 118) ☐
- History of intolerance or adverse event (If checked, go to 118) ☐
- Other, please specify. (If checked, no further questions) _____

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

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

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

- Yes (If checked, go to 79) ☐
- No (If checked, go to 78) ☐
- Unknown (If checked, go to 79) ☐

78. 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 (e.g., tender joint count, swollen joint count, pain) since starting treatment with the requested drug? ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation supporting positive clinical response. **Y** ☐ **N** ☐

79. Has the patient ever received or is currently receiving a biologic (e.g., Remicade) indicated for the treatment of reactive 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. **Y** ☐ **N** ☐

80. Has the patient had an inadequate response to methotrexate? ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy. **Y** ☐ **N** ☐

81. Has the patient had an inadequate response to sulfasalazine? ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy. **Y** ☐ **N** ☐

82. Has the patient experienced an intolerance to sulfasalazine? ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy. **Y** ☐ **N** ☐

83. Does the patient have a contraindication to sulfasalazine (e.g., porphyria, intestinal or urinary obstruction)? ACTION REQUIRED: If Yes, please attach documentation of clinical reason to avoid therapy. **Y** ☐ **N** ☐

84. Has the patient experienced an intolerance to methotrexate? ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy. **Y** ☐ **N** ☐

85. Does the patient have a contraindication to methotrexate? ACTION REQUIRED: If Yes, please attach documentation of clinical reason to avoid therapy. **Y** ☐ **N** ☐

86. Please indicate the contraindication to methotrexate.

- Clinical diagnosis of alcohol use disorder, alcoholic liver disease, or other chronic liver disease (If checked, go to 118) ☐
- Drug interaction (If checked, go to 118) ☐
- Risk of treatment-related toxicity (If checked, go to 118) ☐
- Pregnancy or currently planning pregnancy (If checked, go to 118) ☐

Breastfeeding (If checked, go to 118) ☐

Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension) (If checked, go to 118) ☐

Hypersensitivity (If checked, go to 118) ☐

History of intolerance or adverse event (If checked, go to 118) ☐

Other, please specify. (If checked, no further questions) _____

87. Has the patient been diagnosed with severe, refractory hidradenitis suppurativa? **Y** ☐ **N** ☐

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

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

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

Yes (If checked, go to 93) ☐

No (If checked, go to 91) ☐

Unknown (If checked, go to 93) ☐

91. 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** ☐

92. Which of the following signs and symptoms has the patient experienced an improvement in from baseline? ACTION REQUIRED: Please attach chart notes or medical records supporting positive clinical response.

Reduction in abscess and inflammatory nodule count from baseline (If checked, go to 118) ☐

Reduced formation of new sinus tracts and scarring (If checked, go to 118) ☐

Decrease in frequency of inflammatory lesions from baseline (If checked, go to 118) ☐

Reduction in pain from baseline (If checked, go to 118) ☐

Reduction in suppuration from baseline (If checked, go to 118) ☐

Improvement in frequency of relapses from baseline (If checked, go to 118) ☐

Improvement in quality of life from baseline (If checked, go to 118) ☐

Improvement on a disease severity assessment tool from baseline (If checked, go to 118) ☐

None of the above (If checked, no further questions) ☐

93. Has the patient ever received or is currently receiving a biologic (e.g., Humira) indicated for the treatment of severe, refractory hidradenitis suppurativa (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. **Y** ☐ **N** ☐

94. Has the patient experienced an inadequate response after at least 90 days of treatment with an oral antibiotic used for the treatment of hidradenitis suppurativa (e.g., clindamycin, metronidazole, moxifloxacin, rifampin, tetracyclines)? ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy. **Y** ☐ **N** ☐

95. Has the patient experienced an intolerance to oral antibiotics used for the treatment of hidradenitis suppurativa? ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy. **Y** ☐ **N** ☐

96. Does the patient have a contraindication to oral antibiotics used for the treatment of hidradenitis suppurativa? ACTION REQUIRED: If Yes, please attach documentation of clinical reason to avoid therapy. **Y** ☐ **N** ☐

97. Is the requested drug being prescribed by or in consultation with an oncologist or hematologist? **Y** ☐ **N** ☐

98. Has the patient had an inadequate response to systemic corticosteroids? ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy. **Y** ☐ **N** ☐

99. Has the patient experienced an intolerance to corticosteroids? ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy. **Y** ☐ **N** ☐

100. Does the patient have a contraindication to corticosteroids? ACTION REQUIRED: If Yes, please attach documentation of clinical reason to avoid therapy. **Y** ☐ **N** ☐

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

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

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

- Yes (If checked, go to 105) ☐
- No (If checked, go to 104) ☐
- Unknown (If checked, go to 105) ☐

104. 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** ☐

105. Has the patient ever received or is currently receiving Otezla or a biologic (e.g., Humira) indicated for the treatment of Behcet's disease (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. **Y** ☐ **N** ☐

106. Has the patient had an inadequate response to at least one non-biologic medication for Behcet's disease (e.g., azathioprine, colchicine, cyclosporine, systemic 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** ☐

107. Does the patient have a diagnosis of Stevens-Johnson syndrome or toxic epidermal necrolysis? **Y** ☐ **N** ☐

108. Is the requested drug being prescribed by or in consultation with an oncologist, hematologist, or dermatologist? **Y** ☐ **N** ☐

109. Is the requested drug being prescribed by or in consultation with an oncologist, hematologist, or rheumatologist? **Y** ☐ **N** ☐

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

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

- Yes (If checked, go to 113) ☐
- No (If checked, go to 112) ☐
- Unknown (If checked, go to 113) ☐

112. 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? ACTION REQUIRED: If yes, please attach chart notes or medical record documentation supporting positive clinical response. **Y** ☐ **N** ☐

113. Does the patient have severe immunotherapy-related inflammatory arthritis? **Y** ☐ **N** ☐

114. Has the patient had an inadequate response to corticosteroids? ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy. **Y** ☐ **N** ☐

115. Has the patient had an inadequate response to a conventional synthetic drug (e.g., methotrexate, sulfasalazine, leflunomide, hydroxychloroquine)? ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy. **Y** ☐ **N** ☐

116. Does the patient have an intolerance or contraindication to corticosteroids? ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy. If therapy is if not advisable, please attach documentation of clinical reason to avoid therapy. **Y** ☐ **N** ☐

117. Does the patient have an intolerance or contraindication to a conventional synthetic drug (e.g., methotrexate, sulfasalazine, leflunomide, hydroxychloroquine)? ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy. If therapy is if not advisable, please attach documentation of clinical reason to avoid therapy. **Y** ☐ **N** ☐

118. What is the diagnosis?

- Rheumatoid arthritis (If checked, go to 119) ☐
- Plaque psoriasis (If checked, go to 128) ☐
- Psoriatic arthritis (If checked, go to 124) ☐
- Psoriatic arthritis WITH co-existent plaque psoriasis (If checked, go to 123) ☐
- Ankylosing spondylitis (If checked, go to 119) ☐
- Non-radiographic axial spondyloarthritis (If checked, go to 119) ☐
- Polyarticular juvenile idiopathic arthritis (If checked, go to 120) ☐
- Oligoarticular juvenile idiopathic arthritis (If checked, go to 120) ☐
- Reactive arthritis (If checked, go to 135) ☐
- Hidradenitis suppurativa (If checked, go to 137) ☐
- Behcet's disease (If checked, go to 135) ☐
- Graft versus host disease (If checked, go to 140) ☐
- Immune checkpoint inhibitor toxicity - Stevens-Johnson syndrome (If checked, go to 146) ☐
- Immune checkpoint inhibitor toxicity - toxic epidermal necrolysis (If checked, go to 146) ☐
- Immune checkpoint inhibitor toxicity - immunotherapy-related inflammatory arthritis (If checked, go to 135) ☐

119. Do the prescribed dose and frequency exceed either of the following: a) 25 mg twice a week, or b) 50 mg once a week? **Y** ☐ **N** ☐

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

- Less than 63 kg (138.6 lbs) (If checked, go to 121) _____
- 63 kg (138.6 lbs) or greater (If checked, go to 122) _____

121. Does the prescribed dose exceed 0.8 mg per kg? **Y** ☐ **N** ☐

122. Do the prescribed dose and frequency exceed either of the following: a) 25 mg twice a week, or b) 50 mg once a week? **Y** ☐ **N** ☐

123. What is the patient's age?

- 2 years to less than 4 years of age (If checked, go to 125) ☐
- 4 years to less than 18 years of age (If checked, go to 130) ☐
- 18 years of age or older (If checked, go to 129) ☐

124. What is the patient's age?

- 2 years to less than 18 years of age (If checked, go to 125) ☐
- 18 years of age or older (If checked, go to 127) ☐

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

- Less than 63 kg (138.6 lbs) (If checked, go to 126) _____
- 63 kg (138.6 lbs) or greater (If checked, go to 127) _____

126. Does the prescribed dose exceed 0.8 mg per kg? **Y** ☐ **N** ☐

127.	Do the prescribed dose and frequency exceed either of the following: a) 25 mg twice a week, or b) 50 mg once a week?	**Y** ☐	**N** ☐
128.	What is the patient's age?		
	4 years to less than 18 years of age (If checked, go to 130)	☐	
	18 years of age or older (If checked, go to 129)	☐	
129.	Is the patient currently receiving the requested drug?	**Y** ☐	**N** ☐
130.	What is the patient's weight? Indicate in kilograms (kg).		
	Less than 63 kg (138.6 lbs) (If checked, go to 131)	_____	
	63 kg (138.6 lbs) or greater (If checked, go to 132)	_____	
131.	Does the prescribed dose exceed 0.8 mg per kg?	**Y** ☐	**N** ☐
132.	Do the prescribed dose and frequency exceed either of the following: a) 25 mg twice a week, or b) 50 mg once a week?	**Y** ☐	**N** ☐
133.	Does the prescribed loading dose exceed 50 mg twice a week for 3 months?	**Y** ☐	**N** ☐
134.	Do the prescribed dose and frequency for the maintenance dose exceed either of the following: a) 25 mg twice a week, or b) 50 mg once a week?	**Y** ☐	**N** ☐
135.	Is the requested quantity supported by dosing guidelines found in the compendia or current literature (e.g., Micromedex DrugDex, NCCN compendia, current treatment guidelines)?	**Y** ☐	**N** ☐
136.	Do the prescribed dose and frequency exceed either of the following: a) 25 mg twice a week, or b) 50 mg once a week?	**Y** ☐	**N** ☐
137.	Is the requested quantity supported by dosing guidelines found in the compendia or current literature (e.g., Micromedex DrugDex, NCCN compendia, current treatment guidelines)?	**Y** ☐	**N** ☐
138.	Does the prescribed dose exceed 50 mg?	**Y** ☐	**N** ☐
139.	Is the prescribed frequency for the maintenance dose more frequent than one dose twice every week?	**Y** ☐	**N** ☐
140.	Is the requested quantity supported by dosing guidelines found in the compendia or current literature (e.g., Micromedex DrugDex, NCCN compendia, current treatment guidelines)?	**Y** ☐	**N** ☐
141.	Is the patient currently receiving the requested drug?	**Y** ☐	**N** ☐
142.	Does the prescribed dose exceed 25 mg?	**Y** ☐	**N** ☐
143.	Is the prescribed frequency for the maintenance dose more frequent than one dose every week?	**Y** ☐	**N** ☐
144.	Does the prescribed loading dose exceed 25 mg twice weekly for 4 weeks followed by a maintenance dose of 25 mg?	**Y** ☐	**N** ☐
145.	Is the prescribed frequency for the maintenance dose more frequent than one dose every week?	**Y** ☐	**N** ☐
146.	Is the requested quantity supported by dosing guidelines found in the compendia or current literature (e.g., Micromedex DrugDex, NCCN compendia, current treatment guidelines)?	**Y** ☐	**N** ☐
147.	Does the prescribed dose exceed 50 mg?	**Y** ☐	**N** ☐
148.	Is the prescribed frequency more frequent than one dose twice every week?	**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.

_____

Prescriber (Or Authorized) Signature and Date