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:** 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.

1. Will the requested drug be used in combination with any other biologic (e.g., Humira) or targeted synthetic drug (e.g., Rinvoq, 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], interferonrelease 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?
   - Ulcerative colitis (If checked, go to 7) ☐
   - Crohn's disease (If checked, go to 12) ☐

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

_____

7. Has the patient been diagnosed with moderately to severely active ulcerative colitis (UC)? **Y** ☐ **N** ☐

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

9. Which of the following applies to this request for the requested drug? Initiation of the intravenous (IV) loading dose (If checked, go to 17) ☐

   Initiation of the subcutaneous (SQ) maintenance dose (If checked, go to 19) ☐

   Continuation of the subcutaneous (SQ) maintenance dose (If checked, go to 10) ☐

10. Has the patient achieved or maintained remission OR 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 of remission or positive clinical response to therapy.

   Yes, achieved or maintained remission (If checked, go to 19) ☐

   Yes, achieved or maintained a positive clinical response (If checked, go to 11) ☐

   No or none of the above (If checked, no further questions) ☐ Note: Submit supporting documentation

11. 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 to therapy.

   Stool frequency (If checked, go to 19) ☐

   Rectal bleeding (If checked, go to 19) ☐

   Urgency of defecation (If checked, go to 19) ☐

   C-reactive protein (CRP) (If checked, go to 19) ☐

   Fecal calprotectin (FC) (If checked, go to 19) ☐

   Appearance of the mucosa on endoscopy, computed tomography enterography (CTE), magnetic resonance enterography (MRE), or intestinal ultrasound (If checked, go to 19) ☐

   Improvement on a disease activity scoring tool (e.g., Ulcerative Colitis Endoscopic Index of Severity [UCEIS], Mayo Score) (If checked, go to 19)

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

   ACTION REQUIRED: Submit supporting documentation

12. Has the patient been diagnosed with moderately to severely active Crohn's disease (CD)? **Y** ☐ **N** ☐

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

14. Which of the following applies to this request for the requested drug? Initiation of the intravenous (IV) loading dose (If checked, go to 21) ☐

   Initiation of the subcutaneous (SQ) maintenance dose (If checked, go to 23) ☐

   Continuation of the subcutaneous (SQ) maintenance dose (If checked, go to 15) ☐

15. Has the patient achieved or maintained remission OR 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 of remission or positive clinical response to therapy.

Yes, achieved or maintained remission (If checked, go to 23) ☐

Yes, achieved or maintained a positive clinical response (If checked, go to 16) ☐

No or none of the above (If checked, no further questions) ☐ ACTION REQUIRED: Submit supporting documentation

16. 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 to therapy.

Abdominal pain or tenderness (If checked, go to 23) ☐

Diarrhea (If checked, go to 23) ☐

Body weight (If checked, go to 23) ☐

Abdominal mass (If checked, go to 23) ☐

Hematocrit (If checked, go to 23) ☐

Appearance of the mucosa on endoscopy, computed tomography enterography (CTE), magnetic resonance enterography (MRE), or intestinal ultrasound (If checked, go to 23) ☐

Improvement on a disease activity scoring tool (e.g., Crohn's Disease Activity Index [CDAI] score) (If checked, go to 23) ☐

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

ACTION REQUIRED: Submit supporting documentation

17. Does the prescribed dose exceed an intravenous loading dose of 300 mg at weeks 0, 4, and 8, and a subcutaneous maintenance dose of 200 mg thereafter? **Y** ☐ **N** ☐

18. Is the prescribed frequency for the maintenance dose more frequent than one dose every 4 weeks? **Y** ☐ **N** ☐

19. Does the prescribed maintenance dose exceed 200 mg? **Y** ☐ **N** ☐

20. Is the prescribed frequency for the maintenance dose more frequent than one dose every 4 weeks? **Y** ☐ **N** ☐

21. Does the prescribed dose exceed an intravenous loading dose of 900 mg at weeks 0, 4, and 8, and a subcutaneous maintenance dose of 300 mg thereafter? **Y** ☐ **N** ☐

22. Is the prescribed frequency for the maintenance dose more frequent than one dose every 4 weeks? **Y** ☐ **N** ☐

23. Does the prescribed maintenance dose exceed 300 mg? **Y** ☐ **N** ☐

24. Is the prescribed frequency for the maintenance dose more frequent than one dose every 4 weeks? **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