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: _____ **NPI#:** **Patient Phone:** _____ **Physician Name:**
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 diagnosis?
   - Rheumatoid arthritis (RA) (If checked, go to 2) ☐
   - Polyarticular juvenile idiopathic arthritis (pJIA) (If checked, go to 2) ☐
   - Psoriasis (If checked, go to 2) ☐
   - Microscopic polyangiitis (If checked, go to 2) ☐
   - Other, please specify (If checked, no further questions) ☐
     _____
2. Has the patient had an inadequate response to generic oral methotrexate? ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting inadequate response to generic oral methotrexate. ACTION REQUIRED: Submit supporting documentation **Y** ☐ **N** ☐
3. Has the patient had an intolerance to generic oral methotrexate? ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting intolerance to generic oral methotrexate.
   ACTION REQUIRED: Submit supporting documentation **Y** ☐ **N** ☐
4. Is the patient unable to prepare and administer generic injectable methotrexate? ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation supporting member's inability to prepare and administer generic injectable methotrexate. ACTION REQUIRED: Submit supporting documentation **Y** ☐ **N** ☐
5. Is the patient currently receiving Otrexup? **Y** ☐ **N** ☐
6. How long has the patient received treatment with Otrexup?
   - Less than 3 months (If checked, no further questions) ☐
   - 3 months or greater (If checked, go to 7) ☐

7. 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 Otrexup? **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