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., Dupixent, Humira), targeted synthetic drug (e.g., Cibinqo, Olumiant, Opzelura, Otezla, 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., Cibinqo, 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 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 7) ☐
   Psoriatic arthritis (If checked, go to 16) ☐
   Atopic dermatitis (If checked, go to 25) ☐
   Ulcerative colitis (If checked, go to 42) ☐
   Ankylosing spondylitis (If checked, go to 52) ☐

Non-radiographic axial spondyloarthritis (If checked, go to 52) ☐

Crohn's disease (If checked, go to 61) ☐

Polyarticular juvenile idiopathic arthritis (If checked, go to 71) ☐

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

_____

7. Has the patient been diagnosed with moderately to severely active rheumatoid arthritis (RA)? **Y** ☐ **N** ☐

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

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

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

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

Yes (If checked, go to 14) ☐

No (If checked, go to 12) ☐

Unknown (If checked, go to 14) ☐

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

13. 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. ACTION REQUIRED: Submit supporting documentation **Y** ☐ **N** ☐

14. Has the patient experienced an inadequate response, intolerance, or has a contraindication to at least one tumor necrosis factor (TNF) inhibitor (e.g., Humira)? ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy. ACTION REQUIRED: Submit supporting documentation **Y** ☐ **N** ☐

15. Has the patient ever received or is currently receiving a biologic (other than a TNF inhibitor, e.g., Actemra, Orencia) or targeted synthetic drug (e.g., Xeljanz, Olumiant) indicated for 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.
ACTION REQUIRED: Submit supporting documentation **Y** ☐ **N**

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

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

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

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

Yes (If checked, go to 22) ☐

No (If checked, go to 20) ☐

Unknown (If checked, go to 22) ☐

20. 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** ☐

21. 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 80)
- ☐ Number of tender joints (If checked, go to 80)
- ☐ Dactylitis (If checked, go to 80)
- ☐ Enthesitis (If checked, go to 80)
- ☐ Axial disease (If checked, go to 80)
- ☐ Skin and/or nail involvement (If checked, go to 80)
- ☐ Functional status (If checked, go to 80)
- ☐ C-reactive protein (CRP) (If checked, go to 80)
- ☐ None of the above (If checked, no further questions)

ACTION REQUIRED: Submit supporting documentation

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

23. Has the patient had an inadequate response or intolerance to at least one tumor necrosis factor (TNF) inhibitor (e.g., Humira)? 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

24. Has the patient ever received or is currently receiving a biologic (other than a TNF inhibitor, e.g., Cosentyx, Orencia) or targeted synthetic drug (e.g., Xeljanz, Otezla) indicated for 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** ☐
ACTION REQUIRED: Submit supporting documentation

25. Has the patient been diagnosed with moderate-to-severe atopic dermatitis? **Y** ☐ **N** ☐

26. Is the patient 12 years of age or older? **Y** ☐ **N** ☐

27. Is the requested drug being prescribed by or in consultation with a dermatologist or allergist/immunologist? **Y** ☐ **N** ☐

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

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

- ☐ Yes (If checked, go to 32)
- ☐ No (If checked, go to 30)
- ☐ Unknown (If checked, go to 32)

30. 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

31. 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 ☐

32. 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., Cibinqo) 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

33. 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 34)

_____

☐ Greater than or equal to 10% of BSA (If checked, go to 35)

_____

ACTION REQUIRED: Submit supporting documentation

34. 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

35. Has the patient had an inadequate treatment response with a medium potency to superhigh potency topical corticosteroid in the past year? Y ☐ N ☐

36. 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 40)

_____

☐ No, information is not included (If checked, go to 37)

ACTION REQUIRED: Submit supporting documentation

37. 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 ☐

38. 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

39. 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 ☐ ☐

40. Has the patient had an inadequate response to treatment with a systemic drug product (e.g., oral cyclosporine, azathioprine, methotrexate, mycophenolate mofetil) indicated for the 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

41. 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, go to 80)

_____

☐ No (If checked, no further questions)

ACTION REQUIRED: Submit supporting documentation

☐

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

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

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

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

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

- Yes (If checked, go to 50)
- No (If checked, go to 47) ☐
- Unknown (If checked, go to 50) ☐

47. 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.

- Yes, achieved or maintained remission (If checked, go to 80) ☐
- Yes, achieved or maintained a positive clinical response (If checked, go to 48) ☐
- None of the above (If checked, go to 49) ☐

ACTION REQUIRED: Submit supporting documentation

48. 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 80) ☐
- Rectal bleeding (If checked, go to 80) ☐
- Urgency of defecation (If checked, go to 80) ☐
- C-reactive protein (CRP) (If checked, go to 80) ☐
- Fecal calprotectin (FC) (If checked, go to 80) ☐
- Appearance of the mucosa on endoscopy, computed tomography enterography (CTE), magnetic resonance enterography (MRE), or intestinal ultrasound (If checked, go to 80) ☐
- Improvement on a disease activity scoring tool (e.g., Ulcerative Colitis Endoscopic Index of Severity [UCEIS], Mayo Score) (If checked, go to 80) ☐
- None of the above (If checked, go to 49) ☐

ACTION REQUIRED: Submit supporting documentation

49. Is this a request for an increase in dosing regimen due to the patient having refractory, severe, or extensive disease at the current dose? **Y** ☐ **N** ☐

50. Has the patient had an inadequate response or intolerance to at least one tumor necrosis factor (TNF) inhibitor (e.g., Humira)? 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

51. Has the patient ever received or is currently receiving a biologic (other than a tumor necrosis factor [TNF] inhibitor, e.g., Entyvio, Stelara) or targeted synthetic drug (e.g., Xeljanz) indicated for the treatment of moderately to severely active ulcerative colitis (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. ACTION REQUIRED: Submit supporting documentation — Y ☐ N ☐

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

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

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

55. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program? Yes (If checked, go to 58) ☐

No (If checked, go to 56) ☐

Unknown (If checked, go to 58) ☐

56. 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 ☐

57. 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 80) ☐

Total spinal pain (If checked, go to 80) ☐

Inflammation (e.g., morning stiffness) (If checked, go to 80) ☐

Swollen joints (If checked, go to 80) ☐

Tender joints (If checked, go to 80) ☐

C-reactive protein (CRP) (If checked, go to 80) ☐

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

ACTION REQUIRED: Submit supporting documentation

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

Yes - Active ankylosing spondylitis (If checked, go to 59) ☐

Yes - Active non-radiographic axial spondyloarthritis (If checked, go to 59) ☐

No (If checked, no further questions) ☐

59. Has the patient experienced an inadequate response or intolerance to at least one tumor necrosis factor (TNF) inhibitor (e.g., Humira)? ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy. — Y ☐ N ☐

60. Has the patient ever received or is currently receiving a biologic (other than a TNF inhibitor, e.g., Cosentyx, Taltz) or targeted synthetic drug (e.g., Xeljanz) indicated for 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.
ACTION REQUIRED: Submit supporting documentation — Y ☐ N ☐

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

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

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

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

65. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program? Yes (If checked, go to 69) ☐

No (If checked, go to 66) ☐

Unknown (If checked, go to 69) ☐

66. 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.

Yes - achieved or maintained remission (If checked, go to 80) ☐

Yes, achieved or maintained a positive clinical response (If checked, go to 67) ☐

None of the above (If checked, go to 68)

ACTION REQUIRED: Submit supporting documentation

67. 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 80) ☐

Diarrhea (If checked, go to 80) ☐

Body weight (If checked, go to 80) ☐

Abdominal mass (If checked, go to 80) ☐

Hematocrit (If checked, go to 80) ☐

Appearance of the mucosa on endoscopy, computed tomography enterography (CTE), magnetic resonance enterography (MRE), or intestinal ultrasound (If checked, go to 80) ☐

Improvement on a disease activity scoring tool (e.g., Crohn's Disease Activity Index [CDAI] score) (If checked, go to 80) ☐

None of the above (If checked, go to 68) ☐

ACTION REQUIRED: Submit supporting documentation

68. Is this a request for an increase in dosing regimen due to the patient having refractory, severe, or extensive disease at the current dose? Y ☐ N ☐

69. Has the patient had an inadequate response or intolerance to at least one tumor necrosis factor (TNF) inhibitor (e.g., Humira)? 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

70. Has the patient ever received or is currently receiving a biologic (other than a tumor necrosis factor [TNF] inhibitor, e.g., Entyvio, Stelara) indicated for the treatment of moderately to severely active Crohn'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 ☐

ACTION REQUIRED: Submit supporting documentation

71. Has the patient been diagnosed with active polyarticular juvenile idiopathic arthritis? Y ☐ N ☐

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

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

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

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

- Yes (If checked, go to 78) ☐
- No (If checked, go to 76) ☐
- Unknown (If checked, go to 78) ☐

76. 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** ☐

77. 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 80)
- Number of joints with limitation of movement (If checked, go to 80) ☐

Functional ability (If checked, go to 80) ☐

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

ACTION REQUIRED: Submit supporting documentation

78. Has the patient had an inadequate response or intolerance to at least one tumor necrosis factor (TNF) inhibitor (e.g., Humira)? 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

79. Has the patient ever received or is currently receiving a biologic (other than a TNF inhibitor, e.g., Actemra, Orencia) or targeted synthetic drug indicated for the treatment of active polyarticular 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** ☐

ACTION REQUIRED: Submit supporting documentation

80. What is the diagnosis?

Rheumatoid arthritis (If checked, go to 82) ☐

Psoriatic arthritis (If checked, go to 81) ☐

Atopic dermatitis (If checked, go to 85) ☐

Ulcerative colitis (If checked, go to 110) ☐

Crohn's disease (If checked, go to 102) ☐

Ankylosing spondylitis (If checked, go to 82) ☐

Non-radiographic axial spondyloarthritis (If checked, go to 82) ☐

Polyarticular juvenile idiopathic arthritis (If checked, go to 123) ☐

81. What is the patient's age?

2 years of age to 17 years of age (If checked, go to 123) ☐

18 years of age or older (If checked, go to 82) ☐

82. What is the requested formulation?

Extended-release tablet (If checked, go to 83) ☐

Oral solution (If checked, no further questions) ☐

83. Does the prescribed dose exceed 15 mg? **Y** ☐ **N** ☐

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

85. What is the requested formulation?

Extended-release tablet (If checked, go to 86) ☐

Oral solution (If checked, no further questions) ☐

86. Is the patient currently receiving the requested drug? **Y** ☐ **N** ☐

87. What is the patient's age?

12 years of age to 17 years of age (If checked, go to 88) ☐

18 years of age to less than 65 years of age (If checked, go to 89) ☐

65 years of age or older (If checked, go to 95) ☐

88. What is the patient's weight?

☐

Less than 40 kilograms (kg) (If checked, no further questions) ☐

Greater than or equal to 40 kilograms (kg) (If checked, go to 89) ☐

89. Does the prescribed dose exceed 15 mg? **Y** ☐ **N** ☐

90. Does the prescribed dose exceed 30 mg? **Y** ☐ **N** ☐

91. Is this a request for an increase in prescribed dose? **Y** ☐ **N** ☐

92. Does the patient require an increased dosage due to lack of clinical response at the current dosage? **Y** ☐ **N** ☐

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

94. 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) ☐

95. Does the prescribed dose exceed 15 mg? **Y** ☐ **N** ☐

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

97. 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) ☐

98. What is the patient's age?

12 years of age to 17 years of age (If checked, go to 99) ☐

18 years of age or older (If checked, go to 100) ☐

99. What is the patient's weight?

Less than 40 kilograms (kg) (If checked, no further questions) ☐

Greater than or equal to 40 kilograms (kg) (If checked, go to 100) ☐

100. Does the prescribed dose exceed 15 mg? **Y** ☐ **N** ☐

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

102. What is the requested formulation?

Extended-release tablet (If checked, go to 103) ☐

Oral solution (If checked, no further questions) ☐

103. Is the patient currently receiving the requested drug? **Y** ☐ **N** ☐

104. Is a loading/induction dose prescribed? **Y** ☐ **N** ☐

105. Does the prescribed dose exceed an induction dose of 45 mg for 12 weeks, and a maintenance dose of 15 mg thereafter? Y ☐ N

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

107. Does the patient have refractory, severe, or extensive disease? Y N

108. Does the prescribed dose exceed an induction dose of 45 mg for 12 weeks, and a maintenance dose of 30 mg thereafter? Y ☐ N

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

110. What is the requested formulation?

Extended-release tablet (If checked, go to 111) ☐

Oral solution (If checked, no further questions) ☐

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

112. Is a loading/induction dose prescribed? Y ☐ N

113. Does the prescribed dose exceed an induction dose of 45 mg for 8 weeks, and a maintenance dose of 15 mg thereafter? Y ☐ N

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

115. Does the patient have refractory, severe, or extensive disease? Y ☐ N

116. Does the prescribed dose exceed an induction dose of 45 mg for 8 weeks, and a maintenance dose of 30 mg thereafter? Y ☐ N

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

118. Does the prescribed dose exceed 15 mg? Y ☐ N

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

120. Does the patient have refractory, severe, or extensive disease? Y ☐ N

121. Does the prescribed dose exceed 30 mg? Y ☐ N

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

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

Less than 10 kg (If checked, no further questions) ☐

_____

10 kg to less than 30 kg (If checked, go to 124) ☐

_____

Greater than or equal to 30 kg (If checked, go to 127) ☐

_____

124. What is the requested formulation?

Extended-release tablet (If checked, no further questions) ☐

Oral solution (If checked, go to 125) ☐

125. Does the prescribed dose exceed 4 mg? Y ☐ N

126. Does the prescribed frequency exceed one dose twice daily? **Y** ☐ **N** ☐

127. What is the requested formulation?

Extended-release tablet (If checked, go to 128) ☐

Oral solution (If checked, go to 130) ☐

128. Does the prescribed dose exceed 15 mg? **Y** ☐ **N** ☐

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

130. Does the prescribed dose exceed 6 mg? **Y** ☐ **N** ☐

131. Does the prescribed frequency exceed one dose twice 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.

_____

Prescriber (Or Authorized) Signature and Date

Now you can get responses to drug PAs immediately and securely online—without faxes, phone calls, or waiting. How? With electronic prior authorization (ePA)! For more information and to register, go to www.caremark.com/epa.