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., 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., 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], 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 25) ☐
   Ankylosing spondylitis (If checked, go to 40) ☐
   Non-radiographic axial spondyloarthritis (If checked, go to 40) ☐
   Ulcerative colitis (If checked, go to 49) ☐
   Immune checkpoint inhibitor-related toxicity - inflammatory arthritis (If checked, go to 56) ☐

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

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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 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. ACTION REQUIRED: Submit supporting documentation **Y** ☐ **N** ☐
15. Is the requested drug being prescribed in combination with methotrexate or leflunomide? **Y** ☐ **N** ☐
16. Please indicate a clinical reason for the patient to not use methotrexate or leflunomide.
    - Clinical diagnosis of alcohol use disorder, alcoholic liver disease, or other chronic liver disease (If checked, go to 67) ☐
    - Drug interaction (If checked, go to 67) ☐
    - Risk of treatment-related toxicity (If checked, go to 67) ☐
    - Pregnancy or currently planning pregnancy (If checked, go to 67) ☐
    - Breastfeeding (If checked, go to 67) ☐
    - Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension) (If checked, go to 67) ☐
    - Hypersensitivity (If checked, go to 67) ☐
    - History of intolerance or adverse event (If checked, go to 67) ☐
    - Other, please specify: (If checked, no further questions) ☐

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    - No clinical reason not to use methotrexate or leflunomide (If checked, no further questions) ☐

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

19. Is the requested drug being prescribed in combination with methotrexate or leflunomide?
Y ☐ **N** ☐

20. Please indicate a clinical reason for the patient to not use methotrexate or leflunomide.

- Clinical diagnosis of alcohol use disorder, alcoholic liver disease, or other chronic liver disease (If checked, go to 21) ☐
- Drug interaction (If checked, go to 21) ☐
- Risk of treatment-related toxicity (If checked, go to 21) ☐
- Pregnancy or currently planning pregnancy (If checked, go to 21) ☐
- Breastfeeding (If checked, go to 21) ☐
- Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension) (If checked, go to 21) ☐
- Hypersensitivity (If checked, go to 21) ☐
- History of intolerance or adverse event (If checked, go to 21) ☐
- Other, please specify: (If checked, no further questions) ☐

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- No clinical reason not to use methotrexate or leflunomide (If checked, no further questions) ☐

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

22. 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.
ACTION REQUIRED: Submit supporting documentation
Y ☐ **N** ☐ ☐

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

24. Please indicate the contraindication to methotrexate.

- Clinical diagnosis of alcohol use disorder, alcoholic liver disease, or other chronic liver disease (If checked, go to 67) ☐
- Drug interaction (If checked, go to 67) ☐

Risk of treatment-related toxicity (If checked, go to 67) ☐

Pregnancy or currently planning pregnancy (If checked, go to 67) ☐

Breastfeeding (If checked, go to 67) ☐

Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension) (If checked, go to 67) ☐

Hypersensitivity (If checked, go to 67) ☐

History of intolerance or adverse event (If checked, go to 67) ☐

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

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

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

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

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

Yes (If checked, go to 31) ☐

No (If checked, go to 29) ☐

Unknown (If checked, go to 31) ☐

29. 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** ☐

30. 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 67) ☐

Number of tender joints (If checked, go to 67) ☐

Dactylitis (If checked, go to 67) ☐

Enthesitis (If checked, go to 67) ☐

Axial disease (If checked, go to 67) ☐

Skin and/or nail involvement (If checked, go to 67) ☐

Functional status (If checked, go to 67) ☐

C-reactive protein (CRP) (If checked, go to 67) ☐

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

ACTION REQUIRED: Submit supporting documentation

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

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

33. What is the patient's disease severity?

Mild to moderate (If checked, go to 34) ☐

Severe (If checked, go to 67) ☐

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

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

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

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

38. 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 67) ☐

Drug interaction (If checked, go to 67) ☐

Risk of treatment-related toxicity (If checked, go to 67)

Pregnancy or currently planning pregnancy (If checked, go to 67)

Breastfeeding (If checked, go to 67)

Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, dyscrasias, uncontrolled hypertension) (If checked, go to 67)

Hypersensitivity (If checked, go to 67)

History of intolerance or adverse event (If checked, go to 67)

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

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39. 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.
ACTION REQUIRED: Submit supporting documentation — **Y** **N**

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

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

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

43. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program?
Yes (If checked, go to 46)

No (If checked, go to 44)

Unknown (If checked, go to 46)

44. 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**

45. 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 67)

Total spine pain (If checked, go to 67)

Inflammation (e.g., morning stiffness) (If checked, go to 67)

Swollen joints (If checked, go to 67) ☐

Tender joints (If checked, go to 67) ☐

C-reactive protein (CRP) (If checked, go to 67) ☐

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

ACTION REQUIRED: Submit supporting documentation

46. 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 47) ☐

Yes - Active non-radiographic axial spondyloarthritis (If checked, go to 47) ☐

No (If checked, no further questions) ☐

47. Has the patient ever received or is currently receiving a biologic (e.g., Humira) or targeted synthetic drug (e.g., Rinvoq, 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. **Y** ☐ **N**

ACTION REQUIRED: Submit supporting documentation ☐

48. Has the patient experienced an inadequate response with at least TWO nonsteroidal antiinflammatory 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 if not advisable, please attach documentation of clinical reason to avoid therapy. **Y** **N**

ACTION REQUIRED: Submit supporting documentation

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

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

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

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

53. Has the patient achieved or maintained remission? ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation of remission. ACTION REQUIRED: Submit supporting documentation **Y** ☐ **N**

54. 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**

55. 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 63) ☐

Rectal bleeding (If checked, go to 63) ☐

Urgency of defecation (If checked, go to 63) ☐

C-reactive protein (CRP) (If checked, go to 63) ☐

Fecal calprotectin (FC) (If checked, go to 63) ☐

Appearance of the mucosa on endoscopy, computed tomography enterography (CTE), magnetic resonance enterography (MRE), or intestinal ultrasound (If checked, go to 63) ☐

Improvement on a disease activity scoring tool (e.g., Ulcerative Colitis Endoscopic Index of Severity [UCEIS], Mayo Score]) (If checked, go to 63) ☐

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

ACTION REQUIRED: Submit supporting documentation ☐

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

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

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

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

60. Has the patient experienced an inadequate response to corticosteroids? 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** ☐

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

62. Is a loading dose prescribed? **Y** **N** ☐

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

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

65. Does the prescribed dose exceed a loading dose of 200 mg at week 0, followed by 100 mg at week 2, and then a maintenance dose of 100 mg thereafter? **Y** ☐ **N** ☐

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

67. Does the prescribed dose exceed 50 mg? **Y** ☐ **N** ☐

68. Is the prescribed frequency for the maintenance dose more frequent than one dose every month? **Y** ☐ **N** ☐

69. 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** ☐

70. Does the prescribed dose exceed 50 mg? **Y** ☐ **N** ☐

71. Is the prescribed frequency more frequent than one dose every month? **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

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