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 drug (e.g., Humira), targeted synthetic drug (e.g., Otezla, Rinvoq, Olumiant), 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., Rinvoq, Olumiant) 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) ☐
   Ulcerative colitis (If checked, go to 26) ☐
   Polyarticular juvenile idiopathic arthritis (If checked, go to 36) ☐
   Oligoarticular juvenile idiopathic arthritis (If checked, go to 36) ☐

Immune checkpoint inhibitor-related diarrhea or colitis (If checked, go to 45) ☐

Ankylosing spondylitis (If checked, go to 49) ☐

Non-radiographic axial spondyloarthritis (If checked, go to 49) ☐

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 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

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., Rinvoq, Olumiant) indicated for the 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**
    ACTION REQUIRED: Submit supporting documentation

16. Is the patient an adult (18 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 58)
- ☐ Number of tender joints (If checked, go to 58)
- ☐ Dactylitis (If checked, go to 58)
- ☐ Enthesitis (If checked, go to 58)
- ☐ Axial disease (If checked, go to 58)
- ☐ Skin and/or nail involvement (If checked, go to 58)
- ☐ Functional status (If checked, go to 58)
- ☐ C-reactive protein (CRP) (If checked, go to 58)
- ☐ 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. Will the requested drug be used in combination with a conventional synthetic drug (e.g., methotrexate, leflunomide, sulfasalazine)? **Y** ☐ **N** ☐

24. 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** ☐
ACTION REQUIRED: Submit supporting documentation

25. 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., Rinvoq, Otezla) indicated for the 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** ☐
ACTION REQUIRED: Submit supporting documentation

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

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

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

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

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

- ☐ Yes (If checked, go to 34)
- ☐ No (If checked, go to 31)
- ☐ Unknown (If checked, go to 34)

31. 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** ☐

32. Has the patient achieved or maintained a positive clinical response to treatment as evidenced by low disease activity or improvement in signs and symptoms of the condition since starting treatment with the requested drug? **Y** ☐ **N** ☐

33. 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 58)
- Rectal bleeding (If checked, go to 58)
- Urgency of defecation (If checked, go to 58)
- C-reactive protein (CRP) (If checked, go to 58)
- Fecal calprotectin (FC) (If checked, go to 58)
- Appearance of the mucosa on endoscopy, computed tomography enterography (CTE), magnetic resonance enterography (MRE), or intestinal ultrasound (If checked, go to 58)
- Improvement on a disease activity scoring tool (e.g., Ulcerative Colitis Endoscopic Index of Severity [UCEIS], Mayo Score]) (If checked, go to 58)
- None of the above (If checked, no further questions)

ACTION REQUIRED: Submit supporting documentation

34. 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

35. 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., Rinvoq) 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**

36. Has the patient been diagnosed with active articular juvenile idiopathic arthritis? **Y** **N**

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

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

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

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

- Yes (If checked, go to 43)
- No (If checked, go to 41)
- Unknown (If checked, go to 43)

41. 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**

42. 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 58) ☐

Number of joints with limitation of movement (If checked, go to 58) ☐

Functional ability (If checked, go to 58) ☐

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

ACTION REQUIRED: Submit supporting documentation

43. 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**

ACTION REQUIRED: Submit supporting documentation ☐

Y ☐ N ☐

44. 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 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.
ACTION REQUIRED: Submit supporting documentation

45. Is the requested drug being prescribed by or in consultation with a hematologist or oncologist? Y ☐ N ☐

46. Has the patient experienced an inadequate response to infliximab or vedolizumab? Y ☐ N ☐
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

47. Has the patient experienced an intolerance to infliximab or vedolizumab? 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 ☐

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

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

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

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

52. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program?
Yes (If checked, go to 55) ☐
No (If checked, go to 53) ☐
Unknown (If checked, go to 55) ☐

53. 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 ☐

54. 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 58) ☐
Total spinal pain (If checked, go to 58) ☐
Inflammation (e.g., morning stiffness) (If checked, go to 58) ☐
Swollen joints (If checked, go to 58) ☐
Tender joints (If checked, go to 58) ☐
C-reactive protein (CRP) (If checked, go to 58) ☐
None of the above (If checked, no further questions) ☐
ACTION REQUIRED: Submit supporting documentation

55. Has the patient been diagnosed with active ankylosing spondylitis (AS) or active nonradiographic axial spondyloarthritis?
Yes - Active ankylosing spondylitis (If checked, go to 56) ☐

Y ☐ N

Yes - Active non-radiographic axial spondyloarthritis (If checked, go to 56) ☐

No (If checked, no further questions) ☐

56. 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.
ACTION REQUIRED: Submit supporting documentation

57. 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., Rinvoq) indicated for the 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. ACTION REQUIRED: Submit supporting documentation
Y ☐ N

58. What is the diagnosis?

Rheumatoid arthritis (If checked, go to 59) ☐

Psoriatic arthritis (If checked, go to 62) ☐

Ulcerative colitis (If checked, go to 65) ☐

Polyarticular juvenile idiopathic arthritis (If checked, go to 80) ☐

Oligoarticular juvenile idiopathic arthritis (If checked, go to 80) ☐

Immune checkpoint inhibitor-related diarrhea or colitis (If checked, go to 83) ☐

Ankylosing spondylitis (If checked, go to 84) ☐

Non-radiographic axial spondyloarthritis (If checked, go to 84) ☐

59. What is the requested formulation?

Immediate release tablet (If checked, go to 60) ☐

Extended release (XR) tablet (If checked, go to 61) ☐

Oral solution (If checked, no further questions) ☐

60. Do the prescribed dose and frequency exceed 5 mg twice daily?
Y ☐ N

61. Do the prescribed dose and frequency exceed 11 mg once daily?
Y ☐ N

62. What is the requested formulation?

Immediate release tablet (If checked, go to 63) ☐

Extended release (XR) tablet (If checked, go to 64) ☐

Oral solution (If checked, no further questions) ☐

63. Do the prescribed dose and frequency exceed 5 mg twice daily?
Y ☐ N

64. Do the prescribed dose and frequency exceed 11 mg once daily?
Y ☐ N

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

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

Y ☐ N ☐

67. Does the prescribed treatment for induction of remission exceed a duration of 16 weeks? Y ☐ N ☐

68. What is the requested formulation?

- Immediate release tablet (If checked, go to 69) ☐
- Extended release (XR) tablet (If checked, go to 70) ☐
- Oral solution (If checked, no further questions) ☐

69. Do the prescribed dose and frequency for induction of remission exceed 10 mg twice daily?

70. Do the prescribed dose and frequency for induction of remission exceed 22 mg once daily? Y ☐ N ☐

71. What is the requested formulation?

- Immediate release tablet (If checked, go to 72) ☐
- Extended release (XR) tablet (If checked, go to 76) ☐
- Oral solution (If checked, no further questions) ☐

72. Do the prescribed dose and frequency for maintenance treatment exceed 5 mg twice daily? Y ☐ N ☐

73. Did the patient experience a loss of response during treatment for maintenance of remission? Y ☐ N ☐

74. Will the lowest effective dose be utilized and limited to the shortest duration needed? Y ☐ N ☐

75. Do the prescribed dose and frequency for maintenance treatment exceed 10 mg twice daily? Y ☐ N ☐

76. Do the prescribed dose and frequency for the maintenance treatment exceed 11 mg once daily? Y ☐ N ☐

77. Did the patient experience a loss of response during treatment for maintenance of remission? Y ☐ N ☐

78. Will the lowest effective dose be utilized and limited to the shortest duration needed? Y ☐ N ☐

79. Do the prescribed dose and frequency for the maintenance treatment exceed 22 mg once daily? Y ☐ N ☐

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

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

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

_____

- Greater than or equal to 10 kg (If checked, go to 82) ☐

_____

82. Does the prescribed dose exceed 5 mg? Y ☐ N ☐

83. 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 ☐

84. What is the requested formulation?

- Immediate release tablet (If checked, go to 85) ☐
- Extended release (XR) tablet (If checked, go to 86) ☐
- Oral solution (If checked, no further questions) ☐

Y ☐ N ☐

85. Do the prescribed dose and frequency exceed 5 mg twice daily? Y ☐ N ☐

86. Do the prescribed dose and frequency exceed 11 mg once 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.