PA Request Criteria

00-000000000

216276

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. Will the requested drug be used in combination with any other biologic (e.g., Cimzia) 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 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 8) ☐

   Crohn's disease (If checked, go to 59) ☐

   Plaque psoriasis (If checked, go to 73) ☐

   Ulcerative colitis (If checked, go to 66) ☐

   Psoriatic arthritis (If checked, go to 35) ☐

Psoriatic arthritis WITH co-existent plaque psoriasis (If checked, go to 7) ☐

Ankylosing spondylitis (If checked, go to 50) ☐

Non-radiographic axial spondyloarthritis (If checked, go to 50)

Polyarticular juvenile idiopathic arthritis (If checked, go to 22) ☐

Oligoarticular juvenile idiopathic arthritis (If checked, go to 22) ☐

Systemic juvenile idiopathic arthritis (If checked, no further questions) ☐

Hidradenitis suppurativa (If checked, go to 88) ☐

Behcet's disease (If checked, go to 99) ☐

Pyoderma gangrenosum (If checked, go to 116) ☐

Uveitis (If checked, go to 105) ☐

Immune checkpoint inhibitor-related toxicity - inflammatory arthritis (If checked, go to 124) ☐

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

_____

7. What is the primary diagnosis being treated?

Psoriatic arthritis (If checked, go to 35) ☐ Plaque psoriasis (If checked, go to 73) ☐

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

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

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

11. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug? **Y** ☐ **N**

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

Yes (If checked, go to 15) ☐

No (If checked, go to 13) ☐

Unknown (If checked, go to 15) ☐

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

14. 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**

15. Has the patient ever received or is currently receiving a biologic (e.g., Enbrel) or targeted synthetic drug (e.g., Rinvoq, Xeljanz) 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. ACTION REQUIRED: Submit supporting documentation **Y** ☐ **N** ☐

Y ☐ N ☐

16. 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 ☐

17. 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

18. Has the patient had 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

☐

19. Has the patient had 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

☐

20. 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

21. Please indicate the contraindication to methotrexate.

- Clinical diagnosis of alcohol use disorder, alcoholic liver disease, or other chronic liver disease (If checked, go to 132) ☐
- Drug interaction (If checked, go to 132) ☐
- Risk of treatment-related toxicity (If checked, go to 132) ☐
- Pregnancy or currently planning pregnancy (If checked, go to 132) ☐
- Breastfeeding (If checked, go to 132) ☐
- Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension) (If checked, go to 132) ☐
- Hypersensitivity (If checked, go to 132) ☐
- History of intolerance or adverse event (If checked, go to 132) ☐
- Other, please specify. (If checked, no further questions) ☐

_____

☐

22. Has the patient been diagnosed with moderately to severely active articular juvenile idiopathic arthritis?
Y ☐ N ☐

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

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

25. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug?
Y ☐ N

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

- Yes (If checked, go to 29)
- No (If checked, go to 27)
- Unknown (If checked, go to 29)

27. 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 or a biosimilar of the requested drug? **Y** **N**

28. 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 132)
- Number of joints with limitation of movement (If checked, go to 132)
- Functional ability (If checked, go to 132)
- None of the above (If checked, no further questions)

ACTION REQUIRED: Submit supporting documentation

Y ☐ N ☐

29. Has the patient ever received or is currently receiving a biologic (e.g., Enbrel) or targeted synthetic drug (e.g., Xeljanz) indicated for the treatment of moderately to severely 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
30. Has the patient had an inadequate response to methotrexate or another conventional synthetic drug (e.g., leflunomide, sulfasalazine, hydroxychloroquine) 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. Y ☐ N ☐
    ACTION REQUIRED: Submit supporting documentation
31. Has the patient had an inadequate response to a trial of scheduled non-steroidal antiinflammatory drugs (NSAIDs) and/or intra-articular glucocorticoids (e.g., triamcinolone hexacetonide)? 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
32. Does the patient have any of the following risk factors for poor outcome: a) involvement of ankle, wrist, hip, sacroiliac joint, and/or temporomandibular joint (TMJ), b) presence of erosive disease or enthesitis, c) delay in diagnosis, d) elevated levels of inflammation markers, or e) symmetric disease? Y ☐ N ☐
33. Does the patient have any of the following risk factors for disease severity and potentially a more refractory disease course: a) positive rheumatoid factor, b) positive anti-cyclic citrullinated peptide antibodies, or c) pre-existing joint damage? Y ☐ N ☐
34. Does the patient meet any of the following: a) high-risk joints are involved (e.g., cervical spine, wrist, or hip), b) high disease activity, or c) high risk for disabling joint disease? Y ☐ N ☐
35. Is the patient an adult (18 years of age or older)? Y ☐ N ☐
36. Is the requested drug being prescribed by or in consultation with a rheumatologist or dermatologist? Y ☐ N
37. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug? Y ☐ N
38. Is the patient currently receiving the requested drug or a biosimilar of the requested drug through samples or a manufacturer's patient assistance program?
    - Yes (If checked, go to 41) ☐
    - No (If checked, go to 39) ☐
    - Unknown (If checked, go to 41) ☐
39. 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 or a biosimilar of the requested drug? Y ☐ N ☐
40. 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 132) ☐
    - Number of tender joints (If checked, go to 132) ☐
    - Dactylitis (If checked, go to 132) ☐
    - Enthesitis (If checked, go to 132) ☐
    - Axial disease (If checked, go to 132) ☐
    - Skin and/or nail involvement (If checked, go to 132) ☐

Functional status (If checked, go to 132) ☐

C-reactive protein (CRP) (If checked, go to 132) ☐

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

ACTION REQUIRED: Submit supporting documentation

41. Has the patient been diagnosed with active psoriatic arthritis (PsA)?

42. Has the patient ever received or is currently receiving a biologic or targeted synthetic drug (e.g., Rinvoq, 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

43. What is the patient's disease severity?

Mild to moderate (If checked, go to 44) ☐ ☐

Severe (If checked, go to 132) ☐

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

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

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

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

48. 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 132) ☐

Drug interaction (If checked, go to 132) ☐

Risk of treatment-related toxicity (If checked, go to 132) ☐

Pregnancy or currently planning pregnancy (If checked, go to 132) ☐

Breastfeeding (If checked, go to 132) ☐

Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension) (If checked, go to 132) ☐

Hypersensitivity (If checked, go to 132) ☐ ☐

History of intolerance or adverse event (If checked, go to 132) ☐

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

_____ ☐

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

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

☐

☐

Y ☐ N ☐

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

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

53. Is the patient currently receiving the requested drug or a biosimilar of the requested drug through samples or a manufacturer's patient assistance program? Yes (If checked, go to 56)

No (If checked, go to 54)

Unknown (If checked, go to 56)

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 or a biosimilar of 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 records supporting positive clinical response.

Functional status (If checked, go to 132) ☐

Total spinal pain (If checked, go to 132) ☐

Inflammation (e.g., morning stiffness) (If checked, go to 132) ☐

Swollen joints (If checked, go to 132) ☐

Tender joints (If checked, go to 132) ☐

C-reactive protein (CRP) (If checked, go to 132) ☐ ☐

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

ACTION REQUIRED: Submit supporting documentation

56. 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 57) ☐ ☐

Yes - Active non-radiographic axial spondyloarthritis (If checked, go to 57) ☐

No (If checked, no further questions) ☐

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

ACTION REQUIRED: Submit supporting documentation ☐

58. Has the patient had 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 not advisable, please attach documentation of clinical reason to avoid therapy. Y ☐ N ☐

ACTION REQUIRED: Submit supporting documentation ☐

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

60. Is the patient 6 years of age or older? Y ☐ N

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

☐

62. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug? Y ☐ N ☐

63. 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 ☐

64. 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 or a biosimilar of the requested drug? Y ☐ N ☐

65. 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 132)

Diarrhea (If checked, go to 132)

Body weight (If checked, go to 132) ☐

Abdominal mass (If checked, go to 132) ☐

Hematocrit (If checked, go to 132) ☐

Appearance of the mucosa on endoscopy, computed tomography enterography (CTE), magnetic resonance enterography (MRE), or intestinal ultrasound (If checked, go to 132) ☐

Improvement on a disease activity scoring tool (e.g., Crohn's Disease Activity Index [CDAI]) score (If checked, go to 132) ☐

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

ACTION REQUIRED: Submit supporting documentation

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

67. Is the patient 5 years of age or older? **Y** ☐ **N** ☐

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

69. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug? **Y** ☐ **N** ☐

70. 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** ☐

71. 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 or a biosimilar of the requested drug? **Y** ☐ **N** ☐

72. 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 132) ☐

Rectal bleeding (If checked, go to 132) ☐

Urgency of defecation (If checked, go to 132) ☐

C-reactive protein (CRP) (If checked, go to 132) ☐

Fecal calprotectin (FC) (If checked, go to 132) ☐

Appearance of the mucosa on endoscopy, computed tomography enterography (CTE), magnetic resonance enterography (MRE), or intestinal ultrasound (If checked, go to 132) ☐

Improvement on a disease activity scoring tool (e.g., Ulcerative Colitis Endoscopic Index of Severity [UCEIS], Mayo Score) (If checked, go to 132) ☐

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

ACTION REQUIRED: Submit supporting documentation

73. Has the patient been diagnosed with moderate to severe plaque psoriasis? **Y** ☐ **N** ☐

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

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

76. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug? **Y** ☐ **N** ☐

77. Is the patient currently receiving the requested drug or a biosimilar of the requested drug through samples or a manufacturer's patient assistance program? Yes (If checked, go to 81) ☐

☐

No (If checked, go to 78) ☐

Unknown (If checked, go to 81) ☐

78. 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 or a biosimilar of the requested drug? **Y** ☐ **N** ☐

79. Has the patient experienced a reduction in body surface area (BSA) affected from baseline? ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation of decreased body surface area affected. **Y** ☐ **N** ☐
ACTION REQUIRED: Submit supporting documentation ☐

80. Has the patient experienced an improvement in signs and symptoms of the condition from baseline (e.g., itching, redness, flaking, scaling, burning, cracking, pain)? ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation of improvement in signs and symptoms. **Y** ☐ **N** ☐
ACTION REQUIRED: Submit supporting documentation ☐

81. Has the patient ever received or is currently receiving a biologic or targeted synthetic drug (e.g., Sotyktu, Otezla) indicated for the treatment of moderate to severe plaque psoriasis (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 medication tried. ACTION REQUIRED: Submit supporting documentation **Y** ☐ **N** ☐ ☐

82. Are crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) affected? ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation of affected areas. **Y** ☐ **N** ☐
ACTION REQUIRED: Submit supporting documentation ☐

83. Is the percentage of body surface area (BSA) affected (prior to starting the requested medication) less than 3%? **Y** ☐ **N** ☐

84. What is the percentage of body surface area (BSA) affected (prior to starting the requested medication)? Indicate percentage. ACTION REQUIRED: Please attach chart notes or medical record documentation of body surface area affected.

Greater than or equal to 3% to less than 10% of BSA (If checked, go to 85) ☐

_____

Greater than or equal to 10% of BSA (If checked, go to 132) ☐

_____

ACTION REQUIRED: Submit supporting documentation ☐

85. Has the patient experienced an inadequate response, or has an intolerance to phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin? 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 ☐

86. Does the patient have a clinical reason to avoid pharmacologic treatment with methotrexate, cyclosporine, and acitretin? ACTION REQUIRED: If Yes, please attach documentation of clinical reason to avoid each therapy. **Y** ☐ **N** ☐
ACTION REQUIRED: Submit supporting documentation

87. Please indicate the clinical reason to avoid pharmacologic treatment with methotrexate, cyclosporine, and acitretin. ☐

Clinical diagnosis of alcohol use disorder, alcoholic liver disease, or other chronic liver disease, (If checked, go to 132) ☐

Drug interaction (If checked, go to 132) ☐

Risk of treatment-related toxicity (If checked, go to 132) ☐

Pregnancy or currently planning pregnancy (If checked, go to 132) ☐

Breastfeeding (If checked, go to 132) ☐

Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension) (If checked, go to 132) ☐

Hypersensitivity (If checked, go to 132) ☐

☐

History of intolerance or adverse event (If checked, go to 132) ☐

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

_____

88. Has the patient been diagnosed with moderate to severe hidradenitis suppurativa? **Y** **N**

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

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

91. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug? **Y** ☐ **N**

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

Yes (If checked, go to 95) ☐

No (If checked, go to 93) ☐

Unknown (If checked, go to 95) ☐

93. 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 or a biosimilar of the requested drug? **Y** ☐ **N**

94. Which of the following has the patient experienced an improvement in since starting treatment with the requested drug or a biosimilar of the requested drug? ACTION REQUIRED: Please attach chart notes or medical records supporting positive clinical response.

Reduction in abscess and inflammatory nodule count from baseline (If checked, go to 132) ☐

Reduced formation of new sinus tracts and scarring (If checked, go to 132) ☐

Decrease in frequency of inflammatory lesions from baseline (If checked, go to 132) ☐

Reduction in pain from baseline (If checked, go to 132) ☐

Reduction in suppuration from baseline (If checked, go to 132) ☐

Improvement in frequency of relapses from baseline (If checked, go to 132) ☐

Improvement in quality of life from baseline (If checked, go to 132) ☐

Improvement on a disease severity assessment tool from baseline (If checked, go to 132) ☐

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

ACTION REQUIRED: Submit supporting documentation

95. Has the patient ever received or is currently receiving a biologic indicated for the treatment of moderate to severe hidradenitis suppurativa (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 medication tried. **Y** ☐ **N**

ACTION REQUIRED: Submit supporting documentation

96. Has the patient had an inadequate response after at least 90 days of treatment with an oral antibiotic used for the treatment of hidradenitis suppurativa (e.g., clindamycin, metronidazole, moxifloxacin, rifampin, tetracyclines)? 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

97. Has the patient had an intolerance to oral antibiotics used for the treatment of hidradenitis suppurativa? 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 ☐

98. Does the patient have a contraindication to oral antibiotics used for the treatment of hidradenitis suppurativa? ACTION REQUIRED: If Yes, please attach documentation of clinical reason to avoid therapy.
ACTION REQUIRED: Submit supporting documentation

Y ☐ N ☐

99. Is the requested drug being prescribed by or in consultation with a rheumatologist?

Y ☐ N ☐

100. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug? Y ☐ N ☐

101. Is the patient currently receiving the requested drug or a biosimilar of the requested drug through samples or a manufacturer's patient assistance program?
- Yes (If checked, go to 103) ☐
- No (If checked, go to 102) ☐
- Unknown (If checked, go to 103) ☐

102. 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 or a biosimilar of the requested drug? Y ☐ N ☐

103. Has the patient ever received or is currently receiving Otezla or a biologic indicated for the treatment of Behcet'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

104. Has the patient had an inadequate response to at least one non-biologic medication for Behcet's disease (e.g., azathioprine, colchicine, cyclosporine, systemic corticosteroids)? 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

105. Has the patient been diagnosed with non-infectious intermediate, posterior, or panuveitis? Y ☐ N ☐

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

107. Is the requested drug being prescribed by or in consultation with an ophthalmologist or rheumatologist? Y ☐ N ☐

108. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug? Y ☐ N ☐

109. Is the patient currently receiving the requested drug or a biosimilar of the requested drug through samples or a manufacturer's patient assistance program?
- Yes (If checked, go to 112) ☐
- No (If checked, go to 110) ☐
- Unknown (If checked, go to 112) ☐

110. 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 or a biosimilar of the requested drug? Y ☐ N ☐

111. 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.
- Reduced frequency of disease flares compared to baseline (If checked, go to 132) ☐
- Stability or improvement in anterior chamber (AC) cell grade compared to baseline (If checked, go to 132) ☐
- Stability or improvement in vitreous haze (VH) grade compared to baseline (If checked, go to 132) ☐
- Stability or improvement in visual acuity compared to baseline (If checked, go to 132) ☐
- Reduction in glucocorticoid requirements from baseline (If checked, go to 132) ☐
- No new active inflammatory chorioretinal and/or inflammatory retinal vascular lesions relative to baseline (If checked, go to 132) ☐
- None of the above (If checked, no further questions)

ACTION REQUIRED: Submit supporting documentation ☐

112. Has the patient ever received or is currently receiving a biologic indicated for the treatment of non-infectious intermediate, posterior, and panuveitis (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 ☐

113. Has the patient had an inadequate response to corticosteroids or immunosuppressive therapy (e.g., azathioprine, cyclosporine, methotrexate, mycophenolate mofetil)? 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 ☐

114. Has the patient had an intolerance to corticosteroids and immunosuppressive therapy (e.g., azathioprine, cyclosporine, methotrexate, mycophenolate mofetil)? 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 ☐

115. Does the patient have a contraindication to corticosteroids and immunosuppressive therapy (e.g., azathioprine, cyclosporine, methotrexate, mycophenolate mofetil)? ACTION REQUIRED: If Yes, please attach documentation of clinical reason to avoid therapy.
ACTION REQUIRED: Submit supporting documentation Y ☐ N ☐

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

117. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug? Y ☐ N

118. Is the patient currently receiving the requested drug or a biosimilar of the requested drug through samples or a manufacturer's patient assistance program?
Yes (If checked, go to 120) ☐
No (If checked, go to 119) ☐
Unknown (If checked, go to 120) ☐

119. 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 or a biosimilar of the requested drug? Y ☐ N ☐

120. Has the patient ever received or is currently receiving a biologic indicated for the treatment of pyoderma gangrenosum (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 ☐

121. Has the patient experienced an inadequate response with corticosteroids or immunosuppressive therapy (e.g., cyclosporine, mycophenolate mofetil)? 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 ☐

122. Has the patient experienced an intolerance to corticosteroids and immunosuppressive therapy (e.g., cyclosporine, mycophenolate mofetil)? 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 ☐

123. Does the patient have a contraindication to corticosteroids and immunosuppressive therapy (e.g., cyclosporine, mycophenolate mofetil)? ACTION REQUIRED: If Yes, please attach documentation of clinical reason to avoid therapy.
ACTION REQUIRED: Submit supporting documentation Y ☐ N ☐

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

125. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug? Y ☐ N ☐

126. Is the patient currently receiving the requested drug or a biosimilar of the requested drug through samples or a manufacturer's patient assistance program? Yes (If checked, go to 128) ☐

No (If checked, go to 127) ☐

Unknown (If checked, go to 128) ☐

127. 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: Please attach chart notes or Y ☐ N ☐

☐
☐
☐
☐
☐

medical record documentation supporting positive clinical response. ACTION REQUIRED: Submit supporting documentation

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

129. Has the patient had an inadequate response to corticosteroids or a conventional synthetic drug (e.g., methotrexate, sulfasalazine, leflunomide, hydroxychloroquine)? 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**

130. 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 not advisable, please attach documentation of clinical reason to avoid therapy.
ACTION REQUIRED: Submit supporting documentation **Y** ☐ **N**

131. Does the patient have an intolerance or contraindication to a conventional synthetic drug (e.g., methotrexate, sulfasalazine, leflunomide, hydroxychloroquine)? 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 not advisable, please attach documentation of clinical reason to avoid therapy.
ACTION REQUIRED: Submit supporting documentation **Y** ☐ **N**

132. What is the diagnosis?

- Rheumatoid arthritis (If checked, go to 133) ☐
- Crohn's disease (If checked, go to 172) ☐
- Plaque psoriasis (If checked, go to 164) ☐
- Ulcerative colitis (If checked, go to 180) ☐
- Psoriatic arthritis (If checked, go to 140) ☐
- Psoriatic arthritis WITH co-existent plaque psoriasis (If checked, go to 164) ☐
- Ankylosing spondylitis (If checked, go to 140) ☐
- Non-radiographic axial spondyloarthritis (If checked, go to 140) ☐
- Polyarticular juvenile idiopathic arthritis (If checked, go to 144) ☐
- Oligoarticular juvenile idiopathic arthritis (If checked, go to 144) ☐
- Hidradenitis suppurativa (If checked, go to 148) ☐
- Behcet's disease (If checked, go to 212) ☐
- Pyoderma gangrenosum (If checked, go to 212) ☐
- Uveitis (If checked, go to 143) ☐
- Immunotherapy-related inflammatory arthritis (If checked, go to 212) ☐

133. Is the patient currently receiving the requested drug or a biosimilar of the requested drug? **Y** ☐ **N**

134. Does the prescribed maintenance dose exceed 40 mg? Y ☐ N ☐

135. Is the prescribed frequency for the maintenance dose more frequent than one dose every week? Y ☐ N ☐

136. What is the requested product?

Humira
Abrilada adalimumab (If checked, no further questions) adalimumab-aacf adalimumab-aaty
adalimumab-adaz adalimumab-adbm ☐adalimumab-fkjp ☐adalimumab-ryvk
☐

Amjevita ☐

Cyltezo ☐

Hadlima ☐Hulio ☐

Hyrimoz ☐

Idacio ☐

Simlandi ☐

Yuflyma ☐

Yusimry ☐

137. Does the prescribed maintenance dose exceed 80 mg? Y ☐ N

138. Is the prescribed frequency for the maintenance dose more frequent than one dose every two weeks? Y ☐ N ☐

139. What is the requested product? ☐

Humira ☐Abrilada ☐adalimumab (If checked, no further questions) ☐adalimumab-aacf
☐adalimumab-aaty ☐adalimumab-adaz ☐adalimumab-adbm ☐adalimumab-fkjp
☐adalimumab-ryvk ☐

Amjevita ☐

Cyltezo ☐

Hadlima ☐Hulio ☐

Hyrimoz ☐

Idacio ☐

Simlandi ☐

Yuflyma ☐

Yusimry ☐

☐

140. Does the prescribed dose exceed 40 mg? Y ☐ N

141. Is the prescribed frequency for the maintenance dose more frequent than one dose every two weeks? Y ☐ N

142. What is the requested product?

☐

☐

☐

☐

☐

☐

Humira ☐

Abrilada ☐

adalimumab (If checked, no further questions) ☐

adalimumab-aacf ☐

adalimumab-aaty ☐

adalimumab-adaz ☐

adalimumab-adbm ☐

adalimumab-fkjp ☐

adalimumab-ryvk ☐

Amjevita ☐

Cyltezo ☐

Hadlima ☐

Hulio ☐

Hyrimoz ☐

Idacio ☐

Simlandi ☐

Yuflyma ☐

Yusimry ☐

143. What is the patient's age?

2 years of age to less than 18 years of age (If checked, go to 144) ☐

18 years of age or older (If checked, go to 164) ☐

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

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

_____

10 kg or greater (If checked, go to 145) ☐

_____

145. Does the prescribed dose exceed 40 mg? **Y** ☐ **N**

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

147. What is the requested product?

Humira ☐Abrilada ☐adalimumab (If checked, no further questions) ☐adalimumab-aacf

adalimumab-aaty adalimumab-

adaz adalimumab-adbm

adalimumab-fkjp adalimumab-ryvk ☐

Amjevita ☐

Cyltezo ☐

Hadlima ☐ Hulio ☐

Hyrimoz ☐

Idacio ☐

Simlandi ☐

Yuflyma ☐ ☐

Yusimry ☐ ☐

148. What is the patient's age?

12 years of age to less than 18 years of age (If checked, go to 149) ☐

18 years of age or older (If checked, go to 150) ☐

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

Less than 30 kilograms (kg) (If checked, no further questions) ☐

_____

30 kg or greater (If checked, go to 150) ☐

_____

150. Is the patient currently receiving the requested drug or a biosimilar of the requested drug? **Y** ☐ **N**

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

152. Does the prescribed maintenance dose exceed 40 mg? **Y** ☐ **N** ☐

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

154. What is the requested product?

Humira ☐ Abrilada ☐ adalimumab (If checked, no further questions) ☐ adalimumab-aacf ☐

☐ adalimumab-aaty ☐ adalimumab-adaz ☐ adalimumab-adbm ☐ adalimumab-fkjp ☐

☐ adalimumab-ryvk ☐

Amjevita ☐

Cyltezo

Hadlima ☐ Hulio ☐ ☐

Hyrimoz ☐

Idacio ☐ ☐

Simlandi ☐

Yuflyma ☐

Yusimry ☐

☐

☐

☐

☐

☐

☐

155. Does the prescribed maintenance dose exceed 80 mg? **Y** ☐ **N**

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

157. What is the requested product?

Humira ☐

Abrilada ☐

adalimumab (If checked, no further questions) ☐

adalimumab-aacf ☐

adalimumab-aaty ☐

adalimumab-adaz ☐

adalimumab-adbm ☐

adalimumab-fkjp ☐

adalimumab-ryvk ☐

Amjevita ☐

Cyltezo ☐

Hadlima ☐

Hulio ☐

Hyrimoz ☐

Idacio ☐

Simlandi ☐

Yuflyma ☐

Yusimry ☐

158. Does the prescribed dose exceed a loading dose of 160 mg on day 1 and 80 mg on day 15, and a maintenance dose of 40 mg thereafter? **Y** ☐ **N**

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

160. What is the requested product?

Humira ☐Abrilada ☐adalimumab (If checked, no further questions) ☐adalimumab-aacf

adalimumab-aaty adalimumab-

adaz adalimumab-adbm

adalimumab-fkjp adalimumab-

ryvk

Amjevita ☐

Cyltezo ☐ ☐

Hadlima ☐ Hulio ☐

Hyrimoz ☐

Idacio ☐

Simlandi ☐

Yuflyma ☐

Yusimry ☐

161. Does the prescribed dose exceed a loading dose of 160 mg on day 1 and 80 mg on day 15, and a maintenance dose of 80 mg thereafter? **Y** ☐ **N**

162. Does the prescribed frequency for the maintenance dose exceed one dose every 2 weeks? **Y** ☐ **N**

163. What is the requested product?

Humira ☐

Abrilada ☐

adalimumab (If checked, no further questions) ☐

adalimumab-aacf ☐ ☐

adalimumab-aaty ☐ ☐

adalimumab-adaz ☐

adalimumab-adbm ☐

adalimumab-fkjp ☐

adalimumab-ryvk ☐

Amjevita ☐

Cyltezo ☐

Hadlima ☐

Hulio ☐

Hyrimoz ☐

Idacio ☐

Simlandi ☐

Yuflyma ☐

Yusimry ☐

164. Is the patient currently receiving the requested drug or a biosimilar of the requested drug? **Y** ☐ **N**

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

☐

☐

☐

166. Does the prescribed maintenance dose exceed 40 mg? Y ☐ N ☐

167. Is the prescribed frequency for the maintenance dose more frequent than one dose every two weeks? Y ☐ N ☐

168. What is the requested product?

- Humira ☐
- Abrilada ☐
- adalimumab (If checked, no further questions) ☐
- adalimumab-aacf ☐
- adalimumab-aaty ☐
- adalimumab-adaz ☐
- adalimumab-adbm ☐
- adalimumab-fkjp ☐
- adalimumab-ryvk ☐
- Amjevita ☐
- Cyltezo ☐
- Hadlima ☐
- Hulio ☐
- Hyrimoz ☐
- Idacio ☐
- Simlandi ☐
- Yuflyma ☐
- Yusimry ☐

169. Does the prescribed dose exceed a loading dose of 80 mg on day 1 and 40 mg on day 8, and a maintenance dose of 40 mg thereafter? Y ☐ N ☐

170. Is the prescribed frequency for the maintenance dose more frequent than one dose every two weeks? Y ☐ N

171. What is the requested product?

- Humira Abrilada adalimumab (If checked, no ☐
- further questions) adalimumab-aacf ☐
- adalimumab-aaty adalimumab-adaz ☐
- adalimumab-adbm adalimumab-fkjp ☐
- adalimumab-ryvk ☐
- Amjevita ☐
- Cyltezo ☐
- Hadlima ☐
- Hulio ☐
- Hyrimoz ☐
- Idacio ☐
- Simlandi ☐

Yuflyma ☐

Yusimry ☐

172. Is the patient currently receiving the requested drug or a biosimilar of the requested drug? **Y** ☐ **N**

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

174. Does the prescribed maintenance dose exceed 40 mg? **Y** ☐ **N**

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

176. What is the requested product?

Humira ☐

Abrilada ☐

adalimumab (If checked, no further questions) ☐

adalimumab-aacf ☐

adalimumab-aaty ☐

adalimumab-adaz ☐

adalimumab-adbm ☐

adalimumab-fkjp ☐

adalimumab-ryvk ☐

Amjevita ☐

Cyltezo ☐

Hadlima ☐

Hulio ☐

Hyrimoz ☐

Idacio ☐

Simlandi ☐

Yuflyma ☐

Yusimry ☐

177. Does the prescribed dose exceed a loading dose of 160 mg on day 1 and 80 mg on day 15, and a maintenance dose of 40 mg thereafter? **Y** ☐ **N**

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

179. What is the requested product?

Humira Abrilada adalimumab (If checked, no further questions) ☐

adalimumab-aacf ☐

adalimumab-aaty ☐

adalimumab-adaz ☐

adalimumab-adbm ☐

adalimumab-fkjp ☐

adalimumab-ryvk ☐

Amjevita ☐

Cyltezo ☐

Hadlima ☐

Hulio ☐

Hyrimoz ☐

Idacio ☐☐

Simlandi ☐ ☐

Yuflyma ☐

Yusimry ☐ ☐

180. Is the patient currently receiving the requested drug or a biosimilar of the requested drug? **Y** ☐ **N** ☐

181. What is the patient's age?

5 years of age to less than 18 years of age (If checked, go to 182) ☐

18 years of age or older (If checked, go to 189) ☐

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

Less than 20 kilograms (kg) (If checked, no further questions) ☐ ☐

_____

20 kg or greater (If checked, go to 183) ☐

_____

183. Does the prescribed maintenance dose exceed 40 mg? **Y** ☐ **N** ☐

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

185. What is the requested product?

Humira Abrilada adalimumab (If checked, no further questions) adalimumab-aacf ☐

adalimumab-aaty adalimumab-adaz ☐

adalimumab-adbm adalimumab-fkjp ☐

adalimumab-ryvk ☐

Amjevita ☐

Cyltezo ☐

Hadlima ☐ ☐

Hulio ☐

Hyrimoz ☐ ☐

Idacio ☐

Simlandi ☐☐

Yuflyma ☐☐

Yusimry ☐☐

186. Does the prescribed maintenance dose exceed 80 mg? **Y** ☐☐ **N** ☐

187. Is the prescribed frequency for the maintenance dose more frequent than one dose every two weeks? Y ☐ N ☐

188. What is the requested product?

- Humira ☐
- Abrilada ☐
- adalimumab (If checked, no further questions) ☐
- adalimumab-aacf ☐
- adalimumab-aaty ☐
- adalimumab-adaz ☐
- adalimumab-adbm ☐
- adalimumab-fkjp ☐
- adalimumab-ryvk ☐
- Amjevita ☐
- Cyltezo ☐
- Hadlima ☐
- Hulio ☐
- Hyrimoz ☐
- Idacio ☐
- Simlandi ☐
- Yuflyma ☐
- Yusimry ☐

189. Does the prescribed maintenance dose exceed 40 mg? Y ☐ N ☐

190. Is the prescribed frequency for the maintenance dose more frequent than one dose every two weeks? Y ☐ N ☐

191. What is the requested product?

- Humira ☐
- Abrilada ☐
- adalimumab (If checked, no further questions) ☐
- adalimumab-aacf ☐
- adalimumab-aaty ☐
- adalimumab-adaz ☐
- adalimumab-adbm ☐
- adalimumab-fkjp ☐
- adalimumab-ryvk ☐
- Amjevita ☐
- Cyltezo ☐
- Hadlima ☐
- Hulio ☐
- Hyrimoz ☐
- Idacio ☐
- Simlandi ☐

Yuflyma ☐

Yusimry ☐

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

193. Is this a continuation of a regimen with the requested drug or a biosimilar of the requested drug that was started before the patient turned 18 years old? **Y** ☐ **N**

194. Is the patient well-controlled on the requested regimen? **Y** ☐ **N**

195. What is the requested product?

Humira ☐

Abrilada ☐

adalimumab (If checked, no further questions) ☐

adalimumab-aacf ☐

adalimumab-aaty ☐

adalimumab-adaz ☐

adalimumab-adbm ☐

adalimumab-fkjp ☐

adalimumab-ryvk ☐

Amjevita ☐

Cyltezo ☐

Hadlima ☐

Hulio ☐

Hyrimoz ☐

Idacio ☐

Simlandi ☐

Yuflyma ☐

Yusimry ☐

196. Does the prescribed maintenance dose exceed 80 mg? **Y** ☐ **N**

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

198. Is this a continuation of a regimen with the requested drug or a biosimilar of the requested drug that was started before the patient turned 18 years old? Y ☐ N ☐

199. Is the patient well-controlled on the requested regimen? Y ☐ N ☐

200. What is the requested product?

- Humira ☐
- Abrilada ☐
- adalimumab (If checked, no further questions) ☐
- adalimumab-aacf ☐
- adalimumab-aaty ☐
- adalimumab-adaz ☐
- adalimumab-adbm ☐
- adalimumab-fkjp ☐
- adalimumab-ryvk ☐
- Amjevita ☐
- Cyltezo ☐
- Hadlima ☐
- Hulio ☐
- Hyrimoz ☐
- Idacio ☐
- Simlandi ☐
- Yuflyma ☐
- Yusimry ☐

201. What is the patient's age?

- 5 years of age to less than 18 years of age (If checked, go to 202) ☐
- 18 years of age or older (If checked, go to 209) ☐

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

- Less than 20 kilograms (kg) (If checked, no further questions) ☐
- _____ 20 kg or greater (If checked, go to 203) ☐
- _____ ☐

203. Does the prescribed dose exceed a loading dose of 160 mg on day 1, 80 mg on day 8, and 80 mg on day 15, and a maintenance dose of 40 mg thereafter? Y ☐ N ☐

204. Is the prescribed frequency for the maintenance dose more frequent than one dose every week? Y ☐ N ☐

205. What is the requested product?

- Humira Abrilada adalimumab (If checked, no ☐
- further questions) adalimumab-aacf ☐
- adalimumab-aaty adalimumab-adaz ☐
- ☐
- ☐

adalimumab-adbm adalimumab- ☐

fkjp adalimumab-ryvk ☐

Amjevita ☐

Cyltezo ☐

Hadlima ☐

Hulio ☐

Hyrimoz ☐

Idacio ☐

Simlandi ☐

Yuflyma ☐

Yusimry ☐

206. Does the prescribed dose exceed a loading dose of 160 mg on day 1, 80 mg on day 8, and 80 mg on day 15, and a maintenance dose of 80 mg thereafter? **Y** ☐ **N**

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

208. What is the requested product? ☐

Humira ☐

Abrilada ☐

adalimumab (If checked, no further questions) ☐

adalimumab-aacf ☐

adalimumab-aaty ☐

adalimumab-adaz ☐

adalimumab-adbm ☐

adalimumab-fkjp ☐

adalimumab-ryvk ☐

Amjevita ☐

Cyltezo ☐

Hadlima ☐

Hulio ☐

Hyrimoz ☐

Idacio ☐

Simlandi ☐

Yuflyma ☐

Yusimry ☐

209. Does the prescribed dose exceed a loading dose of 160 mg on day 1 and 80 mg on day 15, and a maintenance dose of 40 mg thereafter? **Y** ☐ **N** ☐

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

211. What is the requested product?

Humira Abrilada adalimumab (If checked, no further questions) adalimumab-aacf ☐

adalimumab-aaty ☐

adalimumab-adbm ☐

adalimumab-ryvk ☐

Amjevita ☐

Cyltezo ☐

Hadlima ☐

Hulio ☐

Hyrimoz ☐

Idacio ☐

Simlandi ☐

Yuflyma ☐

Yusimry ☐

212. 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** ☐

213. Does the prescribed maintenance dose exceed 40 mg? **Y** ☐ **N** ☐

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

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

216. What is the requested product?

Humira Abrilada adalimumab (If checked, no further questions) adalimumab-aacf ☐

adalimumab-aaty ☐

adalimumab-adbm ☐

adalimumab-ryvk ☐

Amjevita ☐

Cyltezo ☐

Hadlima ☐

Hulio ☐

Hyrimoz ☐

Idacio ☐

Simlandi ☐

Yuflyma ☐

Yusimry ☐

217. What is the requested product?

Humira Abrilada adalimumab (If checked, no further questions) adalimumab-aacf ☐

adalimumab-aaty adalimumab-adaz ☐

adalimumab-adbm adalimumab-fkjp ☐

adalimumab-ryvk ☐

Amjevita ☐

Cyltezo ☐

Hadlima

Hulio ☐

Hyrimoz ☐

Idacio ☐

Simlandi ☐

Yuflyma ☐

Yusimry ☐

218. Does the prescribed maintenance dose exceed 80 mg? **Y** ☐ **N**

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

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

221. What is the requested product?

Humira Abrilada adalimumab (If checked, no further questions) adalimumab-aacf ☐

adalimumab-aaty adalimumab-adaz ☐

adalimumab-adbm adalimumab-fkjp ☐

adalimumab-ryvk ☐

☐

☐

☐

☐

☐

☐

☐

☐

☐

☐

☐

☐

☐

☐

Amjevita ☐

Cyltezo ☐

Hadlima Hulio ☐

Hyrimoz ☐

Idacio ☐

Simlandi ☐

Yuflyma ☐

Yusimry ☐

222. What is the requested product?

Humira ☐Abrilada ☐adalimumab (If checked, no further questions) ☐adalimumab-aacf ☐adalimumab-aaty ☐adalimumab-adaz ☐adalimumab-adbm ☐adalimumab-fkjp ☐adalimumab-ryvk ☐

Amjevita ☐

Cyltezo ☐

Hadlima ☐Hulio ☐

Hyrimoz ☐

Idacio ☐

Simlandi ☐

Yuflyma ☐

Yusimry ☐

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.