Simponi, Simponi Aria
Prior Authorization Request

Send completed form to: Case Review Unit, CVS Caremark Prior Authorization Fax: 1-866-249-6155

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-249-6155**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

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Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____
Request Initiated For: _____

1. What drug is being prescribed? ❑ Simponi ❑ Simponi Aria ❑ Other _____

2. Has the patient been diagnosed with any of the following?
   - ❑ Moderately to severely active rheumatoid arthritis (RA)
   - ❑ Active psoriatic arthritis (PsA)
   - ❑ Moderately to severely active ulcerative colitis (UC)
   - ❑ Active ankylosing spondylitis (AS)
   - ❑ Active axial spondyloarthritis
   - ❑ Other _____

3. What is the ICD-10 code? _____

Section A: Preferred Product

4. These are the preferred products for which coverage is provided for treatment of the following conditions when Simponi is being prescribed: *If Simponi Aria is being prescribed, skip to #8.*
   a) Ankylosing spondylitis (AS): **Cosentyx, Humira, Enbrel**
   b) Psoriatic arthritis (PsA): **Cosentyx, Enbrel, Humira, Otezla**
   c) Rheumatoid arthritis: **Enbrel, Humira, Kevzara, Orencia (SC)/Orencia ClickJect**
   d) Ulcerative colitis (UC): **Humira (primary), Simponi (secondary)***
   Note: Secondary preferred product for UC is Simponi. This preferred product option only applies to members who have had a documented inadequate response or intolerable adverse event with Humira.

   Can the patient's treatment be switched to a preferred product?
   ❑ Yes - Please specify: _____ ***If Yes, please call 1-866-814-5506 to have the updated form faxed to your office OR you may complete the PA electronically (ePA). You may sign up online via CoverMyMeds at: www.covermymeds.com/epa/caremark/ or call 1-866-452-5017.***
   ❑ No
   ❑ Not applicable - Requested for condition not listed above, *skip to Section B: All Requests*

5. Is this request for continuation of therapy with the requested product? ❑ Yes ❑ No *If No, skip to #7*

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6. Is the patient currently receiving the requested product through samples or a manufacturer's patient assistance program? If unknown, answer Yes. ❑ Yes ❑ No *If No, skip to Section B: All Requests*

7. Has the patient had a documented inadequate response or intolerable adverse event with any of the following preferred products? Please indicate ALL that apply. ***ACTION REQUIRED: If Yes, attach supporting chart note(s).***

❑ Cosentyx:	❑ Inadequate response	❑ Intolerable adverse event
❑ Enbrel:	❑ Inadequate response	❑ Intolerable adverse event
❑ Humira:	❑ Inadequate response	❑ Intolerable adverse event
❑ Kevzara:	❑ Inadequate response	❑ Intolerable adverse event
❑ Orencia (SC)/Orencia ClickJect:	❑ Inadequate response	❑ Intolerable adverse event
❑ Otezla:	❑ Inadequate response	❑ Intolerable adverse event

❑ None of the above

Section B: All Requests

8. Is this request for continuation of therapy? ❑ Yes ❑ No *If No, skip to #12*

9. Is the patient currently receiving Simponi or Simponi Aria through samples or a manufacturer's patient assistance program? ❑ Yes - Simponi ❑ Yes - Simponi Aria ❑ No ❑ Unknown *If Yes or Unknown, skip to #12*

10. How long has the patient been receiving the requested medication? _____ months
For RA requests: *If less than 3 months, skip to #14.*
For all other requests: *If less than 3 months, no further questions.*

11. Has the patient achieved or maintained positive clinical response to treatment as evidenced by low disease activity or improvement in signs and symptoms? ❑ Yes ❑ No
For RA requests: *If Yes, skip to #14;* ***For all other requests:*** *If Yes, no further questions.*

12. Has the patient received any of the following medications?
If Yes, please indicate the most recent medication and skip to diagnosis section.
❑ Actemra ❑ Cimzia ❑ Cosentyx ❑ Enbrel ❑ Humira ❑ Inflectra ❑ Kevzara ❑ Kineret ❑ Orencia
❑ Remicade ❑ Renflexis ❑ Rituxan ❑ Siliq ❑ Simponi ❑ Simponi Aria ❑ Stelara ❑ Taltz ❑ Tremfya ❑ Xeljanz ❑ Xeljanz XR ❑ No

13. Has the patient undergone pretreatment screening for latent tuberculosis (TB) infection with either a TB skin test or an interferon gamma release assay (e.g., QFT-GIT, T-SPOT.TB)? ❑ Yes ❑ No

Complete the following section based on the patient's diagnosis.

Section C: Rheumatoid Arthritis

14. Is the prescribed agent being prescribed in combination with methotrexate? ❑ Yes ❑ No
If No, indicate clinical reason:
_____

15. Has the patient experienced an inadequate response after at least 3 months of treatment with the methotrexate dose greater than or equal to 20 mg per week? *If Yes, no further questions* ❑ Yes ❑ No

16. Has the patient experienced intolerance to methotrexate? *If Yes, no further questions* ❑ Yes ❑ No

17. Does the patient have a contraindication to methotrexate? ❑ Yes ❑ No
If Yes, indicate the contraindication:
_____

Section D: Ankylosing Spondylitis or Axial Spondyloarthritis

18. Has the patient experienced an inadequate response with at least TWO nonsteroidal anti-inflammatory drugs (NSAIDs), or has an intolerance or contraindication to at least two NSAIDs? ❑ Yes ❑ No

Section E: Ulcerative Colitis - Simponi Only

19. Does the patient have dependence on corticosteroids? ❑ Yes ❑ No *If No, skip to #21*

20. Which of the following best describes the patient's dependence with corticosteroids?
    ❑ Patient requires continuous corticosteroid therapy, *no further questions*
    ❑ Corticosteroids cannot be successfully tapered without a return of ulcerative colitis symptoms, *no further questions*
    ❑ None of the above

21. Has the patient tried and had an inadequate response to at least one conventional therapy option?
    If Yes, indicate below and no further questions.
    ❑ Yes - Azathioprine (Azasan, Imuran)
    ❑ Yes - Corticosteroid (e.g., budesonide [Entocort, Uceris], hydrocortisone [Cortifoam, Colocort, Solu-Cortef, Cortef], methylprednisolone [Medrol, Solu-Medrol], prednisone)
    ❑ Yes - Cyclosporine (Sandimmune)
    ❑ Yes - Mesalamine (e.g., Asacol, Lialda, Pentasa, Canasa, Rowasa)
    ❑ Yes - Mercaptopurine (Purinethol)
    ❑ Yes - Sulfasalazine
    ❑ Yes - Tacrolimus (Prograf)
    ❑ Yes - Metronidazole (Flagyl) or Ciprofloxacin (Cipro) (for pouchitis only)
    ❑ No

22. Does the patient have a contraindication or intolerance to at least one conventional therapy option (e.g., azathioprine [Azasan, Imuran], corticosteroid [e.g., budesonide, hydrocortisone, methylprednisolone, prednisone], cyclosporine [Sandimmune], mesalamine [Asacol, Lialda, Pentasa, Canasa, Rowasa], mercaptopurine [Purinethol], sulfasalazine, tacrolimus, metronidazole/ciprofloxacin [for pouchitis only])? ❑ Yes ❑ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____

Prescriber or Authorized Signature **Date (mm/dd/yy)**