CVS caremark™ {{PANUMCODE}}

Simponi, Simponi Aria

Prior Authorization Request

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.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: {{MEMFIRST}} {{MEMLAST}} **Date**: {{TODAY}}
Patient's ID: {{MEMBERID}} **Patient's Date of Birth:** {{MEMBERDOB}}
Physician's Name: {{PHYFIRST}} {{PHYLAST}}
Specialty: _____, NPI#: _____
Physician Office Telephone: {{PHYSICIANPHONE}} **Physician Office Fax:** {{PHYSICIANFAX}}
Request Initiated For: {{DRUGNAME}}

1. What is the prescribed dose and frequency?
   a) Loading dose:
   - ❑ Simponi 50 mg Quantity and Frequency: _____
   - ❑ Simponi 100 mg Quantity and Frequency: _____
   - ❑ Simponi Aria 50 mg Quantity and Frequency: _____

   ❑ Other _____

   b) Maintenance dose:
   - ❑ Simponi 50 mg Quantity and Frequency: _____
   - ❑ Simponi 100 mg Quantity and Frequency: _____
   - ❑ Simponi Aria 50 mg Quantity and Frequency: _____

   ❑ Other _____

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

3. What is the ICD-10 code? _____

4. What is the patient's weight? _____ kg/lbs ***(circle one)***

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

Section A: Preferred Product ***If Simponi Aria is being prescribed, skip to Section B: All Requests.***

5. These are the preferred products for which coverage is provided for treatment of the following indications when Simponi is being prescribed:
   a) Ankylosing spondylitis: **Cosentyx, Enbrel, Humira, Remicade, Simponi Aria, Cimzia syringe (secondary)**
   b) Psoriatic arthritis: **Cosentyx, Enbrel, Humira, Otezla, Remicade, Simponi Aria, Stelara SC, Tremfya**
   c) Rheumatoid arthritis: **Enbrel, Humira, Kevzara, Orencia (SC)/Orencia Clickject, Remicade, Rinvoq, Simponi Aria, Xeljanz/Xeljanz XR**
   d) Ulcerative colitis: **Humira (primary), Remicade, Stelara SC, Xeljanz/Zeljanz XR, Zeposia (secondary)**

   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.*

6. Is this request for continuation of therapy with the requested product? ❑ Yes ❑ No *If No, skip to #8*

7. 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.*

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

❑ Cimzia syringe:	❑ Inadequate response	❑ Intolerable adverse event
❑ 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
❑ Rinvoq:	❑ Inadequate response	❑ Intolerable adverse event
❑ Stelara SC:	❑ Inadequate response	❑ Intolerable adverse event
❑ Xeljanz/Xeljanz XR:	❑ Inadequate response	❑ Intolerable adverse event
❑ Zeposia:	❑ Inadequate response	❑ Intolerable adverse event
❑ Tremfya:	❑ Inadequate response	❑ Intolerable adverse event

   ❑ None of the above

9. Does the patient have one of the following documented clinical reasons to avoid the preferred products that are TNF inhibitors (Cimzia syringe, Enbrel and/or Humira)?
   ACTION REQUIRED: If Yes, attach supporting chart note(s).
   ❑ Yes - History of demyelinating disorder - *Indicate drug(s):* _____
   ❑ Yes - History of congestive heart failure - *Indicate drug(s):* _____
   ❑ Yes - History of hepatitis B virus infection - *Indicate drug(s):* _____
   ❑ Yes - Autoantibody formation/lupus-like syndrome (attributed to TNF inhibitor) - *Indicate drug(s):* _____
   ❑ Yes - Risk of lymphoma - *Indicate drug(s):* _____
   ❑ No - None of the above
   ❑ Not applicable - Requested medication is not a TNF inhibitor

Section B: All Requests

10. Will the requested drug be used in combination with any other biologic, (e.g., Humira) or targeted synthetic disease-modifying antirheumatic drug (DMARD) (e.g., Olumiant, Otezla, Xeljanz)? ❑ Yes ❑ No

11. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic DMARD (e.g., Rinvoq, Olumiant, Xeljanz) associated with an increased risk of tuberculosis?
    If Yes, skip to #13 ❑ Yes ❑ No

12. Has the patient had a tuberculosis (TB) test (e.g., tuberculosis skin test [PPD], interferon-release assay [IGRA], chest x-ray) within 6 months of initiating therapy? *If Yes, skip to #15* ❑ Yes ❑ No

13. Does the patient have risk factors for tuberculosis (TB) (e.g., persons with close contact to people with infectious TB disease; persons who have recently immigrated from areas of the world with high rates of TB [e.g., Africa, Asia, Eastern Europe, Latin America, Russia]; children less than 5 years of age who have a positive TB test; groups with high rates of TB transmission [e.g., homeless persons, injection drug users, persons with HIV infection], or persons who work or reside with people who are at an increased risk for active TB [e.g., hospitals, long-term care facilities, correctional facilities, homeless shelters])? ❑ Yes ❑ No *If No, skip to #18*

14. Has the patient been tested for tuberculosis (TB) within the previous 12 months? ❑ Yes ❑ No

15. What were the results of the TB test? ❑ Positive for TB ❑ Negative for TB, *skip to #18* ❑ Unknown

16. Does the patient have latent or active tuberculosis (TB)? ❑ Latent ❑ Active ❑ Unknown

17. Has treatment for latent tuberculosis (TB) infection been initiated or completed?
❑ Yes - treatment initiated ❑ Yes - treatment completed ❑ No

18. Is the patient currently receiving requested drug? ❑ Yes ❑ No

19. Is this request for continuation of therapy with the requested drug?
❑ Yes ❑ No *If No, skip to diagnosis section.*

20. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program? *If Yes or Unknown, or diagnosis is Rheumatoid Arthritis, skip to diagnosis section*
❑ Yes - Simponi ❑ Yes - Simponi Aria ❑ No ❑ Unknown

21. Has the patient achieved clinical remission or maintained 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?
❑ Yes ❑ No

Complete the following section based on the patient's diagnosis, if applicable.

Section C: Rheumatoid Arthritis

Continuation

22. Has the patient achieved or maintained positive clinical response since starting treatment with the requested drug?
❑ Yes ❑ No

23. What is the percent of disease activity improvement from baseline in tender joint count, swollen joint count, pain, or disability? ***ACTION REQUIRED: Please attach chart notes or medical record documentation supporting positive clinical response and no further questions.*** _____ ***%***

Initiation

24. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic DMARD (e.g., Rinvoq, Xeljanz) that is indicated for moderately to severely active rheumatoid arthritis?
ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried. ❑ Yes ❑ No

25. Is the requested drug being prescribed in combination with methotrexate and/or leflunomide?
❑ Yes - methotrexate ❑ Yes - leflunomide ❑ No - None of the above
If No, indicate drug and clinical reason: _____

26. Does the patient meet BOTH of the following: a) the patient was tested for the rheumatoid factor (RF) biomarker AND b) the RF biomarker test was positive? ***ACTION REQUIRED: If Yes, please attach laboratory results, chart notes, or medical record documentation of biomarker testing and no further questions.*** ❑ Yes ❑ No

27. Does the patient meet BOTH of the following: a) the patient was tested for the anti-cyclic citrullinated peptide (anti-CCP) biomarker AND b) the anti-CCP biomarker test was positive? ***ACTION REQUIRED: If Yes, please attach laboratory results, chart notes, or medical record documentation of biomarker testing and no further questions.*** ❑ Yes ❑ No

28. Has the patient been tested for the rheumatoid factor (RF) biomarker? ***ACTION REQUIRED: If Yes, please attach laboratory results, chart notes, or medical record documentation of biomarker testing.*** ❑ Yes ❑ No

29. Has the patient been tested for the anti-cyclic citrullinated peptide (anti-CCP) biomarker? ***ACTION REQUIRED: If Yes, please attach laboratory results, chart notes, or medical record documentation of biomarker testing.*** ❑ Yes ❑ No

30. Has the patient been tested for the C-reactive protein (CRP) and/or erythrocyte sedimentation rate (ESR) biomarker(s)? ***ACTION REQUIRED: If Yes, please attach laboratory results, chart notes, or medical record documentation of biomarker testing.*** ❑ Yes ❑ No

31. Please indicate if the patient tested positive or negative for the C-reactive protein (CRP) biomarker, or if the test was not completed. ❑ Positive for CRP ❑ Negative for CRP ❑ Test for CRP was not completed

32. Please indicate if the patient tested positive or negative for the erythrocyte sedimentation rate (ESR) biomarker, or if the test was not completed. ❑ Positive for ESR ❑ Negative for ESR ❑ Test for ESR was not completed

33. 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 and no further questions.*** ❑ Yes ❑ No

34. 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 and no further questions.*** ❑ Yes ❑ No

35. Does the patient have a contraindication to methotrexate? ❑ Yes ❑ No
ACTION REQUIRED: If Yes, please attach documentation of clinical reason to avoid therapy and indicate the contraindication: _____

Section D: Psoriatic Arthritis

Continuation

36. 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 ❑ Enthesitis
❑ Number of tender joints ❑ Skin and/or nail involvement
❑ Dactylitis ❑ None of the above

Section E: Ankylosing Spondylitis or Axial Spondyloarthritis

Continuation

37. 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 ❑ Total spinal pain
❑ Inflammation (e.g., morning stiffness) ❑ None of the above

Initiation

38. Has the patient ever received (including current utilizers) a biologic (e.g., Cimzia) indicated for active ankylosing spondylitis or active axial spondyloarthritis? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried and no further question.*** ❑ Yes ❑ No

39. 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? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy. If therapy is if not advisable, please attach documentation of clinical reason to avoid therapy.*** ❑ Yes ❑ No

Section F: Ulcerative Colitis - Simponi Only

40. Has the patient achieved or maintained remission? ***ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation of remission and no further questions.*** ❑ Yes ❑ No

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41. 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 and no further questions.
❑ Stool frequency
❑ Rectal bleeding
❑ Urgency of defecation
❑ C-reactive protein (CRP)
❑ Fecal calprotectin (FC)
❑ Endoscopic appearance of the mucosa
❑ Improvement on a disease activity scoring tool (e.g., Ulcerative Colitis Endoscopic Index of Severity [UCEIS], Mayo Score])
❑ None of the above

42. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic disease modifying drug (e.g., Xeljanz) indicated for moderately to severely active ulcerative colitis?
ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried and no further questions. ❑ Yes ❑ No

43. Has the patient tried and had an inadequate response to at least one conventional therapy option?
ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy 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), balsalazide, or olsalazine
❑ Yes - Mercaptopurine (Purinethol)
❑ Yes - Sulfasalazine
❑ Yes - Tacrolimus (Prograf)
❑ Yes - Metronidazole (Flagyl) or Ciprofloxacin (Cipro) (for pouchitis only)
❑ No

44. Does the patient have a contraindication or intolerance to at least one conventional therapy option (e.g., azathioprine [Azasan, Imuran], corticosteroid [e.g., budesonide [Entocort, Uceris], hydrocortisone, methylprednisolone, prednisone], cyclosporine [Sandimmune], mesalamine [Asacol, Lialda, Pentasa, Canasa, Rowasa], balsalazide, olsalazine, mercaptopurine [Purinethol], sulfasalazine, tacrolimus [Prograf], metronidazole/ciprofloxacin [for pouchitis only])? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including clinical reason to avoid therapy.*** ❑ Yes ❑ No

Section G: Articular Juvenile Idiopathic Arthritis - Simponi Aria Only

Continuation

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.***
❑ Number of joints with active arthritis (e.g., swelling, pain, limitation of motion)
❑ Number of joints with limitation of movement
❑ Functional ability
❑ None of the above

Initiation

46. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic disease-modifying antirheumatic drug (DMARD) (e.g., Xeljanz) indicated for active articular juvenile idiopathic arthritis?
ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried and no further questions. ❑ Yes ❑ No

47. Has the patient had an inadequate response to methotrexate or another non-biologic DMARD 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 and no further questions.*** ❑ Yes ❑ No

48. Does the patient have any of the following risk factors?
    - ❑ Positive anti-cyclic citrullinated peptide antibodies
    - ❑ Positive rheumatoid factor
    - ❑ Pre-existing joint damage
    - ❑ None of the above

49. Does the patient meet any of the following?
    - ❑ High disease activity
    - ❑ High risk for disabling joint disease
    - ❑ High risk joints are involved (e.g., cervical spine, wrist, or hip)
    - ❑ None of the above

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)**

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