Simponi Aria

Prior Authorization Request

CVS Caremark administers the medical drug prior authorization program on behalf of Harvard Pilgrim Health Care. Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form to CVS Caremark, toll-free at 1-844-851-0882** to initiate the review process. If you have questions regarding the prior authorization please contact CVS Caremark at **1-844-387-1435.**

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: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____ **NPI#:** _____
Specialty: _____ **HPHC Provider ID#:**_____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Rendering Provider Info: ❑ Same as Requesting Provider
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____ **HPHC Provider ID:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Additional Demographic Information:

Please indicate the place of service for the requested drug:
❑ Ambulatory Surgical ❑ Home ❑ Inpatient Hospital ❑ Off Campus Outpatient Hospital
❑ On Campus Outpatient Hospital ❑ Office ❑ Pharmacy

Drug Information:
*Strength/Measure*_____ *Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un
*Directions(sig)*_____ *Route of administration*_____
*Dosing frequency*_____

Criteria Questions:
1. What is the diagnosis?
   ❑ Rheumatoid arthritis ❑ Psoriatic arthritis
   ❑ Ankylosing spondylitis ❑ Other _____
2. What is the ICD-10 code? _____

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

Section A: Rheumatoid Arthritis
3. Has the patient been diagnosed with moderately to severely active rheumatoid arthritis (RA)?
   ❑ Yes ❑ No
4. Has the patient received Simponi Aria in a paid claim through a pharmacy or medical benefit in the previous 120 days? ❑ Yes ❑ No *If No, skip to #7*

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5. How long has the patient been receiving the requested medication?
   _____ weeks / months ***(circle one)***

6. Has the patient achieved or maintained positive clinical response to treatment as evidenced by low disease activity or improvement in signs and symptoms of RA? *If Yes, skip to #8* ❑ Yes ❑ No

7. Has the patient received any of the following medications in a paid claim through a pharmacy or medical benefit in the previous 120 days? If yes, please specify the most recent medication.
   ❑ Actemra ❑ Cimzia ❑ Cosentyx, *skip to #11*
   ❑ Enbrel ❑ Humira ❑ Inflectra
   ❑ Kevzara ❑ Kineret ❑ Orencia
   ❑ Remicade ❑ Renflexis ❑ Rituxan
   ❑ Siliq, *skip to #11* ❑ Simponi ❑ Stelara, *skip to #11*
   ❑ Taltz, *skip to #11* ❑ Tremfya, *skip to #11* ❑ Xeljanz
   ❑ Xeljanz XR
   ❑ No, none of the above, *skip to #10*

8. Is Simponi Aria being prescribed in combination with methotrexate?
   If Yes, no further questions ❑ Yes ❑ No

9. Please indicate a clinical reason for the patient to not use methotrexate and *No further questions*

   _____

10. 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

11. Is Simponi Aria being prescribed in combination with methotrexate?
    If Yes, skip to #13 ❑ Yes ❑ No

12. Please indicate a clinical reason for the patient to not use methotrexate:

    _____

13. Has the patient experienced an inadequate response after at least 3 months of treatment with methotrexate?
    ❑ Yes ❑ No *If No, skip to #15*

14. What was the maximum titrated methotrexate dose? _____mg per week
    If >20mg/week, no futher questions

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

16. Does the patient have a contraindication to methotrexate? ❑ Yes ❑ No

17. Please indicate the contraindication and *No further questions*: _____

<u>Section B: Psoriatic Arthritis</u>

18. Has the patient been diagnosed with active psoriatic arthritis (PsA)? ❑ Yes ❑ No

19. Has the patient received Simponi Aria in a paid claim through a pharmacy or medical benefit in the previous 120 days? ❑ Yes ❑ No *If No, skip to #22*

20. How long has the patient been receiving the requested medication?
    _____ weeks / months ***(circle one)***

21. Has the patient achieved or maintained positive clinical response to treatment as evidenced by low disease activity or improvement in signs and symptoms of RA? *If Yes, No further questions* ❑ Yes ❑ No

22. Has the patient received any of the following medications? If yes, please specify the most recent medication and *No further questions*.

❑ Actemra	❑ Cimzia	❑ Cosentyx
❑ Enbrel	❑ Humira	❑ Inflectra
❑ Kevzara	❑ Orencia	❑ Remicade
❑ Renflexis	❑ Siliq	❑ Simponi
❑ Stelara	❑ Taltz	❑ Tremfya
❑ Xeljanz	❑ Xeljanz XR	❑ No, none of the above

Section C: Ankylosing Spondylitis

23. Has the patient been diagnosed with active ankylosing spondylitis (AS)? ❑ Yes ❑ No

24. Has the patient received Simponi Aria in a paid claim through a pharmacy or medical benefit in the previous 120 days? ❑ Yes ❑ No *If No, skip to #27*

25. How long has the patient been receiving the requested medication?
_____ weeks / months ***(circle one)***

26. Has the patient achieved or maintained positive clinical response to treatment as evidenced by low disease activity or improvement in signs and symptoms of RA? *If Yes, No further questions* ❑ Yes ❑ No

27. Has the patient received any of the following medications? If yes, please specify the most recent medication.

❑ Actemra, *skip to #29*	❑ Cimzia, *no further questions*	❑ Cosentyx, *no further questions*
❑ Enbrel, *no further questions*	❑ Humira, *no further questions*	❑ Inflectra, *no further questions*
❑ Kevzara, *skip to #29*	❑ Orencia, *skip to #29*	❑ Remicade, *no further questions*
❑ Renflexis, *no further questions*		❑ Siliq, *skip to #29*
❑ Simponi, *skip to #29*	❑ Stelara, *skip to #29*	❑ Taltz, *skip to #29*
❑ Tremfya, *skip to #29*	❑ Xeljanz, *skip to #29*	❑ Xeljanz XR, *skip to #29*
❑ No		

28. 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

29. Has the patient experienced an inadequate response with at least TWO nonsteroidal anti-inflammatory drugs (NSAIDs) over a 4-week period in total at maximum recommended or tolerated anti-inflammatory dose? *If Yes, no further questions* ❑ Yes ❑ No

30. Does the patient have an intolerance or contraindication to at least TWO NSAIDs? ❑ 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)**

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 Simponi Aria HPHC – 05/2018.