BlueCross BlueShield Federal Employee Program.

(golimumab) SIMPONI PRIOR APPROVAL REQUEST

Send completed form to:
FAX: 855-895-3504
FOR URGENT FAX: 844-244-0226

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

FOR CLAIMS ADJUDICATED THROUGH THE PHARMACY BENEFIT:
For Standard and Basic Option patients, Actemra SC, Enbrel, Humira, Otezla, Rinvoq, Skyrizi, Stelara SC, Taltz, Tremfya, and Xeljanz/ Xeljanz XR are preferred products. Patients who switch to a preferred product will be eligible for 2 copays at no cost in the benefit year.

Simponi (golimumab)

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its **entirety** for processing

1. Has the patient been on Simponi continuously for the last **6 months**, excluding samples? ***Please select answer below:***
   ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer questions on **PAGE 3**
   ❑**NO** – this is **INITIATION** of therapy, please answer the following questions:
2. Is this request for brand or generic? ❑Brand ❑Generic
3. Has the patient been tested for latent tuberculosis (TB)? ❑Yes***** ❑No
   ****If YES***, was the result of the test positive or negative for TB infection? ❑Negative ❑Positive*****
   ****If POSITIVE***, has the patient completed treatment or is the patient currently receiving treatment for latent TB? ❑Yes ❑No
4. Is the patient at risk for hepatitis B virus (HBV) infection? ❑Yes***** ❑No
   ****If YES***, has HBV infection been ruled out or has the patient already started treatment for HBV infection? ❑Yes ❑No
5. Does the patient have any active infections including tuberculosis (TB) or hepatitis B virus (HBV)? ❑Yes ❑No
6. Will the patient be given live vaccines while on Simponi? ❑Yes ❑No
7. Will Simponi be used in combination with another biologic *****disease-modifying antirheumatic drug (DMARD) or targeted synthetic DMARD? ❑Yes***** ❑No
   ****If YES***, please specify medication: _____
   ****DMARDs: Actemra, Avsola, Cimzia, Cosentyx, Enbrel, Entyvio, Humira, Ilumya, Inflectra, Kevzara, Kineret, Olumiant, Orencia, Otezla, Remicade, Renflexis, Riabni, Rinvoq, Rituxan, Ruxience, Siliq, Simponi Aria, Skyrizi, Sotyktu, Spevigo, Stelara, Taltz, Tremfya, Truxima, Xeljanz/Xeljanz XR***
8. What is the patient's diagnosis?
   ❑Ankylosing Spondylitis (AS) (axial spondyloarthritis)
   a. **Standard/Basic Option patient, for claims adjudicated through the pharmacy benefit:** Would you like to switch the patient to a preferred product? ❑Yes***** ❑No
      ****If YES,*** please select the preferred product: ❑Enbrel ❑Humira ❑Rinvoq ❑Taltz
   b. Does the patient have active ankylosing spondylitis? ❑Yes ❑No
   c. Has the patient had either an inadequate treatment response or intolerance to at least two different NSAIDs (non-steroidal anti-inflammatory drugs) over a four-week period in total at maximum recommended or tolerated dose? ❑Yes ❑No*****
      ****If NO***, does the patient have a contraindication to NSAIDs? ❑Yes ❑No
   d. Does the prescriber agree to administer Simponi within the FDA labeled maintenance dose of 50mg subcutaneously (SubQ) every four weeks? ❑Yes ❑No

PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL DIAGNOSES

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(golimumab) SIMPONI PRIOR APPROVAL REQUEST

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PAGE 2 - PHYSICIAN COMPLETES

Patient Name: _____ **DOB:** _____ **Patient ID:** _____

❑Psoriatic Arthritis (PsA)

a. **Standard/Basic Option patient, <u>for claims adjudicated through the pharmacy benefit</u>:** Would you like to switch the patient to a preferred product? ❑Yes***** ***(*If YES, please select the preferred product below)*** ❑No
❑Enbrel ❑Humira ❑Otezla ❑Rinvoq ❑Skyrizi ❑Stelara SC ❑Taltz ❑Tremfya ❑Xeljanz/Xeljanz XR

b. Does the patient have active psoriatic arthritis? ❑Yes ❑No

c. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to a three month trial of at least one conventional DMARD? ❑Yes ❑No

d. Does the prescriber agree to administer Simponi within the FDA labeled maintenance dose of 50mg subcutaneously (SubQ) every four weeks? ❑Yes ❑No

❑Rheumatoid Arthritis (RA)

a. **Standard/Basic Option patient, <u>for claims adjudicated through the pharmacy benefit</u>:** Has the patient tried and failed Enbrel, Humira, Rinvoq, or Xeljanz/Xeljanz XR? ***Please select answer below:***

❑**Yes:** Would you like to switch the patient to a preferred product? ❑Yes***** ❑No
****If YES***, select the preferred product: ❑Actemra SC ❑Enbrel ❑Humira ❑Rinvoq ❑Xeljanz/Xeljanz XR

❑**No**: Would you like to switch the patient to a preferred product? ❑Yes***** ❑No
****If YES***, select the preferred product: ❑Enbrel ❑Humira ❑Rinvoq ❑Xeljanz/Xeljanz XR

b. Does the patient have moderate to severely active rheumatoid arthritis? ❑Yes ❑No

c. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to a three month trial of at least one conventional DMARD? ❑Yes ❑No

d. Does the patient have an intolerance or contraindication to methotrexate (MTX)? ❑Yes ❑No*****
****If NO***, will Simponi be used in combination with methotrexate? ❑Yes ❑No

e. Does the prescriber agree to administer Simponi within the FDA labeled maintenance dose of 50mg subcutaneously (SubQ) every four weeks? ❑Yes ❑No

❑Ulcerative Colitis (UC)

a. **Standard/Basic Option patient, <u>for claims adjudicated through the pharmacy benefit</u>:** Has the patient tried and failed Humira? ❑Yes ❑No*****
****If NO***, would you like to switch the patient to a preferred product? ❑Yes***** ❑No
****If YES***, select the preferred product: ❑Humira ❑Rinvoq ❑Stelara SC

b. Is the patient dependent on corticosteroids (the patient requires continuous corticosteroids or cannot be successfully tapered off corticosteroids without return of UC symptoms)? ❑Yes ❑No*****
****If NO***, does the patient have an intolerance or contraindication or have they had an inadequate treatment response to at least one conventional therapy option? ❑Yes ❑No

c. Does the prescriber agree to administer Simponi within the FDA labeled maintenance dose of 100mg subcutaneously (SubQ) every four weeks? ❑Yes ❑No

❑Other diagnosis **(*please specify*)**: _____

<u>FOR CLAIMS ADJUDICATED THROUGH THE PHARMACY BENEFIT:</u>
STANDARD AND BASIC OPTION PATIENT REQUESTS REQUIRES <u>PAGE 5</u> TO BE COMPLETED

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(golimumab) SIMPONI
PRIOR APPROVAL REQUEST

Send completed form to:
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FOR URGENT FAX: 844-244-0226

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

FOR CLAIMS ADJUDICATED THROUGH THE PHARMACY BENEFIT:
For Standard and Basic Option patients, Actemra SC, Enbrel, Humira, Otezla, Rinvoq, Skyrizi, Stelara SC, Taltz, Tremfya, and Xeljanz/ Xeljanz XR are preferred products. Patients who switch to a preferred product will be eligible for 2 copays at no cost in the benefit year.

CONTINUATION OF THERAPY (PA RENEWAL)

Simponi (golimumab)

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its **entirety** for processing

1. Has the patient been on Simponi continuously for the last **6 months**, excluding samples? ***Select answer below:***
   ❑**NO** – this is **INITIATION** of therapy, please answer the questions on **PAGE 1**
   ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following questions:
2. Is this request for brand or generic? ❑Brand ❑Generic
3. Has the patient's condition improved or stabilized with Simponi? ❑Yes ❑No
4. Does the patient have any active infections including tuberculosis (TB) or hepatitis B virus (HBV)? ❑Yes ❑No
5. Will the patient be given live vaccines while on Simponi? ❑Yes ❑No
6. Will Simponi be used in combination with another biologic *disease-modifying antirheumatic drug (DMARD) or targeted synthetic DMARD? ❑Yes* ❑No
   ****If YES***, please specify medication: _____
   ****DMARDs: Actemra, Avsola, Cimzia, Cosentyx, Enbrel, Entyvio, Humira, Ilumya, Inflectra, Kevzara, Kineret, Olumiant, Orencia, Otezla, Remicade, Renflexis, Riabni, Rinvoq, Rituxan, Ruxience, Siliq, Simponi Aria, Skyrizi, Sotyktu, Spevigo, Stelara, Taltz, Tremfya, Truxima, Xeljanz/Xeljanz XR***
7. What is the patient's diagnosis?
   ❑Ankylosing Spondylitis (AS) (axial spondyloarthritis)
   a. **Standard/Basic Option patient, for claims adjudicated through the pharmacy benefit:** Would you like to switch the patient to a preferred product? ❑Yes* ❑No
      ****If YES,*** please select the preferred product: ❑Enbrel ❑Humira ❑Rinvoq ❑Taltz
   b. Does the prescriber agree to administer Simponi within the FDA labeled maintenance dose of 50mg subcutaneously (SubQ) every four weeks? ❑Yes ❑No

   ❑Psoriatic Arthritis (PsA)
   a. **Standard/Basic Option patient, for claims adjudicated through the pharmacy benefit:** Would you like to switch the patient to a preferred product? ❑Yes* ***(*If YES, please select the preferred product below)*** ❑No
      ❑Enbrel ❑Humira ❑Otezla ❑Rinvoq ❑Skyrizi ❑Stelara SC ❑Taltz ❑Tremfya ❑Xeljanz/Xeljanz XR
   b. Does the prescriber agree to administer Simponi within the FDA labeled maintenance dose of 50mg subcutaneously (SubQ) every four weeks? ❑Yes ❑No

PLEASE PROCEED TO PAGE 4 FOR ADDITIONAL DIAGNOSES

Send completed form to:
FAX: 855-895-3504 FOR URGENT FAX:
844-244-0226

BlueCross BlueShield Federal Employee Program.

(golimumab) SIMPONI PRIOR APPROVAL REQUEST

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PAGE 4 - PHYSICIAN COMPLETES

Patient Name: _____ **DOB:** _____ **Patient ID: R**_____

❑ Rheumatoid Arthritis (RA)

a. **Standard/Basic Option patient, <u>for claims adjudicated through the pharmacy benefit</u>:** Has the patient tried and failed Enbrel, Humira, Rinvoq, or Xeljanz/Xeljanz XR ? ***Please select answer below:***

❑**Yes:** Would you like to switch the patient to a preferred product? ❑Yes***** ❑No

****If YES***, select the preferred product: ❑Actemra SC ❑Enbrel ❑Humira ❑Rinvoq ❑Xeljanz/Xeljanz XR

❑**No**: Would you like to switch the patient to a preferred product? ❑Yes***** ❑No

****If YES***, select the preferred product: ❑Enbrel ❑Humira ❑Rinvoq ❑Xeljanz/Xeljanz XR

b. Does the patient have an intolerance or contraindication to methotrexate (MTX)? ❑Yes ❑No*****

****If NO***, will Simponi be used in combination with methotrexate? ❑Yes ❑No

c. Does the prescriber agree to administer Simponi within the FDA labeled maintenance dose of 50mg subcutaneously (SubQ) every four weeks? ❑Yes ❑No

❑ Ulcerative Colitis (UC)

a. **Standard/Basic Option patient, <u>for claims adjudicated through the pharmacy benefit</u>:** Has the patient tried and failed Humira? ❑Yes ❑No*****

****If NO***, would you like to switch the patient to a preferred product? ❑Yes***** ❑No

****If YES***, please select the preferred product: ❑Humira ❑Rinvoq ❑Stelara SC

b. Does the prescriber agree to administer Simponi within the FDA labeled maintenance dose of 100mg subcutaneously (SubQ) every four weeks? ❑Yes ❑No

❑ Other diagnosis **(*please specify*)**: _____

<u>FOR CLAIMS ADJUDICATED THROUGH THE PHARMACY BENEFIT:</u>
STANDARD AND BASIC OPTION PATIENT REQUESTS REQUIRES <u>PAGE 5</u> TO BE COMPLETED

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PAGE 5 - PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R_____

FOR CLAIMS ADJUDICATED THROUGH THE PHARMACY BENEFIT:
STANDARD AND BASIC OPTION PATIENT REQUESTS REQUIRES PAGE 5 TO BE COMPLETED

1. Does the patient have a history of demyelinating disorder? ❑Yes ❑No
2. Does the patient have a history of congestive heart failure? ❑Yes ❑No
3. Does the patient have a history of hepatitis B virus (HBV) infection? ❑Yes ❑No
4. Does the patient have autoantibody formation / lupus-like syndrome? ❑Yes ❑No
5. Please select the diagnosis and answer the following question:

❑**Ankylosing Spondylitis (AS) / Psoriatic Arthritis (PsA) / Rheumatoid Arthritis (RA)**

a. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to **TWO** of the preferred products? ***Please select answer below:***

❑**Yes:** Please specify the preferred products and results below:

_____

_____

❑**No:** Is there a clinical reason for not trying **TWO** of the preferred products? ❑Yes***** ❑No

****If YES***, please describe the clinical reason below:

_____

_____

❑**Ulcerative Colitis (UC)**

a. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to a preferred product: Humira, Rinvoq, or Stelara SC? ***Please select answer below:***

❑**Yes:** Please specify the preferred product(s) and result(s) below:

_____

_____

❑**No:** Is there a clinical reason for not trying a preferred product? ❑Yes***** ❑No

****If YES***, please describe the clinical reason below:

_____

_____