Simponi Aria

CareFirst 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 1-855-330-1720**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-888-877-0518.** 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: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth: _____**
Physician's Name: _____
Specialty: _____ **NPI#: _____**
Physician Office Telephone: _____ **Physician Office Fax: _____**

Referring Provider Info: ❑ Same as Requesting Provider
Name: _____ **NPI#: _____**
Fax: _____ **Phone: _____**

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

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

Required Demographic Information:

Patient Weight: _____kg

Patient Height: _____cm

What is the ICD-10 code? _____

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

Site of Service Questions:

A. Where will this drug be administered?
- ❑ Ambulatory surgical, *skip to Clinical Criteria Questions*
- ❑ Home infusion, *skip to Clinical Criteria Questions*
- ❑ Off-campus Outpatient Hospital, *Continue to B*
- ❑ On-campus Outpatient Hospital, *Continue to B*
- ❑ Physician office, *skip to Clinical Criteria Questions*
- ❑ Pharmacy, *skip to Clinical Criteria Questions*

B. Is the patient less than 14 years of age?
- ❑ Yes, *skip to Clinical Criteria Questions*
- ❑ No, *Continue to C*

C. Is this request to continue previously established treatment with the requested medication? ***ACTION REQUIRED: If No, please attach supporting clinical documentation.***
- ❑ Yes - This is a continuation of an existing treatment., *Continue to D*
- ❑ No - This is a new therapy request (patient has not received requested medication in the last 6 months)., *skip to Clinical Criteria Questions*

D. Has the patient experienced an adverse event with the requested product that has not responded to conventional interventions (eg acetaminophen, steroids, diphenhydramine, fluids, or other pre-medications) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after an infusion? ***ACTION REQUIRED: If Yes, please attach supporting clinical documentation.***
- ❑ Yes, *skip to Clinical Criteria Questions*
- ❑ No, *Continue to E*

E. Is the patient medically unstable which may include respiratory, cardiovascular, or renal conditions that may limit the member's ability to tolerate a large volume or load or predispose the member to a severe adverse event that cannot be managed in an alternate setting without appropriate medical personnel and equipment?
ACTION REQUIRED: If Yes, please attach supporting clinical documentation.
- ❑ Yes, *skip to Clinical Criteria Questions*
- ❑ No, *Continue to F*

F. Does the patient have severe venous access issues that require the use of special interventions only available in the outpatient hospital setting? ***ACTION REQUIRED: If Yes, please attach supporting clinical documentation.***
- ❑ Yes, *skip to Clinical Criteria Questions*
- ❑ No, *Continue to G*

G. Does the patient have significant behavioral issues and/or physical or cognitive impairment that would impact the safety of the infusion therapy AND the patient does not have access to a caregiver? ***ACTION REQUIRED: If Yes, please attach supporting clinical documentation.***
- ❑ Yes, *skip to Clinical Criteria Questions*
- ❑ No, *Continue to H*

H. Are ***all*** alternative infusion sites (pharmacy, physician office, ambulatory care, etc.) **greater than** 30 miles from the patient's home? ***ACTION REQUIRED: If Yes, please attach supporting documentation.***
- ❑ Yes, *Continue to Clinical Criteria Questions*
- ❑ No, *Continue to Clinical Criteria Questions*

Clinical Criteria Questions:

1. Will the requested drug be used in combination with any other biologic (e.g., Humira) or targeted synthetic drug (e.g., Olumiant, Otezla, Xeljanz) for the same indication?
❒ Yes, *Continue to 2*
❒ No, *Continue to 2*

2. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic drug (e.g., Olumiant, Xeljanz) associated with an increased risk of tuberculosis?
❒ Yes, *Continue to 6*
❒ No, *Continue to 3*

3. Has the patient had a tuberculosis (TB) test (e.g., tuberculosis skin test [TST], interferon-release assay [IGRA]) within 6 months of initiating therapy?
❒ Yes, *Continue to 4*
❒ No, *Continue to 4*

4. What were the results of the tuberculosis (TB) test?
❒ Positive for TB, *Continue to 5*
❒ Negative for TB, *Continue to 6*
❒ Unknown, *Continue to 6*

5. Which of the following applies to the patient?
❒ Patient has latent TB and treatment for latent TB has been initiated, *Continue to 6*
❒ Patient has latent TB and treatment for latent TB has been completed, *Continue to 6*
❒ Patient has latent TB and treatment for latent TB has not been initiated, *Continue to 6*
❒ Patient has active TB, *Continue to 6*

6. What is the diagnosis?
❒ Rheumatoid arthritis, *Continue to 7*
❒ Psoriatic arthritis, *Continue to 25*
❒ Ankylosing spondylitis, *Continue to 40*
❒ Non-radiographic axial spondyloarthritis, *Continue to 40*
❒ Polyarticular juvenile idiopathic arthritis, *Continue to 49*
❒ Oligoarticular juvenile idiopathic arthritis, *Continue to 49*
❒ Immune checkpoint inhibitor-related toxicity - inflammatory arthritis, *Continue to 62*
❒ Other, please specify. _____, *No further questions*

7. Has the patient been diagnosed with moderately to severely active rheumatoid arthritis (RA)?
❒ Yes, *Continue to 8*
❒ No, *Continue to 8*

8. Is the patient an adult (18 years of age or older)?
❒ Yes, *Continue to 9*
❒ No, *Continue to 9*

9. Is the requested drug being prescribed by or in consultation with a rheumatologist?
❒ Yes, *Continue to 10*
❒ No, *Continue to 10*

10. Is this request for continuation of therapy with the requested drug?
❒ Yes, *Continue to 11*
❒ No, *Continue to 14*

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

❒ Yes, *Continue to 14*

❒ No, *Continue to 12*

❒ Unknown, *Continue to 14*

12. Has the patient achieved or maintained a positive clinical response since starting treatment with the requested drug?
❒ Yes, *Continue to 13*
❒ No, *Continue to 13*

13. 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.
❒ Yes, *Continue to 70*
❒ No, *Continue to 70*

14. Has the patient ever received or is currently receiving a biologic (e.g., Humira) 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.
❒ Yes, *Continue to 15*
❒ No, *Continue to 17*

15. Is the requested drug being prescribed in combination with methotrexate or leflunomide?
❒ Yes, *Continue to 70*
❒ No, *Continue to 16*

16. Please indicate a clinical reason for the patient to not use methotrexate or leflunomide.

❒ Clinical diagnosis of alcohol use disorder, alcoholic liver disease, or other chronic liver disease, *Continue to 70*

❒ Drug interaction, *Continue to 70*

❒ Risk of treatment-related toxicity, *Continue to 70*

❒ Pregnancy or currently planning pregnancy, *Continue to 70*

❒ Breastfeeding, *Continue to 70*
❒ Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension), *Continue to 70*

❒ Hypersensitivity, *Continue to 70*

❒ History of intolerance or adverse event, *Continue to 70*

❒ Other, please specify. _____, *Continue to 70*

❒ No clinical reason not to use methotrexate or leflunomide, *Continue to 70*

17. 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.
❒ Yes, *Continue to 19*
❒ No, *Continue to 18*

18. 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.
❒ Yes, *Continue to 19*
❒ No, *Continue to 19*

19. Is the requested drug being prescribed in combination with methotrexate or leflunomide?
❒ Yes, *Continue to 21*
❒ No, *Continue to 20*

20. Please indicate a clinical reason for the patient to not use methotrexate or leflunomide.

❒ Clinical diagnosis of alcohol use disorder, alcoholic liver disease or other chronic liver disease, *Continue to 21*

❒ Drug interaction, *Continue to 21*

❒ Risk of treatment-related toxicity, *Continue to 21*

❒ Pregnancy or currently planning pregnancy, *Continue to 21*

❒ Breastfeeding, *Continue to 21*
❒ Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension), *Continue to 21*

❒ Hypersensitivity, *Continue to 21*

❒ History of intolerance or adverse event, *Continue to 21*

❒ Other, please specify. _____, *Continue to 21*

❒ No clinical reason not to use methotrexate or leflunomide, *Continue to 21*

21. 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.
❒ Yes, *Continue to 70*
❒ No, *Continue to 22*

22. 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.
❒ Yes, *Continue to 70*
❒ No, *Continue to 23*

23. Does the patient have a contraindication to methotrexate? ***ACTION REQUIRED***: If Yes, please attach documentation of clinical reason to avoid therapy.
❒ Yes, *Continue to 24*
❒ No, *Continue to 24*

24. Please indicate the contraindication to methotrexate.

❒ Clinical diagnosis of alcohol use disorder, alcoholic liver disease, or other chronic liver disease, *Continue to 70*

❒ Drug interaction, *Continue to 70*

❒ Risk of treatment-related toxicity, *Continue to 70*

❒ Pregnancy or currently planning pregnancy, *Continue to 70*

❒ Breastfeeding, *Continue to 70*
❒ Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension), *Continue to 70*

❒ Hypersensitivity, *Continue to 70*

❒ History of intolerance or adverse event, *Continue to 70*

❒ Other, please specify. _____, *Continue to 70*

25. Is the patient 2 years of age or older?
❒ Yes, *Continue to 26*
❒ No, *Continue to 26*

26. Is the requested drug being prescribed by or in consultation with a rheumatologist or dermatologist?
❒ Yes, *Continue to 27*
❒ No, *Continue to 27*

27. Is this request for continuation of therapy with the requested drug?
❒ Yes, *Continue to 28*
❒ No, *Continue to 31*

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

❒ Yes, *Continue to 31*

❒ No, *Continue to 29*

❒ Unknown, *Continue to 31*

29. 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?
❒ Yes, *Continue to 30*
❒ No, *Continue to 30*

30. 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 ***ACTION REQUIRED****: Submit supporting documentation, Continue to 70*

❒ Number of tender joints ***ACTION REQUIRED****: Submit supporting documentation, Continue to 70*

❒ Dactylitis ***ACTION REQUIRED****: Submit supporting documentation, Continue to 70*

❒ Enthesitis ***ACTION REQUIRED****: Submit supporting documentation, Continue to 70*

❒ Axial disease ***ACTION REQUIRED****: Submit supporting documentation, Continue to 70*

❒ Skin and/or nail involvement ***ACTION REQUIRED****: Submit supporting documentation, Continue to 70*

❒ Functional status ***ACTION REQUIRED****: Submit supporting documentation, Continue to 70*

❒ C-reactive protein (CRP) ***ACTION REQUIRED****: Submit supporting documentation, Continue to 70*

❒ None of the above, *Continue to 70*

31. Has the patient been diagnosed with active psoriatic arthritis (PsA)?
❒ Yes, *Continue to 32*
❒ No, *Continue to 32*

32. Has the patient ever received or is currently receiving a biologic (e.g., Humira) or targeted synthetic drug (e.g., Rinvoq, Otezla) indicated for the treatment of 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.
❒ Yes, *Continue to 70*
❒ No, *Continue to 33*

33. What is the patient's disease severity?

❒ Mild to moderate, *Continue to 34*

❒ Severe, *Continue to 70*

34. Does the patient have enthesitis or predominantly axial disease?
❒ Yes, *Continue to 70*
❒ No, *Continue to 35*

35. 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.
❒ Yes, *Continue to 70*
❒ No, *Continue to 36*

36. 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.
❒ Yes, *Continue to 70*
❒ No, *Continue to 37*

37. Does the patient have a contraindication to methotrexate or leflunomide? ***ACTION REQUIRED***: If Yes, please attach documentation of clinical reason to avoid therapy.
❒ Yes, *Continue to 39*
❒ No, *Continue to 38*

38. 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.
❒ Yes, *Continue to 70*
❒ No, *Continue to 70*

39. Please indicate the contraindication to methotrexate or leflunomide.

❒ Clinical diagnosis of alcohol use disorder, alcoholic liver disease, or other chronic liver disease, *Continue to 70*

❒ Drug interaction, *Continue to 70*

❒ Risk of treatment-related toxicity, *Continue to 70*

❒ Pregnancy or currently planning pregnancy, *Continue to 70*

❒ Breastfeeding, *Continue to 70*

❒ Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension), *Continue to 70*

❒ Hypersensitivity, *Continue to 70*

❒ History of intolerance or adverse event, *Continue to 70*

❒ Other, please specify. _____, *Continue to 70*

40. Is the patient an adult (18 years of age or older)?

❒ Yes, *Continue to 41*

❒ No, *Continue to 41*

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

❒ Yes, *Continue to 42*

❒ No, *Continue to 42*

42. Is this request for continuation of therapy with the requested drug?

❒ Yes, *Continue to 43*

❒ No, *Continue to 46*

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

❒ Yes, *Continue to 46*

❒ No, *Continue to 44*

❒ Unknown, *Continue to 46*

44. 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?

❒ Yes, *Continue to 45*

❒ No, *Continue to 45*

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.

❒ Functional status ***ACTION REQUIRED****: Submit supporting documentation, Continue to 70*

❒ Total spine pain ***ACTION REQUIRED****: Submit supporting documentation, Continue to 70*

❒ Inflammation (e.g., morning stiffness) ***ACTION REQUIRED****: Submit supporting documentation, Continue to 70*

❒ Swollen joints ***ACTION REQUIRED****: Submit supporting documentation, Continue to 70*

❒ Tender joints ***ACTION REQUIRED****: Submit supporting documentation, Continue to 70*

❒ C-reactive protein ***ACTION REQUIRED****: Submit supporting documentation, Continue to 70*

❒ None of the above, *Continue to 70*

46. Has the patient been diagnosed with active ankylosing spondylitis (AS) or active non-radiographic axial spondyloarthritis (nr-axSpA)?

❒ Yes - Active ankylosing spondylitis, *Continue to 47*

❒ Yes - Active non-radiographic axial spondyloarthritis, *Continue to 47*

❒ No, *Continue to 47*

47. Has the patient ever received or is currently receiving a biologic (e.g., Humira) or targeted synthetic drug (e.g., Rinvoq, Xeljanz) indicated for the treatment of active ankylosing spondylitis or active 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.
❒ Yes, *Continue to 70*
❒ No, *Continue to 48*

48. 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 (if applicable), including response to therapy. If therapy is if not advisable, please attach documentation of clinical reason to avoid therapy.
❒ Yes, *Continue to 70*
❒ No, *Continue to 70*

49. Has the patient been diagnosed with active articular juvenile idiopathic arthritis?
❒ Yes, *Continue to 50*
❒ No, *Continue to 50*

50. Is the patient 2 years of age or older?
❒ Yes, *Continue to 51*
❒ No, *Continue to 51*

51. Is the requested drug being prescribed by or in consultation with a rheumatologist?
❒ Yes, *Continue to 52*
❒ No, *Continue to 52*

52. Is this request for continuation of therapy with the requested drug?
❒ Yes, *Continue to 53*
❒ No, *Continue to 56*

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

❒ Yes, *Continue to 56*

❒ No, *Continue to 54*

❒ Unknown, *Continue 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?
❒ Yes, *Continue to 55*
❒ No, *Continue to 55*

55. 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) ***ACTION REQUIRED****: Submit supporting documentation, Continue to 70*
❒ Number of joints with limitation of movement ***ACTION REQUIRED****: Submit supporting documentation, Continue to 70*
❒ Functional ability ***ACTION REQUIRED****: Submit supporting documentation, Continue to 70*
❒ None of the above, *Continue to 70*

56. Has the patient ever received or is currently receiving a biologic (e.g., Humira) or targeted synthetic drug (e.g., Xeljanz) indicated for the treatment of 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.
❒ Yes, *Continue to 70*
❒ No, *Continue to 57*

57. 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.
❒ Yes, *Continue to 70*
❒ No, *Continue to 58*

58. Has the patient had an inadequate response to a trial of scheduled non-steroidal anti-inflammatory 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.
❒ Yes, *Continue to 59*
❒ No, *Continue to 60*

59. Does the patient have one 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?
❒ Yes, *Continue to 70*
❒ No, *Continue to 60*

60. 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?
❒ Yes, *Continue to 61*
❒ No, *Continue to 61*

61. 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?
❒ Yes, *Continue to 70*
❒ No, *Continue to 70*

62. Is the requested drug being prescribed by or in consultation with an oncologist, hematologist, or rheumatologist?

❒ Yes, *Continue to 63*
❒ No, *Continue to 63*

63. Is this request for continuation of therapy with the requested drug?
❒ Yes, *Continue to 64*
❒ No, *Continue to 66*

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

❒ Yes, *Continue to 66*

❒ No, *Continue to 65*

❒ Unknown, *Continue to 66*

65. 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 medical record documentation supporting positive clinical response.
❒ Yes, *Continue to 70*
❒ No, *Continue to 70*

66. Does the patient have moderate or severe immunotherapy-related inflammatory arthritis?
❒ Yes, *Continue to 67*
❒ No, *Continue to 67*

67. 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.
❒ Yes, *Continue to 70*
❒ No, *Continue to 68*

68. 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.
❒ Yes, *Continue to 69*
❒ No, *Continue to 69*

69. 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 if not advisable, please attach documentation of clinical reason to avoid therapy.
❒ Yes, *Continue to 70*
❒ No, *Continue to 70*

70. What is the diagnosis?

❒ Rheumatoid arthritis, *Continue to 71*

❒ Psoriatic arthritis, *Continue to 78*

❒ Ankylosing spondylitis, *Continue to 71*

❒ Non-radiographic axial spondyloarthritis, *Continue to 71*

❒ Polyarticular juvenile idiopathic arthritis, *Continue to 91*

❒ Oligoarticular juvenile idiopathic arthritis, *Continue to 91*

❒ Immune checkpoint inhibitor-related toxicity - inflammatory arthritis, *Continue to 98*

71. Is the patient currently receiving Simponi Aria?
❒ Yes, *Continue to 72*
❒ No, *Continue to 75*

72. Does the prescribed dose exceed 2 milligrams per kilogram (mg/kg)?
❒ Yes, *Continue to 73*
❒ No, *Continue to 73*

73. Is the prescribed frequency of the maintenance dose more frequent than one dose every 8 weeks?
❒ Yes, *Continue to 74*
❒ No, *Continue to 74*

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

❒ 100 kg (220.5 lbs) or less _____kg, *No further questions*

❒ Greater than 100 kg (220.5 lbs) _____kg, *No further questions*

75. Does the prescribed dose exceed a loading dose of 2 milligrams per kilogram (mg/kg) at weeks 0 and 4, followed by a maintenance dose of 2 mg/kg thereafter?
❒ Yes, *Continue to 76*
❒ No, *Continue to 76*

76. Is the prescribed frequency of the maintenance dose more frequent than one dose every 8 weeks?
❒ Yes, *Continue to 77*
❒ No, *Continue to 77*

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

❒ 100 kg (220.5 lbs) or less _____kg, *No further questions*

❒ Greater than 100 kg (220.5 lbs) _____kg, *No further questions*

78. Is the patient currently receiving Simponi Aria?
❒ Yes, *Continue to 79*
❒ No, *Continue to 85*

79. Is the prescribed frequency for the maintenance dose more frequent than one dose every 8 weeks?
❒ Yes, *Continue to 80*
❒ No, *Continue to 80*

80. What is the patient's age?

❒ 2 years old to less than 18 years old, *Continue to 81*

❒ 18 years old or older, *Continue to 83*

81. Does the prescribed dose exceed 80 mg/m2?
❒ Yes, *Continue to 82*
❒ No, *Continue to 82*

82. What is the patient's weight? Indicate in kilograms (kg).
❒ 100 kg (220.5 lbs) or less _____kg, *No further questions*
❒ Greater than 100 kg (220.5 lbs) _____kg, *No further questions*

83. Does the prescribed dose exceed 2 milligrams per kilogram (mg/kg)?
❒ Yes, *Continue to 84*
❒ No, *Continue to 84*

84. What is the patient's body weight? Indicate in kilograms (kg).
❒ 100 kg (220.5 lbs) or less _____kg, *No further questions*
❒ Greater than 100 kg (220.5 lbs) _____kg, *No further questions*

85. Is the prescribed frequency for the maintenance dose more frequent than one dose every 8 weeks?
❒ Yes, *Continue to 86*
❒ No, *Continue to 86*

86. What is the patient's age?
❒ 2 years old to less than 18 years old, *Continue to 87*
❒ 18 years old or older, *Continue to 89*

87. Does the prescribed dose exceed a loading dose of 80 mg/m2 at weeks 0 and 4, followed by a maintenance dose of 80 mg/m2 thereafter?
❒ Yes, *Continue to 88*
❒ No, *Continue to 88*

88. What is the patient's weight? Indicate in kilograms (kg).
❒ 100 kg (220.5 lbs) or less _____kg, *No further questions*
❒ Greater than 100 kg (220.5 lbs) _____kg, *No further questions*

89. Does the prescribed dose exceed a loading dose of 2 milligrams per kilogram (mg/kg) at weeks 0 and 4, followed by a maintenance dose of 2 mg/kg thereafter?
❒ Yes, *Continue to 90*
❒ No, *Continue to 90*

90. What is the patient's weight? Indicate in kilograms (kg).
❒ 100 kg (220.5 lbs) or less _____kg, *No further questions*
❒ Greater than 100 kg (220.5 lbs) _____kg, *No further questions*

91. Is the patient currently receiving Simponi Aria?
❒ Yes, *Continue to 92*
❒ No, *Continue to 95*

92. Is the prescribed frequency for the maintenance dose more frequent than one dose every 8 weeks?
❒ Yes, *Continue to 93*
❒ No, *Continue to 93*

93. Does the prescribed dose exceed 80 mg/m2?
❒ Yes, *Continue to 94*
❒ No, *Continue to 94*

94. What is the patient's weight? Indicate in kilograms (kg).
❒ 100 kg (220.5 lbs) or less _____kg, *No further questions*
❒ Greater than 100 kg (220.5 lbs) _____kg, *No further questions*

95. Is the prescribed frequency for the maintenance dose more frequent than one dose every 8 weeks?
❒ Yes, *Continue to 96*
❒ No, *Continue to 96*

96. Does the prescribed dose exceed a loading dose of 80 mg/m2 at weeks 0 and 4, followed by a maintenance dose of 80 mg/m2 thereafter?
❒ Yes, *Continue to 97*
❒ No, *Continue to 97*

97. What is the patient's weight? Indicate in kg.
❒ 100 kg (220.5 lbs) or less _____kg, *No further questions*
❒ Greater than 100 kg (220.5 lbs) _____kg, *No further questions*

98. Is the requested quantity supported by dosing guidelines found in the compendia or current literature (e.g., Micromedex DrugDex, NCCN compendia, current treatment guidelines)?
❒ Yes, *Continue to 99*
❒ No, *Continue to 99*

99. Is the patient currently receiving Simponi Aria?
❒ Yes, *Continue to 100*
❒ No, *Continue to 103*

100. Does the prescribed dose exceed 2 milligrams per kilogram (mg/kg)?
❒ Yes, *Continue to 101*
❒ No, *Continue to 101*

101. Is the prescribed frequency of the maintenance dose more frequent than one dose every 8 weeks?
❒ Yes, *Continue to 102*
❒ No, *Continue to 102*

102. What is the patient's weight? Indicate in kilograms (kg).
❒ 100 kg (220.5 lbs) or less _____kg, *No further questions*
❒ Greater than 100 kg (220.5 lbs) _____kg, *No further questions*

103. Does the prescribed dose exceed a loading dose of 2 milligrams per kilogram (2 mg/kg) at weeks 0 and 4, followed by a maintenance dose of 2 mg/kg thereafter?
❒ Yes, *Continue to 104*
❒ No, *Continue to 104*

104. Is the prescribed frequency of the maintenance dose more frequent than one dose every 8 weeks?
❒ Yes, *Continue to 105*
❒ No, *Continue to 105*

105. What is the patient's weight? Indicate in kilograms (kg).
❒ 100 kg (220.5 lbs) or less _____kg, *No further questions*
❒ Greater than 100 kg (220.5 lbs) _____kg, *No further questions*

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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