BlueCross BlueShield Federal Employee Program

SIMPONI
PRIOR APPROVAL REQUEST

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.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

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 Humira including preferred Humira biosimilars, Actemra SC including preferred Actemra SC biosimilars, Enbrel, 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 this medication 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? ❑Positive* ❑Negative
   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 this therapy? ❑Yes ❑No
7. Will Simponi be used in combination with another biologic *DMARD or targeted synthetic DMARD? ❑Yes* ❑No
   If YES, please specify medication: _____
   DMARDs: Actemra or an Actemra biosimilar, Avsola, Bimzelx, Cimzia, Cosentyx, Enbrel, Entyvio, Humira or a Humira biosimilar, Ilumya, Inflectra, Kevzara, Kineret, Olumiant, Orencia, Otezla, Remicade, Renflexis, Riabni, Rinvoq, Rituxan, Ruxience, Siliq, Simponi/Simponi Aria, Skyrizi, Sotyktu, Spevigo, Stelara, Taltz, Tremfya, Truxima, Xeljanz/Xeljanz XR, Zymfentra.
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 participate in this program and switch the patient to one of the preferred products: Humira/preferred biosimilar, Enbrel, Rinvoq, or Taltz? ❑Yes* ❑No
      If YES, select the preferred product: ❑Humira/preferred biosimilar ❑Enbrel ❑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 2 different NSAIDs over a 4-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 not to exceed the FDA labeled maintenance dose of 50 mg subcutaneously (SubQ) every 4 weeks? ❑Yes ❑No

PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL DIAGNOSES

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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 participate in this program and switch the patient to one of the preferred products: Humira/preferred biosimilar, Enbrel, Otezla, Rinvoq, Skyrizi, Stelara SC, Taltz, Tremfya, or Xeljanz/Xeljanz XR? ❑Yes***** ***(*If YES, please select answer below)*** ❑No
❑Humira/preferred biosimilar ❑Enbrel ❑Otezla ❑Rinvoq ❑Skyrizi ❑Stelara SC ❑Taltz ❑Tremfya ❑Xeljanz/Xeljanz XR

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

c. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to a 3-month trial of at least one conventional disease modifying antirheumatic drug (DMARD)? ❑Yes ❑No

d. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 50 mg subcutaneously (SubQ) every 4 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 Humira or a Humira biosimilar, Enbrel, Rinvoq, or Xeljanz/Xeljanz XR? ***Please select answer below:***

❑**Yes:** Would you like to participate in this program and switch the patient to one of the preferred products: Humira/preferred biosimilar, Actemra SC, Enbrel, Rinvoq, or Xeljanz/Xeljanz XR? ❑Yes***** ❑No

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

❑**No**: Would you like to participate in this program and switch the patient to one of the preferred products: Humira/preferred biosimilar, Enbrel, Rinvoq, or Xeljanz/Xeljanz XR? ❑Yes***** ❑No

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

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

c. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to a 3-month trial of at least one conventional disease modifying antirheumatic drug (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 (MTX)? ❑Yes ❑No

e. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 50 mg subcutaneously (SubQ) every 4 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 or a Humira biosimilar? ❑Yes ❑No*****

****If NO***, would you like to participate in this program and switch the patient to one of the preferred products: Humira/preferred biosimilar, Rinvoq, Skyrizi, Stelara SC, or Tremfya? ❑Yes***** ❑No

****If YES***, select the preferred product: ❑Humira/preferred biosimilar ❑Rinvoq ❑Skyrizi ❑Stelara SC ❑Tremfya

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 not to exceed the FDA labeled maintenance dose of 100mg subcutaneously (SubQ) every 4 weeks? ❑Yes ❑No

❑Other (***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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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 Humira including preferred Humira biosimilars, Actemra SC including preferred Actemra SC biosimilars, Enbrel, 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 this medication 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 therapy? ❑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 this therapy? ❑Yes ❑No
6. Will Simponi be used in combination with another biologic *DMARD or targeted synthetic DMARD? ❑Yes* ❑No
   If YES, please specify medication: _____
   DMARDs: Actemra or an Actemra biosimilar, Avsola, Bimzelx, Cimzia, Cosentyx, Enbrel, Entyvio, Humira or a Humira biosimilar, Ilumya, Inflectra, Kevzara, Kineret, Olumiant, Orencia, Otezla, Remicade, Renflexis, Riabni, Rinvoq, Rituxan, Ruxience, Siliq, Simponi/Simponi Aria, Skyrizi, Sotyktu, Spevigo, Stelara, Taltz, Tremfya, Truxima, Xeljanz/Xeljanz XR, Zymfentra.
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 participate in this program and switch the patient to one of the preferred products: Humira/preferred biosimilar, Enbrel, Rinvoq, or Taltz? ❑Yes* ❑No
      If YES, select the preferred product: ❑Humira/preferred biosimilar ❑Enbrel ❑Rinvoq ❑Taltz
   b. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 50 mg subcutaneously (SubQ) every 4 weeks? ❑Yes ❑No

   ❑Psoriatic Arthritis (PsA)
   a. **Standard/Basic Option patient, for claims adjudicated through the pharmacy benefit:** Would you like to participate in this program and switch the patient to one of the preferred products: Humira/preferred biosimilar, Enbrel, Otezla, Rinvoq, Skyrizi, Stelara SC, Taltz, Tremfya, or Xeljanz/Xeljanz XR? ❑Yes* ***(*If YES, please select answer below)*** ❑No
      ❑Humira/preferred biosimilar ❑Enbrel ❑Otezla ❑Rinvoq ❑Skyrizi ❑Stelara SC ❑Taltz ❑Tremfya ❑Xeljanz/Xeljanz XR
   b. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 50 mg subcutaneously (SubQ) every 4 weeks? ❑Yes ❑No

PLEASE PROCEED TO PAGE 4 FOR ADDITIONAL DIAGNOSES

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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 Humira or a Humira biosimilar, Enbrel, Rinvoq, or Xeljanz/Xeljanz XR? ***Please select answer below:***

❑**Yes:** Would you like to participate in this program and switch the patient to one of the preferred products: Humira/preferred biosimilar, Actemra SC, Enbrel, Rinvoq, or Xeljanz/Xeljanz XR? ❑Yes***** ❑No

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

❑**No**: Would you like to participate in this program and switch the patient to one of the preferred products: Humira/preferred biosimilar, Enbrel, Rinvoq, or Xeljanz/Xeljanz XR? ❑Yes***** ***(*If YES, select answer below)*** ❑No

❑Humira/preferred biosimilar ❑Enbrel ❑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 (MTX)? ❑Yes ❑No

c. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 50 mg subcutaneously (SubQ) every 4 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 or a Humira biosimilar? ❑Yes ❑No*****

****If NO***, would you like to participate in this program and switch the patient to one of the preferred products: Humira/preferred biosimilar, Rinvoq, Skyrizi, Stelara SC, or Tremfya? ❑Yes***** ❑No

****If YES***, please select the preferred product: ❑Humira/preferred biosimilar ❑Rinvoq ❑Skyrizi ❑Stelara SC ❑Tremfya

b. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 100mg subcutaneously (SubQ) every 4 weeks? ❑Yes ❑No

❑ Other **(*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. Please select the diagnosis and answer the following question:

❑**Ankylosing Spondylitis (AS)**

a. Does the patient have an intolerance or contraindication* or have they had an inadequate treatment response to TWO of the following preferred medications: Humira or a Humira biosimilar, Enbrel, Rinvoq, or Taltz?

Contraindications include (not all inclusive): allergy, autoantibody formation/lupus-like syndrome, or a history of congestive heart failure, hepatitis B virus infection, malignancy, or demyelinating disorder such as multiple sclerosis, Guillain-Barre syndrome, or optic neuritis.

Please select answer: ❑Yes ❑No*

***If NO,** is there a clinical reason for not trying TWO of the preferred medications? ❑Yes ❑No

❑ **Psoriatic Arthritis (PsA)**

a. Does the patient have an intolerance or contraindication* or have they had an inadequate treatment response to TWO of the following preferred medications: Humira or a Humira biosimilar, Enbrel, Otezla, Rinvoq, Skyrizi, Stelara SC, Taltz, Tremfya, or Xeljanz/Xeljanz XR?

Contraindications include (not all inclusive): allergy, autoantibody formation/lupus-like syndrome, or a history of congestive heart failure, hepatitis B virus infection, malignancy, or demyelinating disorder such as multiple sclerosis, Guillain-Barre syndrome, or optic neuritis.

Please select answer: ❑Yes ❑No*

***If NO,** is there a clinical reason for not trying TWO of the preferred medications? ❑Yes ❑No

❑ **Rheumatoid Arthritis (RA)**

a. Does the patient have an intolerance or contraindication* or have they had an inadequate treatment response to TWO of the following preferred medications: Humira or a Humira biosimilar, Actemra SC or an Actemra SC biosimilar, Enbrel, Rinvoq, or Xeljanz/Xeljanz XR?

Contraindications include (not all inclusive): allergy, autoantibody formation/lupus-like syndrome, or a history of congestive heart failure, hepatitis B virus infection, malignancy, or demyelinating disorder such as multiple sclerosis, Guillain-Barre syndrome, or optic neuritis.

Please select answer: ❑Yes ❑No*

***If NO,** is there a clinical reason for not trying TWO of the preferred medications? ❑Yes ❑No

❑**Ulcerative Colitis (UC)**

a. Does the patient have an intolerance or contraindication* or have they had an inadequate treatment response to Humira or a Humira biosimilar, Rinvoq, Skyrizi, Stelara SC, or Tremfya?

Contraindications include (not all inclusive): allergy, autoantibody formation/lupus-like syndrome, or a history of congestive heart failure, hepatitis B virus infection, malignancy, or demyelinating disorder such as multiple sclerosis, Guillain-Barre syndrome, or optic neuritis.

Please select answer: ❑Yes ❑No*

***If NO,** is there a clinical reason for not trying Humira or a Humira biosimilar, Rinvoq, Skyrizi, or Stelara SC? ❑Yes ❑No