

BlueShield. SIMPONI Federal Employee Program. PRIOR APPROVAL REQUEST

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

Attn. Clinical Services
Fax: 1-877-378-4727

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.

| | | atient Inform | ation (req | uired) | | | | Provider | r Inform | ation (re | quired) |
|-----------------------------------|--|--|-------------------------------|--------------------|-------------------------------|----------------|--------------------------|--------------------------------|----------------------------|-------------|------------------------------------|
| Ι | Date: | | | | | | Provider Name | : : | | | |
| F | Patient Name: | | | | | | Specialty: | | NF | PI: | |
| Date of Birth: Sex: □Male □Female | | | | Office Phone: | | Of | fice Fax: | | | | |
| S | Street Address: | | 1 | | | | Office Street A | Address: | I | | |
| (| City: | | State: | | Zip: | | City: | | State: | | Zip: |
| F | Patient ID: R | | | | | 1 | Physician Sign | ature: | I | | <u> </u> |
| | | | <u> </u> | P | HYSICIA | N C | OMPLETES | 5 | | | |
| | | nd Basic Option p brel, Otezla, Rinvo | atients Hun oq, Skyrizi, | ira inc Stelara | cluding prefe SC, Taltz, T | erred Fremi | | ilars, Actemr z/ Xeljanz XF | ra SC inclu R are prefe | rred produ | |
| | | | | | Simpo | ni (ş | golimumab) | | | | |
| | | **Check | _ | _ | | | which medication | - | | efit | |
| | | | NOTE: F | orm m | ust be comp | oletec | l in its entirety | for process | ing | | |
| | \square YES – this \square NO – this i | nt been on this me is a PA renewal for s INITIATION of for brand or gene | or CONTI of therapy, p | NUAT olease a | TION of the answer the f | rapy, | please answer | questions on | | | wer below. |
| | • | nt been tested for l | | | | ′_c* | □No | | | | |
| ٥. | * <i>If YES</i> , wa | s the result of the <i>TIVE</i> , has the pati | test positiv | e or ne | gative for T | B in | fection? □Pos | | _ | or latent T | B? □Yes □No |
| 4. | - | at risk for hepatiti as HBV infection | | | | | | reatment for | HBV infe | ction? | Yes □No |
| 5. | Does the patie | ent have any activ | e infections | includ | ding tubercu | losis | (TB) or hepati | tis B virus (l | HBV)? □ | Yes 🗆 | No |
| 6. | Will the patie | nt be given live va | accines whi | le on t | his therapy? | ? 🗆 Y | es □No | | | | |
| 7. | Will Simponi | be used in combin | nation with | anothe | er biologic * | *DM | ARD or targete | d synthetic l | DMARD? | □Yes* | □No |
| | • • • | lease specify medi | | | | | | | | | |
| | Ilumya, | Ds: Actemra or an A Inflectra, Kevzara, /Simponi Aria, Skyl | Kineret, Olu | miant, | Orencia, Oto | ezla, l | Remicade, Renfl | exis, Riabni, | Rinvoq, Rit | tuxan, Ruxi | ience, Siliq, |
| 8. | What is the pa | atient's diagnosis? | ? | | | | | | | | |
| | | g Spondylitis (AS) | | • | | | | | | | |
| | this pro | ard/Basic Option ogram and switch □Yes* □No | the patient | | | | | | | | ke to participate in Rinvoq, or |
| | * <i>If</i> } | YES, select the pre | eferred proc | luct: 🛚 | ⊒ Humira/pr | eferr | ed biosimilar | □Enbrel | $\square Rinvoq$ | □Taltz | Z |
| | b. Does t | he patient have ac | tive ankylo | sing sp | ondylitis? | □Y€ | es 🗆 No | | | | |
| | period | e patient had eithe in total at maximu NO, does the patie | um recomn | ended | or tolerated | l dose | e? □Yes □I | | 2 different | NSAIDs o | over a 4-week |
| | | he prescriber agre ? □Yes □No | e not to exc | eed th | e FDA labe | led n | naintenance dos | se of 50 mg | subcutaneo | ously (Sub | Q) every 4 |

PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL DIAGNOSES

PAGE 1 of 5



SIMPONI
PRIOR APPROVAL REQUEST

Federal Employee Program PRIOR APPROVAL REQUEST

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| | PAGE 2 - PHYSICIA | N COMPLETES | |
|---|---|--|-----------------------|
| Patient Name: | DOB: | Patient ID: | |
| ☐Psoriatic Arthritis (PsA) | | | |
| this program and switch the | patient to one of the preferred | through the pharmacy benefit: Would you products: Humira/preferred biosimilar, Enbror. Pyes* (*If YES, please select answer below) | el, Otezla, Rinvoq, |
| ☐Humira/preferred biosimil☐Xeljanz/Xeljanz XR | ar □Enbrel □Otezla □Ri | nvoq □Skyrizi □Stelara SC □Taltz □T | Tremfya |
| b. Does the patient have active | psoriatic arthritis (PsA)? \square Y | es □No | |
| c. Does the patient have an into | olerance or contraindication or | have they had an inadequate treatment respondential drug (DMARD)? \(\subseteq Yes \) \(\subseteq No \) | onse to a 3-month |
| d. Does the prescriber agree no weeks? □Yes □No | ot to exceed the FDA labeled n | naintenance dose of 50 mg subcutaneously (S | ubQ) every 4 |
| □Rheumatoid Arthritis (RA) | | | |
| | | through the pharmacy benefit: Has the pate z/Xeljanz XR? Please select answer below: | ient tried and failed |
| | | witch the patient to one of the preferred prod Rinvoq, or Xeljanz/Xeljanz XR? □Yes* | ucts: □No |
| * <i>If YES</i> , select pro □Rinvoq □Xelja | | osimilar □Actemra SC/preferred biosimilar | □Enbrel |
| | ticipate in this program and sy similar, Enbrel, Rinvoq, or Xe | vitch the patient to one of the preferred produ ljanz/Xeljanz XR? □Yes* □No | cts: |
| *If YES, select pro | oduct: Humira/preferred bio | osimilar □Enbrel □Rinvoq □Xeljanz/Xe | ljanz XR |
| b. Does the patient have moder | rate to severely active rheumat | oid arthritis (RA)? □Yes □No | |
| | | have they had an inadequate treatment responsation drug (DMARD)? Yes No | nse to a 3-month |
| d. Does the patient have an into | olerance or contraindication to | methotrexate (MTX)? □Yes □No* | |
| - | | otrexate (MTX)? □Yes □No | |
| e. Does the prescriber agree no weeks? □Yes □No | t to exceed the FDA labeled m | naintenance dose of 50 mg subcutaneously (S | ubQ) every 4 |
| □Ulcerative Colitis (UC) | | | |
| a. Standard/Basic Option pat Humira or a Humira biosimi | | through the pharmacy benefit: Has the pati | ient tried and failed |
| | | d switch the patient to one of the preferred pr C, or Tremfya? □Yes* □No | oducts: |
| *If YES, select the pre- | ferred product: Humira/pred Stelara SC | ferred biosimilar □Rinvoq □Skyrizi □Tremfya | |
| off corticosteroids without re | eturn of UC symptoms)? \Box Ye | | |
| *If NO, does the patient h least one conventional the | | dication or have they had an inadequate treati | nent response to at |
| c. Does the prescriber agree no weeks? □Yes □No | t to exceed the FDA labeled n | naintenance dose of 100mg subcutaneously (S | SubQ) every 4 |
| ☐Other (please specify): | | | |

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

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| | P | atient Inform | ation (require | d) | | Provider 1 | mto | rmatior | l (required) | |
|-----------------------------------|--|--|---|--|-----------------------|---|-------------------------|--------------------------------------|-----------------------|--|
| Γ | Date: | | | | | Provider Name: | | | | |
| Patient Name: | | | | | Specialty: | | NPI: | | | |
| Date of Birth: Sex: □Male □Female | | | | Office Phone: | | Office Fa | x: | | | |
| S | Street Address: | | | | | Office Street Address: | | | | |
| (| City: | | State: | Zip: | | City: | Sta | ite: | Zip: | |
| P | Patient ID: | 1 1 | 1 1 1 | 1 1 | | Physician Signature: | | | | |
| | | • | · · · · · · | PHYSICIA | N C | OMPLETES | | | | |
| | | nd Basic Option pa brel, Otezla, Rinvo switch to | atients Humira oq, Skyrizi, Stela a preferred pro | including prefer ara SC, Taltz, T oduct will be elig | rred remi gible | UGH THE PHARMACY BEN Humira biosimilars, Actemra Tya, and Xeljanz/ Xeljanz XR a for 2 copays at no cost in the b | SC in are proper | ncluding p referred p it year. | | |
| | | CON | NTINUAT | | | ERAPY (PA RENE | WA | L) | | |
| | | | | - | | golimumab) | | | | |
| | | **Check v | | | | which medication is part of the pat | | benefit | | |
| | | | NOTE: Form | must be comp | letec | l in its entirety for processin | g | | | |
| | \square NO – this i \square YES – this | s INITIATION o | of therapy, pleas For CONTINU | se answer the q | uest | 5 months excluding samples a ions on PAGE 1 please answer the following | | | r below: | |
| | - | t's condition imp | | | y?[| ⊒Yes □No | | | | |
| 4. | Does the patie | nt have any active | e infections inc | luding tubercul | losis | (TB) or Hepatitis B Virus (H | IBV) | ? □Yes | □No | |
| 5. | Will the patien | nt be given live va | accines while or | n this therapy? | ΠY | Yes □No | | | | |
| 6. | Will Simponi | be used in combin | nation with ano | ther biologic * | DM | ARD or targeted synthetic Dl | MAR | D? □Ye | s* □No | |
| | *DMARD Ilumya, Ir | iflectra, Kevzara, K | ctemra biosimilo Xineret, Olumian | t, Orencia, Otezl | la, R | Cimzia, Cosentyx, Enbrel, Enty emicade, Renflexis, Riabni, Rin remfya, Truxima, Xeljanz/Xelja | voq, | Rituxan, R | Ruxience, Siliq, | |
| 7. | What is the pa | tient's diagnosis? | • | | | | | | | |
| | a. Standa this pro | | patient, <u>for cl</u> | aims adjudica | | through the pharmacy bene products: Humira/preferred b | | | | |
| | * <i>If</i> Y | ES, select the pre | eferred product: | : Humira/pre | eferr | ed biosimilar | □Ri | invoq | ⊐Taltz | |
| | | ne prescriber agre ' □Yes □No | e not to exceed | the FDA label | ed n | naintenance dose of 50 mg su | bcut | aneously (| (SubQ) every 4 | |
| | this pro Skyrizi | ard/Basic Option ogram and switch , Stelara SC, Talt | the patient to o z, Tremfya, or | ne of the prefer Xeljanz/Xeljan | rred z XI | through the pharmacy bend products: Humira/preferred b R? □Yes* (*If YES, please se nvoq □Skyrizi □Stelara S | oiosii <i>lect a</i> | nilar, Enb <i>nswer belo</i> | orel, Otezla, Rinvoq, | |
| | □Xelja | nnz/Xeljanz XR | | | | • | | | • | |
| | | ne prescriber agre □ Yes □ No | e not to exceed | the FDA label | ed n | naintenance dose of 50 mg su | bcut | aneously (| (SubQ) every 4 | |

PLEASE PROCEED TO PAGE 4 FOR ADDITIONAL DIAGNOSES

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☐ Other (*please specify*): _

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| PAGE 4 - PHYSICIAN COMPLETES | | | | | |
|---|--|--|------------------------------------|--|--|
| Patient Name: | DOB: | Patient ID: R | | | |
| ☐ Rheumatoid Arthritis (RA) | | | | | |
| | | nrough the pharmacy benefit: Ha Xeljanz XR? <i>Please select answer</i> | | | |
| Humira/preferred bi | osimilar, Actemra SC, Enbrel, R e preferred product: □Humira/p | ritch the patient to one of the prefer Rinvoq, or Xeljanz/Xeljanz XR? ☐ preferred biosimilar ☐ Actemra Se ☐ Rinvoq ☐ Xeljanz/Xeljanz XR | Yes* □No C/preferred biosimilar | | |
| Humira/preferred bio | similar, Enbrel, Rinvoq, or Xelja | tch the patient to one of the preferr anz/Xeljanz XR? \(\subseteq Yes* (*\mathbf{If YES}) \) \(\subseteq Rinvoq \) \(\subseteq Xeljanz XR \) | | | |
| • | olerance or contraindication to r used in combination with metho | methotrexate (MTX)? □Yes □Iotrexate (MTX)? □Yes □No | No* | | |
| c. Does the prescriber agree no weeks? □Yes □No | ot to exceed the FDA labeled ma | uintenance dose of 50 mg subcutant | eously (SubQ) every 4 | | |
| ☐ Ulcerative Colitis (UC) | | | | | |
| a. Standard/Basic Option pa Humira or a Humira biosim | | nrough the pharmacy benefit: Ha | is the patient tried and failed | | |
| | participate in this program and lar, Rinvoq, Skyrizi, Stelara SC, | switch the patient to one of the pre or Tremfya? □Yes* □No | eferred products: | | |
| *If YES, please select t | | /preferred biosimilar □Rinvoq SC □Tremfya | □Skyrizi | | |
| b. Does the prescriber agree no weeks? □Yes □No | ot to exceed the FDA labeled ma | aintenance dose of 100mg subcutar | neously (SubQ) every 4 | | |

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

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1.

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| PAG | GE 5 - PHYSICIAN COMPI | LETES |
|---------------|------------------------|---------------|
| Patient Name: | DOB: | Patient ID: R |

| ratient Name: DOB: Patient ID: R |
|---|
| FOR CLAIMS ADJUDICATED THROUGH THE PHARMACY BENEFIT: STANDARD AND BASIC OPTION PATIENT REQUESTS REQUIRES PAGE 5 TO BE COMPLETED |
| 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: \(\sigma\)Yes \(\sigma\)No* |
| * $If NO$, is there a clinical reason for not trying TWO of the preferred medications? \square Yes \square 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, Tremfy 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: \(\sigma\)Yes \(\sigma\)No* |
| * $If NO$, is there a clinical reason for not trying TWO of the preferred medications? \Box Yes \Box 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, Rinvoc 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: \(\sigma\)Yes \(\sigma\)No* |
| *If NO, is there a clinical reason for not trying TWO of the preferred medications? \(\sigma\)Yes \(\sigma\)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: \(\sigma\)Yes \(\sigma\)No* |
| *If NO, is there a clinical reason for not trying Humira or a Humira biosimilar, Rinvoq, Skyrizi, or Stelara SC? \(\sigma\)Yes \(\sigma\)No |

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