BlueCross BlueShield Federal Employee Program.

SIMPONI ARIA
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					

Simponi Aria (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 the questions on **PAGE 3**
   ❑ **NO** – this is **INITIATION** of therapy, please answer the questions below:
2. Is this request for brand or generic? ❑Brand ❑Generic
3. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to a biologic DMARD or targeted synthetic DMARD? ❑Yes ❑No
4. 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
5. 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
6. Does the patient have any active infections including tuberculosis (TB) or hepatitis B virus (HBV)? ❑Yes ❑No
7. Will the patient be given live vaccines while on this therapy? ❑Yes ❑No
8. Will Simponi Aria be used in combination with another biologic *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, Skyrizi, Sotyktu, Spevigo, Stelara, Taltz, Tremfya, Truxima, Xeljanz/ Xeljanz XR***
9. What is the patient's diagnosis?
   ❑ Ankylosing Spondylitis (AS) (axial spondyloarthritis)
      a. Does the patient have active ankylosing spondylitis? ❑Yes ❑No
      b. 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
      c. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 2 mg/kg IV every 8 weeks? ❑Yes ❑No
   ❑ Polyarticular Juvenile Idiopathic Arthritis (pJIA)
      a. 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
      b. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 80 mg/m^2 (based on body surface area) every 8 weeks? ❑Yes ❑No

PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL DIAGNOSES

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PAGE 2 - PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R_____

❑ Psoriatic Arthritis (PsA)

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

b. 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

c. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 2 mg/kg IV every 8 weeks? ❑Yes ❑No

❑ Rheumatoid Arthritis (RA)

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

b. 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

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

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

d. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 2 mg/kg IV every 8 weeks? ❑Yes ❑No

❑ Other **(*please specify*)**: _____

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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					

CONTINUATION OF THERAPY (PA RENEWAL)
Simponi Aria (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:***
   ❑ **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 questions below:

2. Is this request for brand or generic? ❑Brand ❑Generic

3. What is the patient's diagnosis?
   ❑ Ankylosing Spondylitis (AS) (axial spondyloarthritis)
      a. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 2 mg/kg IV every 8 weeks? ❑Yes ❑No
   ❑ Polyarticular Juvenile Idiopathic Arthritis (pJIA)
      a. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 80 mg/m^2 (based on body surface area) every 8 weeks? ❑Yes ❑No
   ❑ Psoriatic Arthritis (PsA)
      a. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 2 mg/kg IV every 8 weeks? ❑Yes ❑No
   ❑ Rheumatoid Arthritis (RA)
      a. Does the patient have an intolerance or contraindication to methotrexate (MTX)? ❑Yes ❑No*****
         ****If NO***, will Simponi Aria be used in combination with methotrexate? ❑Yes ❑No
      b. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 2 mg/kg IV every 8 weeks? ❑Yes ❑No
   ❑ Other **(*please specify*)**: _____

4. Has the patient's condition improved or stabilized with therapy? ❑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 Aria be used in combination with another biologic 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, Skyrizi, Sotyktu, Spevigo, Stelara, Taltz, Tremfya, Truxima, Xeljanz/ Xeljanz XR***

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Message:

Attached is a Prior Authorization request form.

For your convenience, there are 3 ways to complete a Prior Authorization request:

Electronically Online (ePA) Results in 2-3 **minutes** **FASTEST AND EASIEST**	Now you can get responses to drug Prior Authorization requests **securely** online. **Online** submissions may receive **instant** responses and do not require faxing or phone calls. Requests can be made 24 hours a day, 7 days a week. For more information on electronic prior authorization (ePA) and to register, go to **Caremark.com/ePA.**
Phone (4-5 **minutes** for response)	The FEP Clinical Call Center can be reached at **(877)-727-3784** between the hours of 7AM-9PM Eastern Time. A live representative will assist with the Prior Authorization, asking for the same information contained on the attached form. Please review the form and have your answers ready for faster service. The process over the phone takes on average between 4 and 5 minutes.
Fax (3-5 **days** for response)	Fax the attached form to **(877)-378-4727**. Requests sent via fax will be processed and responded to within 5 business days. The form must be filled out completely, if there is any missing information the Prior Authorization request cannot be processed. ***Please only fax the completed form once as duplicate submissions may delay processing times.***