Simponi Aria

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.

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*

Site of Service Questions:

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

B. Is the patient less than 21 years old or 65 years of age or older?
- ❑ Yes – less than 21 years old, *skip to Clinical Criteria Questions*
- ❑ Yes – age 65 years or older, *skip to Clinical Criteria Questions*
- ❑ No

C. Is this request to continue previously established treatment with the requested medication?
- ❑ Yes, this is a continuation of an existing treatment
- ❑ 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 have not responded to conventional interventions (e.g. 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: Attach supporting clinical documentation.***
- ❑ Yes, *skip to Clinical Criteria Questions* ❑ No

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

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: Attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

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

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: Attach supporting clinical documentation.*** *Indicate and continue to Clinical Criteria Questions* ❑ Yes ❑ No

Criteria Questions:

What is the ICD-10 code? _____

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)?
❒ 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 [PPD], interferon-release assay [IGRA], chest x-ray) 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, *No further questions*

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*

❒ 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 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. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 62*
❒ No, *Continue to 62*

14. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic drug (e.g., Rinvoq, Xeljanz) that is indicated for moderately to severely active rheumatoid arthritis? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 15*
❒ No, *Continue to 17*

15. Is Simponi Aria being prescribed in combination with methotrexate or leflunomide?
❒ Yes, *Continue to 62*
❒ No, *Continue to 16*

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

❒ History of intolerance or adverse event, *Continue to 62*

❒ Clinical diagnosis of alcohol use disorder, alcoholic liver disease or other chronic liver disease, *Continue to 62*

❒ Elevated liver transaminases, *Continue to 62*

❒ Interstitial pneumonitis or clinically significant pulmonary fibrosis, *Continue to 62*

❒ Renal impairment, *Continue to 62*

❒ Pregnancy or currently planning pregnancy, *Continue to 62*

❒ Breastfeeding, *Continue to 62*

❒ Blood dyscrasias (e.g., thrombocytopenia, leukopenia, significant anemia), *Continue to 62*

❒ Myelodysplasia, *Continue to 62*

❒ Hypersensitivity, *Continue to 62*

❒ Significant drug interaction, *Continue to 62*

❒ Other, please specify. _____, *Continue to 62*

❒ No clinical reason not to use methotrexate or leflunomide, *Continue to 62*

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. ***ACTION REQUIRED***: Submit supporting documentation
❒ 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. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 19*
❒ No, *Continue to 19*

19. Is Simponi Aria 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.

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

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

❒ Elevated liver transaminases, *Continue to 21*

❒ Interstitial pneumonitis or clinically significant pulmonary fibrosis, *Continue to 21*

❒ Renal impairment, *Continue to 21*

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

❒ Breastfeeding, *Continue to 21*

❒ Blood dyscrasias (e.g., thrombocytopenia, leukopenia, significant anemia), *Continue to 21*

❒ Myelodysplasia, *Continue to 21*

❒ Hypersensitivity, *Continue to 21*

❒ Significant drug interaction, *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. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 62*
❒ 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. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 62*
❒ 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. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 24*
❒ No, *Continue to 24*

24. Please indicate the contraindication.

❒ History of intolerance or adverse event, *Continue to 62*

❒ Clinical diagnosis of alcohol use disorder, alcoholic liver disease or other chronic liver disease, *Continue to 62*

❒ Elevated liver transaminases, *Continue to 62*

❒ Interstitial pneumonitis or clinically significant pulmonary fibrosis, *Continue to 62*

❒ Renal impairment, *Continue to 62*

❒ Pregnancy or currently planning pregnancy, *Continue to 62*

❒ Breastfeeding, *Continue to 62*

❒ Blood dyscrasias (e.g., thrombocytopenia, leukopenia, significant anemia), *Continue to 62*

❒ Myelodysplasia, *Continue to 62*

❒ Hypersensitivity, *Continue to 62*

❒ Significant drug interaction, *Continue to 62*

❒ Other, please specify. _____, *Continue to 62*

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 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 62*

❒ Number of tender joints ***ACTION REQUIRED****: Submit supporting documentation, Continue to 62*

❒ Dactylitis ***ACTION REQUIRED****: Submit supporting documentation, Continue to 62*

❒ Enthesitis ***ACTION REQUIRED****: Submit supporting documentation, Continue to 62*

❒ Axial disease ***ACTION REQUIRED****: Submit supporting documentation, Continue to 62*

❒ Skin and/or nail involvement ***ACTION REQUIRED****: Submit supporting documentation, Continue to 62*

❒ None of the above, *Continue to 62*

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 (including current utilizers) a biologic (e.g., Humira) or targeted synthetic drug (e.g., Rinvoq, Otezla) that is indicated for active psoriatic arthritis? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 62*
❒ No, *Continue to 33*

33. What is the patient's disease severity?

❒ Mild to moderate, *Continue to 34*

❒ Severe, *Continue to 62*

34. Does the patient have enthesitis or predominantly axial disease?
❒ Yes, *Continue to 62*
❒ 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. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 62*
❒ 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. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 62*
❒ 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. ***ACTION REQUIRED***: Submit supporting documentation

❒ Yes, *Continue to 38*

❒ No, *Continue to 39*

38. Please indicate the contraindication.

❒ History of intolerance or adverse event, *Continue to 62*

❒ Clinical diagnosis of alcohol use disorder, alcoholic liver disease or other chronic liver disease, *Continue to 62*

❒ Elevated liver transaminases, *Continue to 62*

❒ Interstitial pneumonitis or clinically significant pulmonary fibrosis, *Continue to 62*

❒ Renal impairment, *Continue to 62*

❒ Pregnancy or currently planning pregnancy, *Continue to 62*

❒ Breastfeeding, *Continue to 62*

❒ Blood dyscrasias (e.g., thrombocytopenia, leukopenia, significant anemia), *Continue to 62*

❒ Myelodysplasia, *Continue to 62*

❒ Hypersensitivity, *Continue to 62*

❒ Significant drug interaction, *Continue to 62*

❒ Other, please specify. _____, *Continue to 62*

39. 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. ***ACTION REQUIRED***: Submit supporting documentation

❒ Yes, *Continue to 62*

❒ No, *Continue to 62*

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

❒ Yes - Active ankylosing spondylitis, *Continue to 41*

❒ Yes - Active non-radiographic axial spondyloarthritis, *Continue to 41*

❒ No, *Continue to 41*

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

❒ Yes, *Continue to 42*

❒ No, *Continue to 42*

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

❒ Yes, *Continue to 43*

❒ No, *Continue to 43*

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

❒ Yes, *Continue to 44*

❒ No, *Continue to 47*

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

❒ Yes, *Continue to 47*

❒ No, *Continue to 45*

❒ Unknown, *Continue to 47*

45. Has the patient achieved or maintained 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 46*
❒ No, *Continue to 46*

46. 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 62*

❒ Total spine pain ***ACTION REQUIRED****: Submit supporting documentation, Continue to 62*
❒ Inflammation (e.g., morning stiffness) ***ACTION REQUIRED****: Submit supporting documentation, Continue to 62*

❒ None of the above, *Continue to 62*

47. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic drug (e.g., Rinvoq, Xeljanz) that is indicated for active ankylosing spondylitis or active non-radiographic axial spondyloarthritis? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 62*
❒ 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. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 62*
❒ No, *Continue to 62*

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 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 62*
❒ Number of joints with limitation of movement ***ACTION REQUIRED****: Submit supporting documentation, Continue to 62*

❒ Functional ability ***ACTION REQUIRED****: Submit supporting documentation, Continue to 62*

❒ None of the above, *Continue to 62*

56. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic drug (e.g., Xeljanz) that is indicated for active articular juvenile idiopathic arthritis? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 62*
❒ 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. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 62*
❒ 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. ***ACTION REQUIRED***: Submit supporting documentation
❒ 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 62*
❒ 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 62*
❒ No, *Continue to 62*

62. What is the diagnosis?

❒ Rheumatoid arthritis, *Continue to 63*

❒ Psoriatic arthritis, *Continue to 70*

❒ Ankylosing spondylitis, *Continue to 63*

❒ Non-radiographic axial spondyloarthritis, *Continue to 63*

❒ Polyarticular juvenile idiopathic arthritis, *Continue to 83*

❒ Oligoarticular juvenile idiopathic arthritis, *Continue to 83*

63. Is the patient currently receiving Simponi Aria?
❒ Yes, *Continue to 64*
❒ No, *Continue to 67*

64. Does the prescribed dose exceed 2 mg per kg?
❒ Yes, *Continue to 65*
❒ No, *Continue to 65*

65. Is the prescribed frequency of the maintenance dose more frequent than one dose every 8 weeks?
❒ Yes, *No Further Questions*
❒ No, *Continue to 66*

66. What is the patient's weight? Indicate in kg.
_____lbs., *No further questions*

67. Does the prescribed dose exceed a loading dose of 2 mg per kg at weeks 0 and 4, followed by a maintenance dose of 2 mg per kg thereafter?
❒ Yes, *Continue to 68*
❒ No, *Continue to 68*

68. Is the prescribed frequency of the maintenance dose more frequent than one dose every 8 weeks?
❒ Yes, *Continue to 69*
❒ No, *Continue to 69*

69. What is the patient's weight? Indicate in kg.
_____lbs., *No further questions*

70. Is the patient currently receiving Simponi Aria?
❒ Yes, *Continue to 71*
❒ No, *Continue to 77*

71. Is the prescribed frequency for the maintenance dose more frequent than one dose every 8 weeks?
❒ Yes, *No Further Questions*
❒ No, *Continue to 72*

72. What is the patient's age?

❒ 2 years old to less than 18 years old, *Continue to 73*

❒ 18 years old or older, *Continue to 75*

73. Does the prescribed dose exceed 80 mg/m2?
❒ Yes, *Continue to 74*
❒ No, *Continue to 74*

74. What is the patient's weight? Indicate in kg.
_____lbs., *No further questions*

75. Does the prescribed dose exceed 2 mg per kg?
❒ Yes, *Continue to 76*
❒ No, *Continue to 76*

76. What is the patient's body weight? Indicate in kg.
_____lbs., *No further questions*

77. Is the prescribed frequency for the maintenance dose more frequent than one dose every 8 weeks?
❒ Yes, *Continue to 78*
❒ No, *Continue to 78*

78. What is the patient's age?
❒ 2 years old to less than 18 years old, *Continue to 79*
❒ 18 years old or older, *Continue to 81*

79. 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 80*
❒ No, *Continue to 80*

80. What is the patient's weight? Indicate in kg.
_____lbs., *No further questions*

81. Does the prescribed dose exceed a loading dose of 2 mg per kg at weeks 0 and 4, followed by a maintenance dose of 2 mg per kg thereafter?
❒ Yes, *Continue to 82*
❒ No, *Continue to 82*

82. What is the patient's weight? Indicate in kg.
_____lbs., *No further questions*

83. Is the patient currently receiving Simponi Aria?
❒ Yes, *Continue to 84*
❒ No, *Continue to 87*

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

85. Does the prescribed dose exceed 80 mg/m2?
❒ Yes, *Continue to 86*
❒ No, *Continue to 86*

86. What is the patient's weight? Indicate in kg.
_____lbs., *No further questions*

87. Is the prescribed frequency for the maintenance dose more frequent than one dose every 8 weeks?
❒ Yes, *Continue to 88*
❒ No, *Continue to 88*

88. 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 89*
❒ No, *Continue to 89*

89. What is the patient's weight? Indicate in kg.
_____lbs., *No further questions*

Step Therapy Override: Complete if Applicable.	Please Circle	
Is the requested drug being used to treat stage four advanced metastatic cancer?	Yes	No
Is the requested drug's use consistent with the FDA-approved indication or the National Comprehensive Cancer Network Drugs & Biologics Compendium indication for the treatment of stage four advanced metastatic cancer and is supported by peer-reviewed medical literature?	Yes	No
Is the requested drug being used for an FDA-approved indication OR an indication supported in the compendia of current literature (examples: AHFS, Lexicomp, Clinical Pharmacology, Micromedex, current accepted guidelines)?	Yes	No
Does the prescribed quantity fall within the manufacturer's published dosing guidelines or within dosing guidelines found in the compendia of current literature (examples: package insert, AHFS, Lexicomp, Clinical Pharmacology, Micromedex, current accepted guidelines)?	Yes	No
Do patient chart notes document the requested drug was ordered with a paid claim at the pharmacy, the pharmacy filled the prescription and delivered to the patient or other documentation that the requested drug was prescribed for the patient in the last 180 days?	Yes	No
Has the prescriber provided proof documented in the patient chart notes that in their opinion the requested drug is effective for the patient's condition?	Yes	No

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)**

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