maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

Simponi Subq

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1	Will the patient be using Simponi in combination with other biologic or targeted synthetic disease modifying antirheumatic drugs (DMARDS)? [Note: Examples of biologic DMARDs include adalimumab SC products (Humira, biosimilars), Cimzia, etanercept SC products (Enbrel, biosimilars), infliximab IV products (Remicade, biosimilars), Actemra (IV or SC), Simponi Aria (IV), Kevzara, Orencia (IV or SC), rituximab IV products (Rituxan, biosimilars), Ilaris, Kineret, Stelara (SC or IV), Siliq, Cosentyx, Taltz, Ilumya, Skyrizi, Tremfya, and Entyvio. Examples of targeted synthetic DMARDs include Otezla, Olumiant, Rinvoq, and Xeljanz/XR.]	Yes	No

PRIOR AUTHORIZATION REQUEST

[If yes, no further questions.]

2 Is the patient currently receiving the requested medication? Yes No
[If no, skip to question 8.]

3 Has the patient been receiving medication samples for the requested medication? Yes No
[If yes, skip to question 8.]

4 Does the patient have a previously approved PA on file with the current plan? Yes No
[Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.]
[If yes, skip to question 6.]

5 What is the diagnosis or indication?
[] Rheumatoid arthritis (If checked, go to 9)

[] Ankylosing spondylitis (AS) (If checked, go to 15)

[] Psoriatic arthritis (PsA) (If checked, go to 12)

[] Ulcerative colitis (If checked, go to 19)

[] Spondyloarthritis (SpA), other subtypes (for example, undifferentiated arthritis, non-radiographic axial SpA, reactive arthritis [Reiter's disease]) [Note: For AS or PsA, refer to the respective criteria.] (If checked, go to 36)

[] Plaque psoriasis without psoriatic arthritis (If checked, no further questions)

[] Other (If checked, no further questions)

6 Has the patient been established on therapy with the requested medication for at least 3 months? Yes No
[If no, skip to question 8.]

7 What is the diagnosis or indication?
[] Rheumatoid arthritis (If checked, go to 43)

[] Ankylosing spondylitis (AS) (If checked, go to 45)

[] Psoriatic arthritis (PsA) (If checked, go to 48)

[] Ulcerative colitis (If checked, go to 50)

[] Spondyloarthritis (SpA), other subtypes (for example, undifferentiated arthritis, non-radiographic axial SpA, reactive arthritis [Reiter's disease])
[Note: For AS or PsA, refer to the respective criteria.] (If checked, go to 53)

[] Plaque psoriasis without psoriatic arthritis (If checked, no further questions)

PRIOR AUTHORIZATION REQUEST

[] Other (If checked, no further questions)

8 What is the diagnosis or indication?
[] Rheumatoid arthritis (If checked, go to 11)

[] Psoriatic arthritis (PsA) (If checked, go to 14)

[] Ankylosing spondylitis (AS) (If checked, go to 16)

[] Ulcerative colitis (If checked, go to 20)

[] Spondyloarthritis (SpA), other subtypes (for example, undifferentiated arthritis, non-radiographic axial SpA, reactive arthritis [Reiter's disease]) [Note: For AS or PsA, refer to the respective criteria.] (If checked, go to 37)

[] Plaque psoriasis without psoriatic arthritis (If checked, no further questions)

[] Other (If checked, no further questions)

9	Has the patient experienced a beneficial clinical response when assessed by at least ONE objective measure? [Note: Examples of standardized and validated measures of disease activity include Clinical Disease Activity Index (CDAI), Disease Activity Score (DAS) 28 using erythrocyte sedimentation rate (ESR) or C-reactive protein (CRP), Patient Activity Scale (PAS)-II, Rapid Assessment of Patient Index Data 3 (RAPID-3), and/or Simplified Disease Activity Index (SDAI).] [If yes, skip to question 11.]	Yes	No
10	Has the patient experienced an improvement in at least ONE symptom, such as decreased joint pain, morning stiffness, or fatigue; improved function or activities of daily living; decreased soft tissue swelling in joints or tendon sheaths? [If no, no further questions.]	Yes	No
11	Is Simponi SC being prescribed by, or in consultation with, a rheumatologist? [If yes, skip to question 24.] [If no, no further questions.]	Yes	No
12	Has the patient experienced a beneficial clinical response from baseline when assessed by at least ONE objective measure? [Note: Examples of objective measures of disease activity include Disease Activity Index for Psoriatic Arthritis (DAPSA), Composite Psoriatic Disease Activity Index (CPDAI), Psoriatic Arthritis Disease Activity Score (PsA DAS), Grace Index, Leeds Enthesitis Score (LEI), Spondyloarthritis Consortium of Canada (SPARCC) enthesitis score, Leeds Dactylitis Instrument Score, Minimal Disease Activity (MDA), Psoriatic Arthritis Impact of Disease (PsAID-12), and/or serum markers (such as, C-reactive protein, erythrocyte sedimentation rate).] [If yes, skip to question 14.]	Yes	No
13	Has the patient experienced an improvement in at least ONE symptom as	Yes	No

PRIOR AUTHORIZATION REQUEST

	compared to baseline such as less joint pain, morning stiffness, or fatigue; improved function or activities of daily living; or decreased soft tissue swelling in joints or tendon sheaths? [if no, no further questions.]		
14	Is Simponi SC being prescribed by, or in consultation with, a rheumatologist or dermatologist? [If yes, skip to question 24.] [If no, no further questions.]	Yes	No
15	Has documentation been submitted to confirm that the patient has experienced a clinically significant response as determined by the provider? ACTION REQUIRED: Submit supporting documentation. [If yes, skip to question 17.] [If no, no further questions.]	Yes	No
16	Does the patient have a documented diagnosis of active ankylosing spondylitis? [If no, no further questions.]	Yes	No
17	Is Simponi SC being prescribed by, or in consultation with, a rheumatologist? [If no, no further questions.]	Yes	No
18	Is the patient greater than or equal to 18 years of age? [If yes, skip to question 27.] [If no, no further questions.]	Yes	No
19	Has documentation been submitted to confirm that the patient has experienced a clinically significant response as determined by the provider? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
20	Is the patient diagnosed with moderately to severely active ulcerative colitis? [If no, no further questions.]	Yes	No
21	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
22	Has the patient had a trial of at least TWO traditional systemic therapy agents for at least 3 months? [Note: Examples include 6-mercaptopurine, azathioprine, cyclosporine, tacrolimus, or a corticosteroid such as prednisone or methylprednisolone.] [If yes, skip to question 32.]	Yes	No
23	Has documentation been submitted to confirm that the patient has an intolerance to at least TWO traditional systemic therapy agents? ACTION REQUIRED: Submit supporting documentation. [Note: Examples include 6-mercaptopurine, azathioprine, cyclosporine, tacrolimus, or a corticosteroid such as prednisone or methylprednisolone.]	Yes	No

PRIOR AUTHORIZATION REQUEST

	[If yes, skip to question 32.] [If no, skip to question 30.]		
24	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
25	Has the patient tried TWO conventional synthetic disease-modifying antirheumatic drugs (DMARD) for at least 3 months? [Note: Examples of conventional synthetic DMARDs include methotrexate (oral or injectable), leflunomide, hydroxychloroquine, and sulfasalazine.] [If yes, skip to question 27.]	Yes	No
26	Has documentation been submitted to confirm that the patient has had an intolerance to at least TWO conventional synthetic agents? ACTION REQUIRED: Submit supporting documentation. [Note: Examples of conventional synthetic disease-modifying antirheumatic drugs (DMARDs) include methotrexate (oral or injectable), leflunomide, hydroxychloroquine, and sulfasalazine.] [If no, no further questions.]	Yes	No
27	Has documentation been submitted to confirm that the patient has an intolerance, contraindication to, or failed treatment for at least 3 months with preferred TNF inhibitors, Enbrel (etanercept) and an adalimumab product (Hadlima, Yusimry, or adalimumab- adbm)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
28	Has documentation been submitted to confirm that the patient has an intolerance, contraindication to, or failed treatment for at least 3 months with Xeljanz (tofacitinib)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
29	Does the dose of the requested medication exceed Food and Drug (FDA) approved label dosing for the indication? [No further questions.]	Yes	No
30	Does the patient have pouchitis? [If no, no further questions.]	Yes	No
31	Has the patient tried therapy with an antibiotic, probiotic, corticosteroid enema, or Rowasa (mesalamine) enema? [Note: Examples of antibiotics include metronidazole and ciprofloxacin. Examples of corticosteroid enema include hydrocortisone enema (Cortenema, generics).] [If no, no further questions.]	Yes	No
32	Does the dose of the requested medication exceed Food and Drug (FDA) approved label dosing for the indication? [If yes, no further questions.]	Yes	No

PRIOR AUTHORIZATION REQUEST

33	Has documentation been submitted to confirm that the patient has an intolerance, contraindication to, or failed treatment for at least 3 months with preferred TNF inhibitors, Enbrel (etanercept) and an adalimumab product (Hadlima, Yusimry, or adalimumab- adbm)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
34	Has documentation been submitted to confirm that the patient has an intolerance, contraindication to, or failed treatment for at least 3 months with Xeljanz (tofacitinib)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
35	Is the requested medication prescribed by or in consultation with a gastroenterologist? [No further questions.]	Yes	No
36	Has documentation been submitted to confirm that the patient has experienced a clinically significant response, as determined by the provider? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
37	Is Simponi SC being prescribed by, or in consultation with, a rheumatologist? [If no, no further questions.]	Yes	No
38	Does the patient have arthritis primarily in the knees, ankles, elbows, wrists, hands, and/or feet? [If no, no further questions.]	Yes	No
39	Has the patient tried at least TWO conventional synthetic disease-modifying antirheumatic drugs (DMARD) for at least 3 months? [Note: Examples of conventional synthetic DMARDs include methotrexate (oral or injectable), leflunomide, hydroxychloroquine, and sulfasalazine.] [If yes, skip to question 41.]	Yes	No
40	Has documentation been submitted to confirm that the patient has an intolerance to at least TWO conventional synthetic disease-modifying antirheumatic drugs (DMARD)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
41	Does the dose of the requested medication exceed Food and Drug Administration (FDA) approved labeled dosing for the indication? [If yes, no further questions.]	Yes	No
42	Has documentation been submitted to confirm that the patient has an intolerance, contraindication to, or failed treatment for at least 3 months with preferred TNF inhibitors, Enbrel (etanercept) and an adalimumab product (Hadlima, Yusimry, or adalimumab- adbm)? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No

PRIOR AUTHORIZATION REQUEST

43	Has the patient experienced a beneficial clinical response when assessed by at least ONE objective measure? [Note: Examples of standardized and validated measures of disease activity include Clinical Disease Activity Index (CDAI), Disease Activity Score (DAS) 28 using erythrocyte sedimentation rate (ESR) or C-reactive protein (CRP), Patient Activity Scale (PAS)-II, Rapid Assessment of Patient Index Data 3 (RAPID-3), and/or Simplified Disease Activity Index (SDAI).] [If yes, no further questions.]	Yes	No
44	Has the patient experienced an improvement in at least ONE symptom, such as decreased joint pain, morning stiffness or fatigue; improved function or activities of daily living; decreased soft tissue swelling in joints or tendon sheaths? [No further questions.]	Yes	No
45	Has documentation been submitted to confirm that the patient has experienced a clinically significant response, as determined by the prescriber? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
46	Has documentation been submitted to confirm that the patient has experienced a beneficial clinical response from baseline when assessed by at least ONE objective measure such as Ankylosing Spondylitis Disease Activity Score (ASDAS), Ankylosing Spondylitis Quality of Life Scale (ASQoL), Bath Ankylosing Spondylitis Disease Activity Index (BASDAI), Bath Ankylosing Spondylitis Functional Index (BASFI), Bath Ankylosing Spondylitis Global Score (BAS-G), Bath Ankylosing Spondylitis Metrology Index (BASMI), Dougados Functional Index (DFI), Health Assessment Questionnaire for the Spondylarthropathies (HAQ-S), and/or serum markers (such as C-reactive protein, erythrocyte sedimentation rate)? ACTION REQUIRED: Submit supporting documentation. [If yes, no further questions.]	Yes	No
47	Has the patient experienced an improvement in at least ONE symptom such as decreased pain or stiffness, or improvement in function or activities of daily living as compared with baseline? [No further questions.]	Yes	No
48	Has the patient experienced a beneficial clinical response from baseline when assessed by at least ONE objective measure? [Note: Examples of objective measures of disease activity include Disease Activity Index for Psoriatic Arthritis (DAPSA), Composite Psoriatic Disease Activity Index (CPDAI), Psoriatic Arthritis Disease Activity Score (PsA DAS), Grace Index, Leeds Enthesitis Score (LEI), Spondyloarthritis Consortium of Canada (SPARCC) enthesitis score, Leeds Dactylitis Instrument Score, Minimal Disease Activity (MDA), Psoriatic Arthritis Impact of Disease (PsAID-12), and/or serum markers (such as C-reactive protein, erythrocyte sedimentation rate).] [If yes, no further questions.]	Yes	No
49	Has the patient experienced an improvement in at least ONE symptom compared	Yes	No

PRIOR AUTHORIZATION REQUEST

	with baseline, such as less joint pain, morning stiffness, or fatigue; improved function or activities of daily living; or decreased soft tissue swelling in joints or tendon sheaths? [No further questions.]		
50	Has documentation been submitted to confirm that the patient has experienced a clinically significant response, as determined by the prescriber? ACTION REQUIRED: Submit supporting documentation. [If no, no further question.]	Yes	No
51	Has documentation been submitted to confirm that the patient has experienced a beneficial clinical response from baseline when assessed by at least ONE objective measure such as fecal markers (such as fecal calprotectin), serum markers (such as C-reactive protein), endoscopic assessment, and/or reduced dose of corticosteroids? ACTION REQUIRED: Submit supporting documentation. [If yes, no further questions.]	Yes	No
52	Has documentation been submitted to confirm that the patient has had clinical improvement in at least ONE symptom, such as decreased pain, fatigue, stool frequency, and/or rectal bleeding as compared with baseline? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
53	Has documentation been submitted to confirm that the patient has experienced a clinically significant response, as determined by the prescriber? ACTION REQUIRED: Submit supporting documentation. [Note: Examples of a response include decreased pain or stiffness and improved function or activities of daily living. The patient may not have a full response, but there should have been a recent or past response to Simponi SC.]	Yes	No

Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior

If you have any questions, call: 1-888-258-8250

PRIOR AUTHORIZATION REQUEST

authorization as per Plan policy and procedures.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.