maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

SIMPONI SQ

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.

CRITERIA FOR APPROVAL

1	Will the patient be using the requested medication 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.	Yes	No

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	Examples of targeted synthetic DMARDs include Otezla, Olumiant, Rinvoq, and Xeljanz/XR.] [If yes, no further questions.]		
2	Is the patient currently receiving the requested medication? [If no, skip to question 7.]	Yes	No
3	Has the patient been receiving medication samples for the requested medication? [If yes, skip to question 7.]	Yes	No
4	Does the patient have a previously approved PA on file with the current plan? [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 no, skip to question 7.]	Yes	No
5	Has the patient been on established therapy for at least 3 months? [If no, skip to question 7.]	Yes	No
6	Has documentation been submitted to confirm that the patient has had a clinically significant response to therapy, as determined by the prescriber? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
7	What is the diagnosis or indication? [] Rheumatoid arthritis (If checked, go to 8) [] Psoriatic arthritis (PsA) (If checked, go to 15) [] Ankylosing spondylitis (AS) (If checked, go to 23) [] Ulcerative colitis (UC) (If checked, go to 29) [] 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 40) [] Plaque psoriasis without psoriatic arthritis (If checked, no further questions) [] Other (If checked, no further questions)		
8	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
9	Has the patient tried TWO conventional synthetic disease-modifying antirheumatic drugs (DMARDs) 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 11.]	Yes	No

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10	Has documentation been submitted to confirm that the patient has had an intolerance to at least TWO conventional synthetic disease-modifying antirheumatic drugs? 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
11	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, Simlandi, Yusimry, or adalimumab-adbm)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
12	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
13	Does the dose of the requested medication exceed Food and Drug Administration (FDA) approved label dosing for the indication? [Dosing: 50 mg subQ once monthly.] [If yes, no further questions.]	Yes	No
14	Is the requested medication being prescribed by, or in consultation with, a rheumatologist? [No further questions.]	Yes	No
15	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
16	Has the patient tried TWO conventional synthetic disease-modifying antirheumatic drugs (DMARDs) 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 18.]	Yes	No
17	Has documentation been submitted to confirm that the patient has had an intolerance to at least TWO conventional synthetic disease-modifying antirheumatic drugs? 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
18	Has documentation been submitted to confirm that the patient has an intolerance,	Yes	No

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	contraindication to, or failed treatment for at least 3 months with preferred TNF inhibitors, Enbrel (etanercept) and an adalimumab product (Hadlima, Simlandi, Yusimry, or adalimumab- adbm)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]		
19	Has documentation been submitted to confirm that the patient has had a treatment failure with a preferred ustekinumab product (Pyzchiva, Stegeyma, and Yesintek) for at least 3 months or is the patient intolerant, or the medication contraindicated? ACTION REQUIRED: Submit support documentation. [If no, no further questions.]	Yes	No
20	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
21	Does the dose of the requested medication exceed Food and Drug Administration (FDA) approved label dosing for the indication? [Dosing: 50 mg subQ once monthly.] [If yes, no further questions.]	Yes	No
22	Is the requested medication being prescribed by, or in consultation with, a rheumatologist? [No further questions.]	Yes	No
23	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
24	Does the patient have a diagnosis of active ankylosing spondylitis? [If no, no further questions.]	Yes	No
25	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, Simlandi, Yusimry, or adalimumab- adbm)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
26	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
27	Does the dose of the requested medication exceed Food and Drug Administration (FDA) approved label dosing for the indication? [Dosing: 50 mg subQ once monthly.] [If yes, no further questions.]	Yes	No

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28	Is the requested medication being prescribed by, or in consultation with, a rheumatologist? [No further questions.]	Yes	No
29	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
30	Is the patient diagnosed with moderately to severely active ulcerative colitis? [If no, no further questions.]	Yes	No
31	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 33.]	Yes	No
32	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.] [If no, no further questions.]	Yes	No
33	Does the patient have pouchitis? [If no, skip to question 35.]	Yes	No
34	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
35	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, Simlandi, Yusimry, or adalimumab- adbm)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
36	Has documentation been submitted to confirm that the patient has had a treatment failure with a preferred ustekinumab product (Pyzchiva, Stegeyma, or Yesintek) for at least 3 months or is the patient intolerant or the medication contraindicated? ACTION REQUIRED: Submit support documentation. [If no, no further questions.]	Yes	No
37	Has documentation been submitted to confirm that the patient has an intolerance, contraindication to, or failed treatment for at least 3 months with Xeljanz	Yes	No

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	(tofacitinib)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]		
38	Does the dose of the requested medication exceed Food and Drug Administration (FDA) approved label dosing for the indication? [Dose: Induction: 200 mg subQ at week 0, followed by 100 mg subQ at week 2, then maintenance, 100 mg subQ every 4 weeks.] [If yes, no further questions.]	Yes	No
39	Is the requested medication prescribed by, or in consultation with, a gastroenterologist? [No further questions.]	Yes	No
40	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
41	Is the patient diagnosed with Spondyloarthritis (SpA)? [If no, no further questions.]	Yes	No
42	Has the patient tried at least TWO conventional synthetic disease-modifying antirheumatic drugs (DMARDs) 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 44.]	Yes	No
43	Has documentation been submitted to confirm that the patient has an intolerance to at least TWO conventional synthetic disease-modifying antirheumatic drugs (DMARDs)? ACTION REQUIRED: Submit supporting documentation. [Note: Examples of conventional synthetic DMARDs include methotrexate (oral or injectable), leflunomide, hydroxychloroquine, and sulfasalazine.] [If no, no further questions.]	Yes	No
44	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, Simlandi, Yusimry, or adalimumab- adbm)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
45	Does the dose of the requested medication exceed Food and Drug Administration (FDA) approved labeled dosing for the indication? [Dosing: 50 mg subQ once monthly.] [If yes, no further questions.]	Yes	No
46	Is the requested medication being prescribed by, or in consultation with, a rheumatologist?	Yes	No

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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 authorization as per Plan policy and procedures.

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

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