Simponi Aria

HMSA Medicare Advantage - 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 1-866-237-5512**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-808-254-4414.** 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.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Patient's Phone Number: _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Additional Demographic Information:

Patient Weight: _____*kg*

Patient Height: _____*ft* _____*inches*

Indicate where the drug is being dispensed:

❑ Office ❑ Outpatient Hospital ❑ Ambulatory Surgical ❑ Inpatient Hospital
❑ Off Campus Outpatient Hospital ❑ Urgent Care ❑ Emergency Room ❑ Birthing Center
❑ Military Facility ❑ Skilled Nursing Facility ❑ Nursing Facility ❑ Hospice
❑ Inpatient Psychiatric ❑ Psychiatric Residential Treatment ❑ End Stage Renal Facility
❑ Psychiatric Facility ❑ Pharmacy ❑ Other

Indicate where the drug is being administered:

❑ Ambulatory surgical ❑ Home ❑ Inpatient Hospital
❑ Office ❑ Outpatient Hospital ❑ Pharmacy

What is the ICD-10 code? _____

Send completed form to: CVS Caremark Specialty Programs. Fax: 1-866-237-5512

 Simponi Aria HMSAMED C26249-A – 03/2026.

CVS Caremark Specialty Programs ● 2969 Mapunapuna Place ● Honolulu, HI 96819
Phone: 1-808-254-4414 ● Fax: 1-866-237-5512 ● www.caremark.com

Criteria Questions:

1. Is the patient currently receiving treatment with Simponi Aria?
❒ Yes, *Continue to #2*
❒ No, *Continue to #4*

2. What is the patient's diagnosis?
❒ Rheumatoid arthritis, *Continue to #3*
❒ Psoriatic arthritis, *Continue to #3*
❒ Ankylosing spondylitis, *Continue to #3*
❒ Non-radiographic axial spondyloarthritis, *Continue to #3*
❒ Articular juvenile idiopathic arthritis, *Continue to #3*
❒ Immune checkpoint inhibitor-related inflammatory arthritis, *Continue to #3*
❒ Other, *Continue to #3*

3. Is the patient receiving benefit from therapy? ***Chart notes or medical record documentation supporting benefit from therapy must be submitted upon request.***
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

4. What is the patient's diagnosis?
❒ Rheumatoid arthritis, *Continue to #5*
❒ Active psoriatic arthritis, *No Further Questions*
❒ Active ankylosing spondylitis, *No Further Questions*
❒ Active non-radiographic axial spondyloarthritis, *No Further Questions*
❒ Active articular juvenile idiopathic arthritis, *No Further Questions*
❒ Immune checkpoint-inhibitor related inflammatory arthritis, *Continue to #8*
❒ Other, *No Further Questions*

5. Is the disease moderately to severely active?
❒ Yes, *Continue to #6*
❒ No, *Continue to #6*

6. Will Simponi Aria be used in combination with methotrexate? ***If Yes, chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy, must be submitted upon request***
❒ Yes, *No Further Questions*
❒ No, *Continue to #7*

7. Does the patient have a clinical reason to avoid methotrexate (e.g., breastfeeding, pregnancy or currently planning pregnancy, renal or hepatic impairment, previous intolerance to methotrexate)? ***If Yes, chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy, must be submitted upon request.(Please provide the clinical reason in the space provided.)***

_____
_____

❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

8. Is the disease moderate or severe?
❒ Yes, *Continue to #9*
❒ No, *Continue to #9*

9. Has the patient had an inadequate response to corticosteroids or a conventional synthetic drug (e.g., methotrexate,

sulfasalazine, leflunomide, hydroxychloroquine)? ***If Yes, chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy, must be submitted upon request.***
❒ Yes, *No Further Questions*
❒ No, *Continue to #10*

10. Does the patient have an intolerance or contraindication to corticosteroids? ***If Yes, chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy, must be submitted upon request.***
❒ Yes, *Continue to #11*
❒ No, *Continue to #11*

11. Does the patient have an intolerance or contraindication to a conventional synthetic drug (e.g., methotrexate, sulfasalazine, leflunomide, hydroxychloroquine)? ***If Yes, chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy, must be submitted upon request.***
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

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)**