CVS CAREMARK

Fax Referral To: 800-323-2445
Phone: 866-278-6634

Simponi™ (golimumab)
Enrollment Form
For Blue Cross Blue Shield of Rhode Island Members

Date: _____ **Needs by Date (Please Specify):** _____

Ship to: ☐ **Patient** ☐ **Office** ☐ **Other:** _____

PATIENT INFORMATION

*(Complete the following or **send patient demographic sheet**)*

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____ Alternate Ph: _____
SS #: _____
Insurance ID: _____
Date of Birth: _____ Gender: _____

PRESCRIBER INFORMATION

Prescriber's Name: _____
State License #: _____ UPIN: _____
DEA #: _____ NPI #: _____
Group or Hospital: _____
Address: _____
City, State Zip: _____
Phone: _____ Fax: _____
Contact Person: _____ Phone: _____

INSURANCE INFORMATION *(If available, please copy and attach the front and back of insurance and prescription drug card)*

Primary Insurance: Subscriber: _____ Subscriber ID#: _____ Name of Insurer: **Blue Cross Blue Shield of RI**
Secondary Insurance: Subscriber: _____ Subscriber ID#: _____ Name of Insurer: _____

STATEMENT OF MEDICAL NECESSITY for BCBS of Rhode Island Members

Diagnosis (ICD-9 Code): ☐ _____ • Date of Diagnosis: _____

Approval Criteria: CHECK ALL BOXES THAT APPLY

Please note: Any areas that are not filled out will be considered not applicable to your patient AND MAY AFFECT THE OUTCOME OF THIS REQUEST
A RESPONSE IS REQUIRED FOR EACH OF THE FOLLOWING:

- Patient is currently receiving other TNF antagonists, abatacept (Orencia) or anakinra (Kineret) ☐ Yes ☐ No
- Patient has tuberculosis, invasive fungal infections, other active serious infections, or a history of recurrent infections. ☐ Yes ☐ No
- Patient had a tuberculin skin test (TST), or a CDC-recommended equivalent, to rule out latent tuberculosis. ☐ Yes ☐ No
- Patient has a latex allergy. ☐ Yes ☐ No
- Patient with new onset CHF or worsening symptoms of CHF. ☐ Yes ☐ No
- Patient has Multiple Sclerosis or any other demyelinating disease. ☐ Yes ☐ No
- Patient is receiving concurrent administration of live vaccines. ☐ Yes ☐ No

Rheumatoid Arthritis:

- Patient is 18 years of age or older. ☐ Yes ☐ No
- Patient has a diagnosis of moderate to severe Rheumatoid Arthritis. ☐ Yes ☐ No
- Patient is taking Simponi in combination with methotrexate. ☐ Yes ☐ No
- Does the patient have a contraindication to methotrexate or is the patient unable to tolerate methotrexate? ☐ Yes ☐ No
- Will Simponi be used in combination with an immunosuppressant other than methotrexate? ☐ Yes ☐ No
- Patient has had a trial of Enbrel (etanercept), Remicade (infliximab), or Humira in the previous 180 days ☐ Yes ☐ No
- Patient has failed or had an inadequate response to one or more disease modifying anti-rheumatic drugs (DMARDs). ☐ Yes ☐ No

Psoriatic Arthritis:

- Patient is 18 years of age or older. ☐ Yes ☐ No
- Patient has a diagnosis of active Psoriatic Arthritis. ☐ Yes ☐ No
- Patient has had a trial of Enbrel (etanercept), Remicade (infliximab), or Humira in the previous 180 days. ☐ Yes ☐ No
- Patient has active arthritis, with 3 or more swollen joints and 3 or more tender joints. ☐ Yes ☐ No
- Patient has psoriasis with a qualifying target lesion of at least 2cm in diameter. ☐ Yes ☐ No
- Patient has arthritis in **any** of the following distributions: ☐ Yes ☐ No
  - ☐ Distal interphalangeal joint involvement ☐ Polyarticular arthritis, without rheumatoid nodules ☐ Arthritis mutilans ☐ Asymmetric arthritis
  - ☐ Ankylosing spondylitis-like arthritis
- Patient has had a failure of DMARD therapy to achieve an adequate clinical response or a medical contraindication to the use of DMARD therapy. Examples of DMARD therapy include methotrexate or sulfasalazine. ☐ Yes ☐ No

Ankylosing Spondylitis:

- Patient is 18 years of age or older. ☐ Yes ☐ No
- Patient has had a trial of Enbrel (etanercept), Remicade (infliximab), or Humira in the previous 180 days. ☐ Yes ☐ No
- Patient has a diagnosis of Ankylosing Spondylitis. ☐ Yes ☐ No
- Patient has failed, had an inadequate response to, or is not indicated for treatment with conventional therapies (e.g. sulfasalazine, methotrexate, or non-steroidal anti-inflammatory drugs). ☐ Yes ☐ No

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY (per 30 days)	REFILLS
☐ Simponi™ (golimumab)	☐ 50 mg/0.5mL	_____		

_____ PRODUCT SUBSTITUTION PERMITTED (Date)

_____ DISPENSE AS WRITTEN (Date)