PRIOR AUTHORIZATION REQUEST
Simponi

PATIENT: Name_____
Address: _____
City, State, Zip_____
D.O.B. _____
Member ID:_____

Prescriber: Name_____
Address _____
City, State, Zip_____
Phone _____
Fax _____
NPI _____

Medication Requested:_____ Qty Requested: _____

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 answer the following questions

1. ☐ Yes ☐ No Is the patient currently receiving Simponi (Aria or SC)?
2. Is the medication to be used in combination with a BIOLOGIC disease-modifying antirheumatic drug (DMARD) or a targeted synthetic DMARD?
   - ☐ Biologic DMARD
   - ☐ Targeted synthetic DMARD
   - ☐ Conventional synthetic DMARD – **Please proceed to question 3**
   - ☐ No, this medication will NOT be used in combination with another BIOLOGIC or Targeted Synthetic disease-modifying anti-rheumatic drug (DMARD) – **Please proceed to question 3**
3. What is the patient's diagnosis?
   - ☐ Rheumatoid arthritis – **Please answer questions 4, 7 – 8, 18**
   - ☐ Ankylosing Spondylitis (AS) – **Please answer question 4, 19**
   - ☐ Psoriatic Arthritis (PsA) – **Please answer question 5, 20**
   - ☐ Ulcerative colitis – **Please answer questions 6, 9 – 12, 21**
   - ☐ 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] – **Please answer questions 4, 13 – 17, 19**
   - ☐ Plaque psoriasis without psoriatic arthritis
   - ☐ All other indications – Please specify _____
4. ☐ Yes ☐ No Is Simponi SC being prescribed by, or in consultation with, a rheumatologist?
5. ☐ Yes ☐ No Is Simponi SC being prescribed by, or in consultation with, a rheumatologist or dermatologist?
6. ☐ Yes ☐ No Has the patient had a trial of one conventional systemic agent or a corticosteroid such as prednisone or methylprednisolone, or was intolerant to one of these agents for ulcerative colitis?
7. ☐ Yes ☐ No Has the patient tried one conventional synthetic disease-modifying antirheumatic drug

If you have any questions, call: 800-753-2851

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(DMARD) for at least 3 months?

8. ☐ Yes ☐ No Has the patient tried one biologic for at least 3 months?
9. ☐ Yes ☐ No Has the patient tried a biologic?
10. ☐ Yes ☐ No Does the patient have pouchitis?
11. ☐ Yes ☐ No Has the patient tried therapy with an antibiotic, probiotic, corticosteroid enema, or Rowasa (mesalamine) enema?
12. ☐ Yes ☐ No Is the requested medication prescribed by or in consultation with a gastroenterologist?
13. ☐ Yes ☐ No Does the patient have arthritis primarily in the knees, ankles, elbows, wrists, hands and/or feet?
14. ☐ Yes ☐ No Has the patient tried at least ONE conventional synthetic DMARD?
15. ☐ Yes ☐ No Does the patient have axial spondyloarthritis?
16. ☐ Yes ☐ No Does the patient have objective signs of inflammation, defined as: a C-reactive protein (CRP) elevated beyond the upper limit of normal for the reporting laboratory?
17. ☐ Yes ☐ No Does the patient have objective signs of inflammation, defined as: sacroiliitis reported on magnetic resonance imaging (MRI)?
18. ☐ Yes ☐ No Has the patient had a response, as determined by the prescriber?
19. ☐ Yes ☐ No Has the patient had a response, as determined by the prescriber?
20. ☐ Yes ☐ No Has the patient had a response, as determined by the prescriber?
21. ☐ Yes ☐ No Has the patient had a response, as determined by the prescriber?

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: 877-251-5896

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