FUTURE SCRIPTS

Please complete ALL information below and fax your request to 1-888-671-5285

Simponi® & Simponi Aria® Prior Authorization Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if **generic substitution** is acceptable ❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

Select the diagnosis below:

- ❑ Ankylosing spondylitis (for example: M45.0, M45.9)
- ❑ Psoriatic arthritis (for example: arthropathic psoriasis; L40.5, L40.59)
- ❑ Rheumatoid arthritis (for example: M05.79, M06.9)
- ❑ Ulcerative colitis (for example: ulcerative pancolitis; K51.00, K51.90, K51.919)
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical Information:

Select if Simponi or Simponi Aria is prescribed by or in consultation with one of the following specialists:

❑ Dermatologist ❑ Gastroenterologist ❑ Rheumatologist

Is the patient receiving Simponi or Simponi Aria in combination with a biologic DMARD (e.g., Enbrel [etanercept], Humira [adalimumab], Cimzia [certolizumab], Orencia [abatacept])? ❑ **Yes** ❑ **No**

Ankylosing Spondylitis:

Does the patient have active disease? ❑ **Yes** ❑ **No**

Has the patient had a trial and failure, contraindication, or intolerance to two non-steroidal anti-inflammatory drugs (NSAIDs)? ❑ **Yes** ❑ **No**

Psoriatic Arthritis:

Does the patient have active disease? ❑ **Yes** ❑ **No**

Rheumatoid Arthritis:

Does the patient have moderately to severely active disease? ❑ **Yes** ❑ **No**

Is the patient receiving concurrent therapy with methotrexate (Rheumatrex, Trexall)? ❑ **Yes** ❑ **No**

If "no" to the above, has the patient had a trial and failure, contraindication, or intolerance to methotrexate (Rheumatrex, Trexall)? ❑ **Yes** ❑ **No**

Ulcerative Colitis:

Does the patient have moderately to severely active disease? ❑ **Yes** ❑ **No**

Is the patient corticosteroid dependent (i.e., an inability to successfully taper corticosteroids without a return of the symptoms of ulcerative colitis)? ❑ **Yes** ❑ **No**

Select if the patient has had a trial and failure, contraindication, or intolerance to the following conventional therapies:

- ❑ 6-mercaptopurine (Purinethol)
- ❑ Aminosalicylate (e.g., mesalamine [Asacol, Pentasa, Rowasa], olsalazine [Dipentum], sulfasalazine [Azulfidine, Sulfazine])
- ❑ Azathioprine (Imuran)
- ❑ Corticosteroids (e.g., prednisone, methylprednisolone)

Simponi® & Simponi Aria® Prior Authorization Request Form (Page 2 of 2)

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Reauthorization:

Is there documentation the patient has had a positive clinical response to therapy? ❑ **Yes** ❑ **No**

Is the patient receiving Simponi or Simponi Aria in combination with a biologic DMARD (e.g., Enbrel [etanercept], Humira [adalimumab], Cimzia [certolizumab], Orencia [abatacept])? ❑ **Yes** ❑ **No**

Quantity Limit Requests:

What is the quantity requested per DAY? _____

What is the reason for exceeding the plan limitations?

❑ Titration or loading dose purposes
❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
❑ Requested strength/dose is not commercially available
❑ Other: _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.