

SIMPONI & SIMPONI ARIA Prior Authorization Form

- Standard Request (72 hours)
 Expedited Request (24 hours)

If you or your prescriber believe that waiting 72 hours for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can request an expedited decision. For expedited requests you will receive a decision within 24 hours. You cannot request an expedited coverage determination if you are requesting reimbursement for a drug you already received.

Demographics

Patient Information		Prescriber Information	
Patient Name:		Prescriber Name:	
DOB:	Age:	NPI#:	Specialty:
Health Plan ID#:		Phone:	Fax:
Pharmacy Name:	Pharmacy Phone:	Office Contact:	Direct Phone # or Ext:

Medication Information

<input type="checkbox"/> Simponi	<input type="checkbox"/> 50mg/0.5mL Prefilled Syringe <input type="checkbox"/> 100mg/mL Prefilled Syringe <input type="checkbox"/> 50mg/0.5mL SmartJect Auto Injector <input type="checkbox"/> 100mg/mL SmartJect Auto Injector	Directions:	Quantity Dispensed:	Day Supply:
<input type="checkbox"/> SIMPONI ARIA	50mg/4ml Solution for Injection			
<input type="checkbox"/> New medication <input type="checkbox"/> Continuation of therapy		Start Date: _____ If this is continuation of therapy, please provide CHART DOCUMENTATION indicating the member showed improvement while on therapy.		

Billing Information

<input type="checkbox"/> Billed by PHARMACY dispensed to the member or provider for administration.	<input type="checkbox"/> Billed under MEDICAL benefit by provider. J CODE: _____ ICD-10 Code: _____	Place of Administration: <input type="checkbox"/> Physician's Office <input type="checkbox"/> Hospital/Clinic <input type="checkbox"/> Patient Home
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Clinical Information

Disease Severity: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	PPD (tuberculin) test: <input type="checkbox"/> Positive <input type="checkbox"/> Negative Date: _____	Is the member currently using another TNF-blocking or biologic agent in combination with Simponi? <input type="checkbox"/> Yes <input type="checkbox"/> No Medication: _____
Does the member currently have evidence of infection? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Rheumatoid Arthritis	Is the member's disease currently active? <input type="checkbox"/> Yes <input type="checkbox"/> No Will the member be taking methotrexate in combination with Simponi? <input type="checkbox"/> Yes <input type="checkbox"/> No	

<input type="checkbox"/> Ankylosing Spondylitis <input type="checkbox"/> Psoriatic Arthritis	Is the member's disease currently active? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Dominant Axial <input type="checkbox"/> Dominant Peripheral																																																																																																																														
<input type="checkbox"/> Ulcerative Colitis	Has the member had a trial and failure of a conventional therapy (such as a corticosteroid, a 5-ASA agent, or an immunosuppressant)? <input type="checkbox"/> Yes <input type="checkbox"/> No																																																																																																																														
Please indicate past medication(s) tried and failed: (**Simponi, when self-administered, requires prior drug therapy with <i>both</i> preferred TNF products.)																																																																																																																															
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