1230 US Highway 11
Gouverneur, NY 13642
Phone: 1-877-635-9545
Prior Authorization Fax: 1-844-712-8129

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

| Member Information (required) | | | Provider Information (required) | | |
|---|---|---|---|---|---|
| Member Name: | | | Provider Name: | | |
| Insurance ID#: | | | NPI#: | Specialty: | |
| Date of Birth: | | | Office Phone: | | |
| Street Address: | | | Office Fax: | | |
| City: | State: | Zip: | Office Street Address: | | |
| Phone: | | | City: | State: | Zip: |

| Medication Information (required) | | |
|---|---|---|
| Medication Name: | Strength: | Dosage Form: |
| ❑ Check if requesting **brand** | Directions for Use: | |
| ❑ Check if request is for **continuation of therapy** | | |

## Clinical Information (required)

**Select the diagnosis below:**

- ❑ Active ankylosing spondylitis
- ❑ Active psoriatic arthritis
- ❑ Moderately to severely active rheumatoid arthritis
- ❑ Moderately to severely active ulcerative colitis
- ❑ 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

Select if the patient will be receiving Simponi or Simponi Aria in combination with the following:

- ❑ Biologic DMARD [e.g., Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Orencia (abatacept)]
- ❑ Janus kinase inhibitor [e.g., Xeljanz (tofacintinib)]
- ❑ Not in combination with a biologic DMARD or janus kinase inhibitor

**For active ankylosing spondylitis, also answer the following:**

Does the patient have history of failure, contraindication, or intolerance to two non-steroidal anti-inflammatory drugs (NSAIDs)? ❑ **Yes** ❑ **No**

**For moderately to severely active rheumatoid arthritis, also answer the following:**

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

If "no," does the patient have history of failure, contraindication, or intolerance to methotrexate (Rheumatrex, Trexall)? ❑ **Yes** ❑ **No**

**For moderately to severely active ulcerative colitis, also answer the following:**

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

Select if the patient has history of 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)

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

**Reauthorization:**

**If this is a reauthorization request, answer the following questions:**

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

Select if the patient will be receiving Simponi or Simponi Aria in combination with the following:

- ❑ Biologic DMARD [e.g., Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Orencia (abatacept)]
- ❑ Janus kinase inhibitor [e.g., Xeljanz (tofacintinib)]
- ❑ Not in combination with a biologic DMARD or janus kinase inhibitor

**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.

**Please fax this form to 1-844-712-8129 to initiate a prior authorization review for the member and medication above.**

**Please note: plan benefits may limit or exclude coverage of specific medications including those requested on this form.**

**I certify, to the best of my knowledge, the statements and information provided on this form are factual and correct.**

**Provider/Representative (and Title):** _____ **Date:** _____

| **PROACT INTERNAL USE ONLY:** | | | | | |
|---|---|---|---|---|---|
| **Clinical Review Decision** | | | | | |
| | **Approved, through** | | | | |
| | **Denied (documentation attached, if necessary)** | | | | |
| **Tracking:** | | | | | |
| 1st Attempt | | 2nd Attempt | | Letter Mailed: | |