Simponi (golimumab)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

MEMBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PHONE NUMBER:	**DATE OF BIRTH:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
PATIENT INSURANCE ID NUMBER:	

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: HTTPS://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI_DISCLOSURE_AUTHORIZATION.PDF

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____

AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**
NPI NUMBER:	**DEA NUMBER:**
PHONE NUMBER:	**FAX NUMBER:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
REQUESTOR (if different than prescriber)**:**	**OFFICE CONTACT PERSON:**

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL** **IF RENEWAL:** DATE THERAPY INITIATED: DURATION OF THERAPY (SPECIFIC DATES):			

Continued on next page.

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MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ YES (if yes, complete below) ☐ NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE)**:**	**DURATION OF THERAPY** (SPECIFY DATES)**:**	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
☐ Active ankylosing spondylitis ☐ Moderate to severely active psoriatic arthritis ☐ Moderate to severely active rheumatoid arthritis ☐ Polyarticular juvenile idiopathic arthritis ☐ Other Diagnosis_____ICD-10 Code(s):_____	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

For <u>all diagnoses,</u> answer the following:
Will the patient be taking Simponi concurrently with another TNF antagonist or biologic, such as Kineret, Remicade, Rituxan, Orencia, Cimzia, Enbrel, Humira, Actemra or Xeljanz? ☐ **Yes** ☐ **No**

Select if Simponi is prescribed by the following specialists:
- ☐ **Dermatologist**
- ☐ **Rheumatologist**

Has the patient tried and had an inadequate response to at least a three month treatment with Enbrel?*
☐ **Yes** ☐ **No** ***Must submit dates of use.***

Has the patient tried and had an inadequate response to at least a three month treatment with Humira?*
☐ **Yes** ☐ **No** ***Must submit dates of use***

For <u>active ankylosing spondylitis</u>, also answer the following:
Has the patient tried and failed at least two (2) NSAIDS or does the patient have a contraindication to NSAIDs?*
☐ **Yes** ☐ **No** ***Must submit documentation.***

Has the patient tried and failed methotrexate? ☐ **Yes** ☐ **No** ***Must submit documentation.***

For <u>moderate to severely active psoriatic arthritis,</u> also answer the following:
Has the patient had a trial and inadequate response to oral disease-modifying anti-rheumatic agents (DMARDs) such as methotrexate, sulfasalazine, cyclosporine or leflunamide(Arava)?* ☐ **Yes** ☐ **No**
Must submit documentation.

Is the patient unable to take a non-biologic DMARD due to chronic liver disease such as chronic hepatitis, fatty liver, nonalcoholicsteatohepatitis/NASH, or elevated liver enzymes?* ☐ **Yes** ☐ **No**
Must submit documentation.

<u>If "no"</u> to the above question, please provide rationale (if applicable), explaining why the patient is unable to take a DMARD: For moderately to severely active rheumatoid arthritis, also answer the following: _____
_____

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For moderately to severely active rheumatoid arthritis, also answer the following:
Has the patient had a trial and inadequate response to methotrexate or another oral non-biologic disease modifying anti-rheumatic agent (DMARD) such as Imuran, Ridaura, sulfasalazine, Plaquenil or Arava?* □ Yes □ No
Must submit documentation.

Is the patient unable to take a non-biologic DMARD due to chronic liver disease such as chronic hepatitis, fatty liver, nonalcoholic steatohepatitis/NASH, or elevated liver enzymes?* □ Yes □ No
Must submit documentation.
If "no" to the above question, please provide rationale (if applicable), explaining why the patient is unable to take a DMARD: _____

For polyarticular juvenile idiopathic arthritis, also answer the following:
Has the patient tried and had an inadequate response or intolerance to an oral disease modifying anti-rheumatic agent [e.g., methotrexate, sulfasalazine, or leflunomide (Arava)]? □ Yes □ No

Is the patient unable to take a non-biologic DMARD due to chronic liver disease (such as chronic hepatitis, fatty liver, nonalcoholic steatohepatitis/NASH, or elevated liver enzymes)? □ Yes □ No

If "no" to the above question, provide the rationale explaining why the patient cannot take the prerequisite DMARDs: _____

Reauthorization:
If this is a reauthorization request, answer the following questions:
Will the patient be taking Simponi concurrently with another TNF antagonist or biologic, such as Kineret, Remicade, Rituxan, Orencia, Cimzia, Enbrel, Humira, Actemra or Xeljanz? □ Yes □ No

Has the patient had a positive clinical response, and is remission of disease maintained with continued use?* □ Yes □ No *Please provide documentation.*

Select if Simponi is prescribed by the following specialists:
- □ **Dermatologist**
- □ **Rheumatologist**

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: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ **Date:** _____

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FAX THIS FORM TO: 800-424-7640
MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program
Attn: CP – 4201
P.O. Box 64811
St. Paul, MN 55164-0811