



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](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:
<input type="checkbox"/> NEW THERAPY <input type="checkbox"/> 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? <input type="checkbox"/> YES (if yes, complete below) <input type="checkbox"/> NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE): 	DURATION OF THERAPY (SPECIFY DATES): 	RESPONSE/REASON FOR FAILURE/ALLERGY:
2. LIST DIAGNOSES:		ICD-10:
<input type="checkbox"/> Active ankylosing spondylitis <input type="checkbox"/> Moderate to severely active psoriatic arthritis <input type="checkbox"/> Moderate to severely active rheumatoid arthritis <input type="checkbox"/> Polyarticular juvenile idiopathic arthritis <input type="checkbox"/> Other Diagnosis _____ ICD-10 Code(s): _____		
3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.		
<p>For all diagnoses, 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? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Select if Simponi is prescribed by the following specialists: <input type="checkbox"/> Dermatologist <input type="checkbox"/> Rheumatologist</p> <p>Has the patient tried and had an inadequate response to at least a three month treatment with Enbrel?* <input type="checkbox"/> Yes <input type="checkbox"/> No <i>*Must submit dates of use.</i></p> <p>Has the patient tried and had an inadequate response to at least a three month treatment with Humira?* <input type="checkbox"/> Yes <input type="checkbox"/> No <i>*Must submit dates of use</i></p>		
<p>For active ankylosing spondylitis, also answer the following: Has the patient tried and failed at least two (2) NSAIDs or does the patient have a contraindication to NSAIDs?* <input type="checkbox"/> Yes <input type="checkbox"/> No <i>*Must submit documentation.</i></p> <p>Has the patient tried and failed methotrexate? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>*Must submit documentation.</i></p>		
<p>For moderate to severely active psoriatic arthritis, 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)?* <input type="checkbox"/> Yes <input type="checkbox"/> No <i>*Must submit documentation.</i></p>		





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

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





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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; c/o Magellan Health, Inc.
4801 E. Washington Street, Phoenix, AZ 85034
Phone: 877-228-7909

