

Simponi (golimumab)
Prior Authorization Request Form

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

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

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: PRIMETHERAPEUTICS.COM/NOPP

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:
REQUESTER (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



Simponi (golimumab)
Prior Authorization Request Form

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

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
- Ulcerative colitis

- Other diagnosis: _____ ICD-10 Code(s):

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

Is patient going to be using drug in combination with a clinical trial? Yes No

Will the patient be taking Simponi concurrently with another biologic or immunomodulatory agent, such as Kineret, Remicade, Rituxan, Orencia, Cimzia, Enbrel, Otezla, Actemra or Xeljanz, etc.,? Yes No

Select if Simponi is prescribed by the following specialists:

- Dermatologist
- Rheumatologist
- Gastroenterologist

Has the patient tried and had an inadequate response to a three month trial of the biosimilar for Humira- adalimumab-aacf? Yes No Please submit documentation.

Does patient have a absolute contraindication to the biosimilar for Humira- adalimumab-aacf? Yes No Please submit documentation.

Has the patient tried and had an inadequate response to a trial of the biosimilar for Actemra, Tyenne(tocilizumab-aazg)? Yes No Please submit documentation.

Does patient have a absolute contraindication to the biosimilar for Actemra, Tyenne(tocilizumab-aazg)? Yes No Please submit documentation.

For active ankylosing spondylitis, also answer the following:

Simponi (golimumab)
Prior Authorization Request Form
Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

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

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 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)?* 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.*

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 ulcerative colitis, also answer the following:

Has patient had an adequate trial of at least 1 of the following standard therapies:? Yes No **Must submit documentation.*

- Corticosteroids such as prednisone or budesonide er (Entocort EC, Uceris)
- Mesalamine products; oral or rectal (Apriso, Asacol, Canasa, Delzicol, Lialda, Pentasa. Rowasa)
- Balsalazide (Colazal, Giazol)
- Olsalazine(Dipentum)
- Azathioprine
- 6-mercaptopurine

Reauthorization:

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

Will the patient be taking Simponi concurrently with another biologic or immunomodulatory agent, such as Kineret, Remicade, Rituxan, Orencia, Cimzia, Enbrel, Otezla, Actemra or Xeljanz? Yes No

Simponi (golimumab)
Prior Authorization Request Form
Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

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

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
- Gastroenterologist

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:** _____

CONFIDENTIALITY NOTICE: The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.

FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Prime Therapeutics Management Prior Authorization Program

Attn: CP-4201

P.O. Box 64811

St. Paul, MN 55164-0811

Phone: 877-228-7909