Please note: All information below is required to process this request.
Mon-Fri: 6am to 6pm Eastern / Sat: 6am to 6pm Eastern

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

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

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:

- ❑ Ankylosing spondylitis
- ❑ Moderate to severe active ulcerative colitis
- ❑ Psoriatic arthritis
- ❑ Rheumatoid arthritis
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

Prescriber's Specialty:

Select if the requested medication is prescribed by one of the following specialists:

- ❑ Dermatologist
- ❑ Gastroenterologist
- ❑ Rheumatologist

For ankylosing spondylitis, psoriatic arthritis, or rheumatoid arthritis, also answer the following:

Select if the patient has tried and failed the following disease-modifying antirheumatic drugs (DMARDs) therapies:

- ❑ Auranofin
- ❑ Azathioprine
- ❑ Hydroxychloroquine
- ❑ Leflunomide
- ❑ Methotrexate
- ❑ Sulfasalazine
- ❑ Other DMARDs (please specify): _____

For moderate to severe active ulcerative colitis, also answer the following:

Is the patient chronically steroid dependent? ❑ **Yes** ❑ **No**

Select if the patient has had an inadequate response or failure to tolerate the following:

- ❑ 6-mercaptopurine
- ❑ Azathioprine
- ❑ Oral aminosalicylates

Has the patient tried and failed budesonide (9 mg daily for 8 weeks) or high dose steroids (40-60 mg prednisone)? ❑ **Yes** ❑ **No**

Medication being provided by: (Please check applicable box below)

❑ Physician's office ❑ PropriumRx ❑ Specialty Pharmacy (specify name): _____

****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.****
Previous therapies will be verified through pharmacy paid claims or submitted chart notes.

Prescriber Signature: _____ **Date:** _____

Simponi® Prior Authorization Request Form (Page 2 of 2)

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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: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.