

**SIMPONI/SIMPONI ARIA (golimumab) (non-preferred) PRIOR AUTHORIZATION FORM**

Cytokine and CAM Antagonists and Quantity Limits/Daily Dose Limits prior authorization guidelines are accessible on the Department's Pharmacy Services website at <http://www.dhs.pa.gov/provider/pharmacyservices/index.htm>.

PRIOR AUTHORIZATION REQUEST INFORMATION		PRESCRIBER INFORMATION	
<input type="checkbox"/> New request	<input type="checkbox"/> Additional info	Total # of pages: _____	
<input type="checkbox"/> Renewal request	(PA#: _____)	Prescriber name: _____	
Name of office contact: _____		Specialty: _____	
Contact's phone number: _____		State license #: _____	
LTC facility contact/phone: _____		NPI: _____	MA Provider ID#: _____
RECIPIENT INFORMATION		Street address: _____	
Recipient Name: _____		Suite #: _____	City/state/zip: _____
Recipient ID#: _____	DOB: _____	Phone: _____	Fax: _____

**CLINICAL INFORMATION**

<b>Product requested:</b>	<input type="checkbox"/> Simponi SQ 50 mg/0.5 ml syringe	<input type="checkbox"/> Simponi SQ 100 mg/ml syringe	<input type="checkbox"/> Simponi Aria IV 50 mg/4 ml vial* (*only approved for treatment of rheumatoid arthritis)
	<input type="checkbox"/> Simponi SQ 50 mg/0.5 ml pen	<input type="checkbox"/> Simponi SQ 100 mg/ml pen	
Directions: _____	Quantity: _____	Refills: _____	Recipient's weight: _____ lbs/kg
Diagnosis ( <i>submit documentation</i> ): _____			Diagnosis code ( <i>required</i> ): _____

**ALL requests**

- Specialty Pharmacy Drug Program:** What Specialty Pharmacy will be used?  Diplomat Specialty  Walgreens Specialty
- Check all that apply to the Recipient and *submit documentation for each*.  
 screened for hepatitis B (antibody and/or surface antigen) and tuberculosis  up-to-date with all age-appropriate immunizations

**INITIAL requests – complete questions applicable to Recipient's diagnosis**

3. <b>Ankylosing spondylitis or psoriatic arthritis:</b> Does the Recipient have a history of trial and failure, contraindication, or intolerance of the following? <input type="checkbox"/> six-week trial each of at least 2 different NSAIDs <input type="checkbox"/> three-month trial of methotrexate or other DMARD	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Submit documentation of all medications tried and outcomes.</i>
4. <b>Rheumatoid arthritis:</b> Does the Recipient have a history of trial and failure, contraindication, or intolerance of <u>at least 3 months</u> of treatment with methotrexate or another DMARD?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Submit documentation of all medications tried and outcomes.</i>
5. <b>Rheumatoid arthritis:</b> Will the Recipient be using Simponi/Simponi Aria in combination with methotrexate?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Submit documentation.</i>
6. <b>Ankylosing spondylitis, psoriatic arthritis, or rheumatoid arthritis:</b> Does the Recipient have a history of trial and failure, contraindication, or intolerance of the preferred agents? <i>Check all that apply.</i> <input type="checkbox"/> Enbrel <input type="checkbox"/> Humira	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Submit documentation of all medications tried and outcomes.</i>
7. <b>Ulcerative colitis:</b> Does the Recipient have a history of trial and failure, contraindication, or intolerance of the following? <input type="checkbox"/> aminosalicylates <input type="checkbox"/> corticosteroids <input type="checkbox"/> immunomodulators	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Submit documentation of all medications tried and outcomes.</i>
8. <b>Ulcerative colitis:</b> Does the Recipient have a history of trial and failure, contraindication, or intolerance of the preferred agent, <u>Humira</u> ?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Submit documentation of all medications tried and outcomes.</i>

**For all other diagnoses,** submit documentation supporting the use of the requested medication for the Recipient's diagnosis.

**RENEWAL requests**

- Since starting Simponi/Simponi Aria, has the Recipient experienced a positive clinical response and/or improved level of functioning?  
 Yes  No *Submit documentation of clinical response.*

**PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION**

Prescriber Signature: _____	Date: _____
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