MedStar Medicare Choice
Pharmacy Services
Phone: 855-266-0712
Fax: 855-862-6517

SIMPONI & SIMPONI ARIA
Prior Authorization Form

□ Standard Request (72 hours) □ Expedited Request (24 hours)	If you or your prescriber believe that waiting 72 hours for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can request an expedited decision. For expedited requests you will receive a decision within 24 hours. You cannot request an expedited coverage determination if you are requesting reimbursement for a drug you already received.

Demographics

Patient Information		Prescriber Information	
Patient Name:		Prescriber Name:	
DOB:	Age:	NPI#:	Specialty:
Health Plan ID#:		Phone:	Fax:
Pharmacy Name:	Pharmacy Phone:	Office Contact:	Direct Phone # or Ext:

Medication Information

□ Simponi	□ 50mg/0.5mL Prefilled Syringe □ 100mg/mL Prefilled Syringe □ 50mg/0.5mLSmartJect Auto Injector □ 100mg/mL SmartJect Auto Injector	Directions:	Quantity Dispensed:	Day Supply:
□ SIMPONI ARIA	50mg/4ml Solution for Injection			

□ New medication □ Continuation of therapy	Start Date:	If this is continuation of therapy, please provide CHART DOCUMENTATION indicating the member showed improvement while on therapy.

Billing Information

□ Billed by **PHARMACY** dispensed to the member *or* provider for administration.	□ Billed under **MEDICAL** benefit by provider. J CODE:_____ ICD-10 Code:_____	Place of Administration: □ Physician's Office □ Hospital/Clinic □ Patient Home

Clinical Information

Disease Severity:
□ Mild
□ Moderate
□ Severe

PPD (tuberculin) test:
□ Positive
□ Negative
Date:_____

Is the member currently using another TNF-blocking or biologic agent in combination with Simponi? □ Yes □ No

Medication:_____

Does the member currently have evidence of infection? □ Yes □ No

□ **Rheumatoid Arthritis**	Is the member's disease currently active? □ Yes □ No Will the member be taking methotrexate in combination with Simponi? □ Yes □ No
□ **Ankylosing Spondylitis** □ **Psoriatic Arthritis**	Is the member's disease currently active? □ Yes □ No □ Dominant Axial □ Dominant Peripheral

☐ **Ulcerative Colitis**	Has the member had a trial and failure of a conventional therapy (such as a corticosteroid, a 5-ASA agent, or an immunosuppressant)?	☐ Yes ☐ No

Please indicate past medication(s) tried and failed:
(Simponi, when self-administered, requires prior drug therapy with *both* preferred TNF products.)**

Medication	Start Date	End Date	Strength	Frequency	Reason for Discontinuing
☐ Methotrexate					
☐ Hydroxychloroquine					
☐ Leflunomide					
☐ Minocycline					
☐ Sulfasalazine					
☐ Azathioprine					
☐ 6-Mercaptopurine					
☐ Cyclosporine					
☐ **ENBREL****					
☐ **HUMIRA****					
☐ Remicade					
☐ Simponi					
☐ NSAIDs (provide names):					
☐ Corticosteroids (provide names):					
☐ Other (provide names):					

Please provide any additional information which should be considered in the space below: