SIMPONI

Prior Authorization Form

IF THIS IS AN URGENT REQUEST, Please Call UPMC Health Plan Pharmacy Services.
Otherwise please return completed form to:

UPMC HEALTH PLAN PHARMACY SERVICES **PHONE 800-979-UPMC (8762)** **FAX 412-454-7722**

PLEASE TYPE OR PRINT NEATLY

Please complete all sections of this form. Incomplete responses may delay this request.

Office Contact:	**Provider Specialty:**	
Provider First Name:	**Provider Last Name:**	
Provider Phone:	**Provider Fax:**	**Provider NPI #:**
Patient Name:	**Patient UPMC Health Plan ID Number:**	**Patient DOB:**

Drug Requested:	**Strength:**	**Frequency:**	**Qty Dispensed:**	**Patient Age:**

Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.

❑ New medication **❑ Ongoing medication**	**If ongoing, provide date started:**	**If medication is ongoing, Did the member show improvement while on therapy?**	**❑ Yes** **❑ No**
Diagnosis:		**Date of diagnosis:**	

Please indicate place of administration / infusion?	❑Physician's Office ❑Hospital/Facility	**Please indicate how medication will be billed:** ❑ Billed directly by the provider via JCODE Provide JCODE:____________________ ❑ Billed by a pharmacy and delivered to the provider ❑ Billed by a pharmacy and delivered to the patient
Please provide facility/provider name and address:		

Please complete the following questions for *all* diagnoses.

Please indicate disease severity:	❑Mild	❑ Moderate	❑Severe	Is there evidence of Infection?	❑ Yes ❑ No
Date of PPD (tuberculin) test:			Result of PPD test:	❑ Positive	❑Negative

Is the member currently using another TNF-blocking agent or biologic agent in combination with Simponi? If yes, please indicate drug name:	❑Yes ❑No

Please indicate the diagnosis on the left and complete the corresponding questions.

❑Rheumatoid Arthritis	Will the member be taking Methotrexate in combination with Simponi?	❑Yes ❑No
	Has the member tried Methotrexate for at least 3 months with an inadequate response?	❑Yes ❑No
	Please provide dates of therapy and dose:	
	Reason for discontinuation:	
❑ Psoriatic Arthritis	Does the member have dominant **peripheral** disease?	❑Yes ❑No
	Does the member have dominant **axial** disease?	❑Yes ❑No
	Please indicate if the member tried and failed any of the following for at least 3 months?	
	❑Methotrexate ❑Cyclosporine (Neoral) ❑Sulfasalazine (Azulfidine) ❑Leflunomide(Arava)	
	Please provide dates of therapy and dose:	
	Reason for discontinuation:	
	Has the member tried and failed any NSAIDs for at least 3 months?	❑Yes ❑No
	Please indicate drug name(s):	
	Please provide dates of therapy and dose:	
	Reason for discontinuation:	
❑Ankylosing Spondylitis	Does the member have dominant **peripheral** disease?	❑Yes ❑No
	Does the member have dominant **axial** disease?	❑Yes ❑No
	Please indicate if the member tried and failed any of the following for at least 3 months?	
	❑Methotrexate ❑Sulfasalazine (Azulfidine)	
	Please provide dates of therapy and dose:	
	Reason for discontinuation:	
	Has the member tried and failed any NSAIDs for at least 3 months? ❑Yes ❑No	
	Please indicate drug name(s):	
	Please provide dates of therapy and dose:	
	Reason for discontinuation:	

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