UPMC Health Plan

SIMPONI ARIA

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: 1-800-979-UPMC (8762) FAX: 412-454-7722

PLEASE TYPE OR PRINT NEATLY
Incomplete responses may delay this request.

Office contact:		**Provider specialty:**	
Provider first name:		**Provider last name:**	
Provider phone #:		**Provider fax #:**	
Patient name:	**Patient UPMC Health Plan Member ID #:**	**Patient DOB:**	**Patient age:**
Drug requested:	**Strength:**	**Frequency:**	**Quantity dispensed (including units):**

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

☐ **New medication** ☐ **Ongoing medication**	**If ongoing, please provide start date:**	**If ongoing, did the member show improvement while on therapy?**	☐ **Yes** ☐ **No**
Diagnosis:		**Date of diagnosis:**	
Please indicate place of administration ☐ Physician office ☐ Hospital/Clinic ☐ Patient home		**Will the medication be (select one):** ☐ Billed directly by the provider via JCODE JCODE: _____ ☐ Billed by a pharmacy and delivered to the provider ☐ Billed by a pharmacy and delivered to the patient	
Please provide hospital/facility name, address, and phone #:			

Please complete the following for all diagnoses:

Please indicate disease severity ☐ Mild ☐ Moderate ☐ Severe

Date of most recent tuberculosis skin test: _____. Result of tuberculosis skin test: ☐ Positive ☐ Negative

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

Is the member currently using another TNF-blocking or biologic agent in combination with Simponi ARIA? ☐ Yes ☐ No
If yes, please provide name of medication: _____

Is the member's disease currently active? ☐ Yes ☐ No

Has the member tried methotrexate for at least three months with an inadequate response? ☐ Yes ☐ No
If yes, please provide dose tried and dates of therapy: _____
Please indicate reason for discontinuation: _____
If no, please provide a reason why methotrexate cannot be used: _____

Will the member be taking methotrexate in combination with Simponi ARIA? ☐ Yes ☐ No

Please provide any additional information in the space below.

All PA forms are available at www.upmchealthplan.com/providers/medical/resources/forms/pharmacy-pa.aspx.