

UPMC Health Plan

SIMPONI

Prior Authorization Form

IF THIS IS AN URGENT REQUEST, 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):
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Generic equivalent drugs will be substituted for brand-name drugs unless you specifically indicate otherwise.

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

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? Yes No

If yes, please provide name of medication: _____

Please indicate past medication(s) tried and failed:

(Simponi, when administered subcutaneously, requires prior drug therapy of both preferred TNF products.)

Medication name	Start date	End date	Strength	Frequency	Reason for failure, discontinuation
<input type="checkbox"/> Methotrexate					
<input type="checkbox"/> Hydroxychloroquine					
<input type="checkbox"/> Leflunomide					
<input type="checkbox"/> Minocycline					
<input type="checkbox"/> Sulfasalazine					
<input type="checkbox"/> Azathioprine					
<input type="checkbox"/> 6-Mercaptopurine					
<input type="checkbox"/> Cyclosporine					
<input type="checkbox"/> Cimzia					
<input type="checkbox"/> ENBREL**					
<input type="checkbox"/> HUMIRA**					
<input type="checkbox"/> Remicade					

Please be sure to complete and include the 2nd page of this form.

****ENBREL AND HUMIRA ARE THE PREFERRED TNF PRODUCTS FOR UPMC HEALTH PLAN**

