Simponi
(golimumab)

Prior Authorization Form
Curascript
Fax (888) 773-7386

Last Name	First Name	Prescriber's Name	Specialty
Home Phone	Work Phone	Office Phone	Office Fax
Home Address / City / State / ZIP		Address / City / State / ZIP	
SCAN ID number	Date of Birth	Est. Start Date	Office Contact
For Specialty Medications Only: Shipping Address (if different from home address) ☐ Physician ☐ Home		Special Instructions (i.e. Non-English Speaking Patient, etc.):	

Medication:		Diagnosis:	
Sig:	Qty:	Refills:	ICD 9 Code:

Secondary/ Supplemental Insurance Company	Phone	Name of Insured	ID Number	Group Number

1. **Has the patient tried Humira for at least three months with an inadequate response prior to the initiation of Simponi?**
   If yes, continue to #3.
   If no, continue to #2.
2. **Does the patient have contraindications to Humira?**
3. **Will Kineret or Orencia be administered concurrently with Simponi?**
4. **Is the diagnosis or indication for the treatment of moderately to severely active Rheumatoid Arthritis?**
   If no continue to #7.
5. **Will methotrexate be administered concurrently with Simponi?**
6. **Is the patient currently taking or has the patient tried and failed at least one Disease-Modifying Anti-Rheumatic Drug (DMARD), other than methotrexate, for the current?**
   Please list DMARD(s) tried and the duration of treatment.
7. **Is the diagnosis or indication for the treatment of active Psoriatic Arthritis?**
   If no, continue to #9.
8. **Is the patient currently taking or has the patient tried and failed methotrexate for the current condition?**
9. **Is the diagnosis or indication for the treatment of active Ankylosing Spondylitis?**
10. **Is the patient currently taking or has the patient tried and failed at least 2 NSAIDs for the current condition?**
    Please list NSAIDs tried and the duration of treatment with each.
11. **Are there any other comments, diagnoses, symptoms, and/or any other information you feel is important to this review?**

Physician's Signature: ____NPI/DEA #: ______________________ Date: _______________

<u>For Internal Use Only</u>
☐ Approved ☐ Denied Reviewer's Initials ___________________ Decision Date ____________________
Comments____

Notice: **Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information.** Our response time for prescription drug coverage requests is 72 hours. View our formulary and Prior Authorization forms online at http://www.scanhealthplan.com.