# US Family Health Plan
# Prior Authorization Request Form for
# golimumab **( Simponi )**

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be **faxed** to **617-562-5296**

OR

The patient may attach the completed form to the prescription and **mail** it to:
**Attn: Pharmacy, 77 Warren St, Brighton, MA 02135**

QUESTIONS? **Call 1-877-880-7007**

## Step 1

**Please complete patient and physician information** (please print):

Patient Name: ____________________ Physician Name: ____________________

Address: ____________________ Address: ____________________

____________________ ____________________

Sponsor ID # ____________________ Phone #: ____________________

Date of Birth: Secure Fax #:

## Step 2

**Please complete the clinical assessment:**

| Question | Yes | No |
|---|---|---|
| **1. Humira is the Department of Defense's preferred targeted biologic agent. Has the patient tried Humira?** | ☐ Yes<br>proceed to question **3** | ☐ No<br>Proceed to question 2 |
| **2. Does the patient have a contraindication to Humira (adalimumab)?** | ☐ Yes<br>Proceed to question **6** on **page 2** | ☐ No<br>Proceed to question 3 |
| **3. Has the patient had an inadequate response to Humira?** | ☐ Yes<br>Proceed to question **6** on **page 2** | ☐ No<br>Proceed to question 4 |
| **4. Has the patient experienced an adverse reaction to Humira that is not expected to occur with the requested agent?** | ☐ Yes<br>Proceed to question **6** on **page 2** | ☐ No<br>Proceed to question 5 |
| **5. Does the patient have a diagnosis of symptomatic congestive heart failure (CHF) and requires a non-TNF (tumor necrosis factor) biologic agent?** | ☐ Yes<br>Proceed to question **6** on **page 2** | ☐ No<br>**STOP**<br>**Coverage not approved** |

| Question | Yes | No |
|---|---|---|
| **6. Is the patient 18 years of age or older?** | ☐ Yes<br>proceed to question **7** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **7. What is the indication or diagnosis?** | ☐ moderate to severe active **rheumatoid arthritis** – proceed to question **8**<br>☐ active **psoriatic arthritis** – proceed to question **12**<br>☐ active **ankylosing spondylitis** – proceed to question **12**<br>☐ moderately to severely active **ulcerative colitis** – proceed to question **10**<br>☐ other indication or diagnosis – **STOP: coverage not approved. Sign & date below.** | |
| **8. Will Simponi be used in combination with methotrexate?** | ☐ Yes<br>proceed to question **9** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **9. Does the patient have an active prescription for methotrexate?** | ☐ Yes<br>proceed to question **12** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **10. Has the patient had an inadequate response or was intolerant to prior treatment?** | ☐ Yes<br>proceed to question **12** | ☐ No<br>proceed to question **11** |
| **11. Does the patient require continuous steroid therapy?** | ☐ Yes<br>proceed to question **12** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **12. Will the patient be receiving other targeted immunomodulatory biologics with Simponi, including but not limited to the following: Actemra, Cimzia, Enbrel, Humira, Kineret, Orencia, Otezla, Remicade, Rituxan, Stelara, or Xeljanz?** | ☐ Yes<br>**STOP**<br>**Coverage not approved** | ☐ No<br>**Sign and date below** |

**Step 3**

**I certify the above is true to the best of my knowledge.** Please sign and date:

______________________________ ____________
Prescriber Signature Date

[30 April 2018]