USFHP 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 855-273-5735

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

https://www.usfamilyhealth.org/for-providers/pharmacy-information/

Prior Authorization does not expire. Clinical documentation may be required.

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:**

1. Humira is the Department of Defense's preferred targeted biologic agent. Has the patient tried Humira?	☐ Yes proceed to question **2**	☐ No proceed to question **4**
2. Has the patient had an inadequate response to Humira?	☐ Yes proceed to question **5**	☐ No proceed to question **3**
3. Has the patient experienced an adverse reaction to Humira that is not expected to occur with the requested agent?	☐ Yes proceed to question **5**	☐ No **STOP** **Coverage not approved**
4. Does the patient have a contraindication to Humira (adalimumab)?	☐ Yes proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Is the patient 18 years of age or older?	☐ Yes proceed to question **6**	☐ No proceed to question **7**

6. For adult patients, what is the indication or diagnosis?	☐ Moderate to severe active **rheumatoid arthritis** – proceed to question **9** ☐ Active **psoriatic arthritis** – proceed to question **9** ☐ Active **ankylosing spondylitis** – proceed to question **10** ☐ Moderately to severely active **ulcerative colitis** – proceed to question **11** ☐ Other indication or diagnosis – **STOP: Coverage not approved**	
7. Does the patient weigh at least 15 kilograms?	☐ Yes proceed to question **8**	☐ No **STOP** **Coverage not approved**
8. For pediatric patients, what is the indication or diagnosis?	☐ Moderately to severely active **ulcerative colitis -** proceed to question **11** ☐ Other indication or diagnosis – **STOP - Coverage not approved**	
9. Has the patient had an inadequate response to non-biologic systemic therapy? (For example: methotrexate, aminosalicylates [for example, sulfasalazine, mesalamine], corticosteroids, immunosuppressants [for example, azathioprine], etc.)?	☐ Yes proceed to question **11**	☐ No **STOP** **Coverage not approved**
10. Has the patient had an inadequate response to at least two nonsteroidal anti-inflammatory drugs (NSAIDs) over a period of at least two months?	☐ Yes proceed to question **11**	☐ No **STOP** **Coverage not approved**
11. Will the patient be receiving any other targeted immunomodulatory biologics concurrently, including but not limited to the following: TNF inhibitors, IL-1, IL-6, IL-17, IL-23, IL-36, JAK inhibitors?	☐ Yes **STOP** **Coverage not approved**	☐ No **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 _____