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 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**

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. Cases of worsening congestive heart failure (CHF) and new onset CHF have been reported with TNF blockers, including SIMPONI. Is the prescriber aware of this?	☐ Yes proceed to question **6**	☐ No **STOP** **Coverage not approved**

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6. Is the patient 18 years of age or older?		☐ Yes proceed to question **7**	☐ No **STOP** **Coverage not approved**
7. What is the indication or diagnosis?	☐ moderate to severe active **rheumatoid arthritis** – proceed to question **8** ☐ active **psoriatic arthritis** – proceed to question **10** ☐ active **ankylosing spondylitis** – proceed to question **11** ☐ oderately to severely active **ulcerative colitis** – proceed to question **10** ☐ other indication or diagnosis – **STOP: coverage not approved. Sign & date below.**		
8. Will Simponi be used in combination with methotrexate?		☐ Yes proceed to question **9**	☐ No **STOP** **Coverage not approved**
9. Does the patient have an active prescription for methotrexate?		☐ Yes proceed to question **12**	☐ No **STOP** **Coverage not approved**
10. Has the patient had an inadequate response to non-biologic systemic therapy? (For example: methotrexate, aminosalicylates [e.g. sulfasalazine, mesalamine], corticosteroids, immunosuppressants [e.g. azathioprine], etc.)?		☐ Yes proceed to question **12**	☐ o **STOP** **Coverage not approved**
11. Has the patient had an inadequate response to at least two NSAIDS over a period of at least two months?		☐ Yes proceed to question **12**	☐ No **STOP** **Coverage not approved**
12. Does the patient have evidence of a negative TB test result in the past 12 months (or TB is adequately managed)?		☐ Yes proceed to question **13**	☐ No **STOP** **Coverage not approved**
13. Will the patient be receiving other targeted immunomodulatory biologics with Simponi, including but not limited to the following: Actemra, Cimzia, Cosentyx, Enbrel, Humira, Ilumya, Kevzara, Kineret, Olumiant, Orencia, Otezla, Remicade, Rituxan, Siliq, Stelara, Taltz, Tremfya or Xeljanz/Xeljanz XR?		☐ 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

[24 April 2019]