

US Family Health Plan Prior Authorization Request Form for Simponi (Golimumab) Prior Authorization Request Form

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 (USFHP).

SPECIAL NOTES: Simponi, Cimzia, Enbrel, and Kineret are non-formulary (Tier 3) under the DoD Uniform Formulary and carry a higher copay for non-Active duty beneficiaries than Humira and Amevive, which are formulary (Tier 2).

Medical necessity forms are available on the US Family Health Plan Pharmacy website at

http://www.usfamilyhealth.org/f-downloadable_forms.html. This form may NOT be used to meet medical

MAIL ORDER	If the prescription is to be filled through the USFHP Mail Order Pharmacy, check here <input type="checkbox"/>	RETAIL	If the prescription is to be filled at a retail pharmacy, check here <input type="checkbox"/>
	<ul style="list-style-type: none"> The completed form and the prescription may be faxed to 1-617-562-5296 OR The patient may attach the completed form to the prescription and mail it to: Attn: Pharmacy, 77 Warren Street, Brighton, MA 02135 		<ul style="list-style-type: none"> The provider may call: 1-877-880-7007 OR The completed form may be faxed to 1-617-562-5296

Drug for which Prior Authorization is requested: Simponi (golimumab)

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:

2

1. Will the patient be receiving Orencia (abatacept), Humira (adalimumab), Kineret (anakinra), Cimzia (certolizumab), Enbrel (etanercept), Remicade (infliximab), or Rituxan (rituximab) in combination with Simponi?	<input type="checkbox"/> Yes Coverage not approved	<input type="checkbox"/> No Please proceed to Question 2
2. Is Simponi being prescribed for moderate to severely active rheumatoid arthritis?	<input type="checkbox"/> Yes Please proceed to Question 3	<input type="checkbox"/> No Please proceed to Question 4
3. Does the patient already have an active prescription for methotrexate?	<input type="checkbox"/> Yes Please sign and date. See quantity limits below	<input type="checkbox"/> No Coverage not approved
4. Is Simponi being prescribed for the treatment of moderate to severely active psoriatic arthritis or the treatment of active ankylosing spondylitis?	<input type="checkbox"/> Yes Please sign and date. See quantity limits below	<input type="checkbox"/> No Coverage not approved

Quantity limits: limited to a 4-week supply in retail and an 8-week supply in mail order

Step 3 I certify the above is correct and accurate to the best of my knowledge. Please sign and date

3

Prescriber Signature

Date