Simponi® (golimumab)

Medication Request Form (MRF) for Healthy Indiana Plan (HIP) and Hoosier Helathwise (HHW)
FAX TO: (858) 790-7100
c/o MedImpact Healthcare Systems, Inc.

Attn: Prior Authorization Department
10181 Scripps Gateway Court, San Diego, CA 92131 - Phone: 1-800-788-2949

Instructions:
This form is to be used by participating providers to obtain coverage for the drug listed above which requires *prior authorization*. Please complete this form and fax it to *Med**Impact*** Healthcare Systems, Inc. at (858) 790-7100. If you have any questions regarding this process, please contact Med***Impact***'s Customer Service at (800) 788-2949.

Member/Provider Information:

MDwise Member's Name:	**Provider's Name:**
MDwise Member's ID #:	**Provider's Specialty:**
MDwise Member's DOB (mm-dd-yy):	**Provider's DEA #:** | **Provider's NPI #:**
Pharmacy used by MDwise Member:	**Provider's Telephone Number/Contact Name (xxx-xxx-xxxx):**
Pharmacy Telephone Number (xxx-xxx-xxxx):	**Provider's Fax Number (xxx-xxx-xxxx):**

Clinical Information:

Requested Drug: ☐ **Simponi®**
NOTE: Simponi Aria® (IV dosage form) is not a covered pharmacy benefit.

Dose and Quantity Requested:

Date Requested: | **Length of Treatment** (please be *specific*)**:**

Documentation of Medical Necessity (*please complete **ONE** of sections 1-4 **and if desired** section 5)***:**

1. Does the patient have a diagnosis of **moderate to severe ulcerative colitis**? ☐ Yes ☐ No

AND

Has this treatment been prescribed by or in consultation with a gastroenterologist? ☐ Yes ☐ No

AND

Has the patient tried or does the patient have a contraindication (CI) to at least **ONE** of the following conventional agents?

mesalamine	☐ Yes	☐ No	If **yes**, describe response/reaction or CI to each medication below:
azathioprine	☐ Yes	☐ No	
methotrexate	☐ Yes	☐ No	
mercaptopurine	☐ Yes	☐ No	
corticosteroids	☐ Yes	☐ No	

AND

The patient will ***NOT*** be on concurrent therapy with Orencia® or Kineret®? ☐ True ☐ False

2. Does the patient have a diagnosis of **moderate to severe rheumatoid arthritis**? ☐ Yes ☐ No

AND

Is this for initial therapy (i.e., Is the patient naïve to this medication)? ☐ Yes ☐ No

If no, has the patient experienced or maintained a ≥20% improvement in tender or swollen joint count while on therapy? ☐ Yes ☐ No

AND

Has this treatment been prescribed by or in consultation with a rheumatologist? ☐ Yes ☐ No

AND

Has the patient tried or does the patient have a contraindication to at least **ONE** of the following DMARD agents?

methotrexate	☐ Yes	☐ No	If **yes**, describe response/reaction or CI to each medication below:
leflunomide	☐ Yes	☐ No	
hydroxychloroquine	☐ Yes	☐ No	
sulfasalazine	☐ Yes	☐ No	

AND

Will the patient be taking methotrexate concurrently with Simponi? ☐ Yes ☐ No

If no, please list the reason for not giving the two concurrently: _____

AND

The patient will ***NOT*** be on concurrent therapy with Orencia or Kineret? ☐ True ☐ False

3. Does the patient have a diagnosis of **psoriatic arthritis**? ☐ Yes ☐ No

AND

Is this for initial therapy (i.e., Is the patient naïve to this medication)? ☐ Yes ☐ No

If no, has the patient experienced or maintained a ≥20% improvement in tender or swollen joint count while on therapy? ☐ Yes ☐ No

AND

Has this treatment been prescribed by or in consultation with a rheumatologist or a dermatologist? ☐ Yes ☐ No

AND

Has the patient tried or does the patient have a contraindication to at least **ONE** of the following DMARD agents?

methotrexate	☐ Yes	☐ No	If **yes**, describe response/reaction or CI to each medication below:
leflunomide	☐ Yes	☐ No	
hydroxychloroquine	☐ Yes	☐ No	
sulfasalazine	☐ Yes	☐ No	

AND

The patient will ***NOT*** be on concurrent therapy with Orencia or Kineret? ☐ True ☐ False

4. Does the patient have a diagnosis of **moderate to severe ankylosing spondylitis**? ☐ Yes ☐ No

AND

Is this for initial therapy (i.e., Is the patient naïve to this medication)? ☐ Yes ☐ No

If no, has the patient experienced or maintained an improvement ≥50% or 2 units on the Bath Ankylosing Spondylitis Disease Activity Index (BASDAI)? ☐ Yes ☐ No

AND

Has this treatment been prescribed by or in consultation with a rheumatologist? ☐ Yes ☐ No

AND

The patient will ***NOT*** be on concurrent therapy with Orencia or Kineret? ☐ True ☐ False

5. Please attach additional information which may indicate ***why this specific medication*** is being requested for this patient.