

Drug Coverage Review Request

NC Golimumab (Simponi®)



SUPPLY ALL PRESCRIBER AND PATIENT INFORMATION

PRESCRIBER

MD First Name _____
 MD Last Name _____
 Address _____
 City _____
 State _____
 Zip Code _____
 Phone _____
 Fax _____
 DEA number (optional) _____

PATIENT

Cardholder ID # _____
 Patient Last Name _____
 Patient First Name _____
 Date of Birth _____
 Address _____
 City _____
 State _____
 Zip Code _____
 Phone _____

Your patient's benefit plan requires that we review certain requests for coverage with the prescribing physician. You have prescribed a medication for your patient that requires prior authorization before benefit coverage can be provided. Please complete the following questions and then fax this form to the toll-free number shown below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the rules of the benefit.

SECTION A

Please answer the following questions.

1. Yes No Will the patient be receiving MORE THAN ONE biologic agent (for example, Humira®, Enbrel®, Cimzia®, Rituxan®, Orencia®, etc.) AT THE SAME TIME?
2. Yes No Not warranted When warranted, will the patient be evaluated and screened for the presence of latent TB infection prior to initiation of therapy with this drug?
3. For which indication is this drug being prescribed?
 - Moderate to severe rheumatoid arthritis*—*please answer question 4.*
 - Active psoriatic arthritis
 - Active ankylosing spondylitis**—*please answer questions 5 to 7.*
 - Other

***Question 4 applies only if the diagnosis is moderate to severe rheumatoid arthritis.**

4. Yes No Will the patient be receiving THIS DRUG AND METHOTREXATE at the same time?

****Questions 5 to 7 apply only if the diagnosis is active ankylosing spondylitis.**

5. Yes No Has the patient received AT LEAST TWO OF THE FOLLOWING drugs: NSAIDs or a COX-2 inhibitor?
6. Yes No If **yes** to the **previous** question, has the patient EXPERIENCED INADEQUATE SYMPTOM RELIEF from AT LEAST TWO NSAIDs and/or a COX-2 inhibitor?
7. Yes No Is the patient UNABLE TO RECEIVE drug therapy with NSAIDs or a COX-2 inhibitor?

SECTION B

Physician Signature

PHYSICIAN SIGNATURE

DATE

FAX COMPLETED FORM TO: 1 800 837-0959

PLEASE DO NOT FAX WITH A COVER SHEET



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