AmeriHealth Caritas North Carolina

Pharmacy Request for Prior Approval – Simponi Aria

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: _____

Prescriber Information

6. Prescriber Name: _____ NPI #: _____
Mailing address: _____ City: _____ State: _____ ZIP: _____
7. Requester Contact Information: _____
Name: _____ Phone #: _____ Fax #: _____

Drug Information

8. Drug Name: _____ 9. Dose: _____ 10. Directions: _____
11. Length of Therapy: __up to 30 days __60 days __90 days __120 days __180 days __365 days __Other: _____

Clinical Information

Request for Ankylosing Spondylitis:

1. Does the beneficiary have a diagnosis of Ankylosing Spondylitis? Yes___ No___
2. Is the beneficiary on another injectable biologic immunomodulator? Yes___ No___
3. Has the beneficiary been considered and screened for the presence of latent tuberculosis infection? Yes___ No___
4. Has the beneficiary been tested with Hep B SAG and Core Ab? Yes___ No___
5. Has the beneficiary experienced inadequate symptom relief from treatment with at least two NSAIDS? Yes___ No___
6. Is the beneficiary unable to receive treatment with NSAIDS due to contraindications? Yes___ No___
7. Does the beneficiary have clinical evidence of severe or rapidly progressing disease? Yes___ No___
8. Has the beneficiary had a trial and failure of Cosentyx, Enbrel or Humira or a clinical reason beneficiary cannot try Cosentyx, Enbrel or Humira? Yes___ No___

Request for Polyarticular Juvenile Idiopathic Arthritis (PJIA):

1. Does the beneficiary have a diagnosis of Polyarticular Juvenile Idiopathic Arthritis? Yes___ No___
2. Is the beneficiary on another injectable biologic immunomodulator? Yes___ No___
3. Has the beneficiary been considered and screened for the presence of latent tuberculosis infection? Yes___ No___
4. Has the beneficiary been tested with Hep B SAG and Core Ab? Yes___ No___
5. Has the beneficiary tried one systemic corticosteroid (e.g., prednisone, methylprednisolone) or methotrexate, leflunomide or sulfasalazine with inadequate response or is unable to take these therapies due to contraindications? Yes___ No___
6. Does the beneficiary have PJIA subtype enthesitis related arthritis? Yes___ No___
7. Has the beneficiary had a trial and failure of Cosentyx, Enbrel or Humira or a clinical reason beneficiary cannot try Cosentyx, Enbrel or Humira? Yes___ No___

Request for Psoriatic Arthritis:

1. Does the beneficiary have a documented definitive diagnosis of Psoriatic Arthritis? Yes___ No___
2. Is the beneficiary 2 years of age or older? Yes___ No___
3. Is the beneficiary on another injectable biologic immunomodulator? Yes___ No___
4. Has the beneficiary been considered and screened for the presence of latent tuberculosis infection? Yes___ No___
5. Has the beneficiary been tested with Hep B SAG and Core Ab? Yes___ No___
6. Does the beneficiary have a documented inadequate response or inability to take methotrexate? Yes___ No___
7. Has the beneficiary had a trial and failure of Cosentyx, Enbrel or Humira or a clinical reason beneficiary cannot try Cosentyx, Enbrel or Humira? Yes___ No___

Request for Rheumatoid Arthritis:

1. Does the beneficiary have a diagnosis of Rheumatoid Arthritis? Yes___ No___
2. Is the beneficiary on another injectable biologic immunomodulator? Yes___ No___
3. Has the beneficiary been considered and screened for the presence of latent tuberculosis infection? Yes___ No___
4. Has the beneficiary been tested with Hep B SAG and Core Ab? Yes___ No___
5. Has the beneficiary experienced a therapeutic failure/inadequate response with methotrexate or at least one disease modifying antirheumatic drug (e.g., leflunomide, hydroxychloroquine, minocycline, sulfasalazine)? Yes___ No___

Fax this form to: 1-877-234-4274, or call Pharmacy Prior Authorization: 1-866-885-1406

AmeriHealth Caritas North Carolina

Pharmacy Request for Prior Approval – Simponi Aria

6. Is the beneficiary unable to receive methotrexate or disease modifying antirheumatic drug due to contraindications or intolerabilities? Yes___ No___
7. Does the beneficiary have clinical evidence of severe or rapidly progressing disease? Yes___ No___
8. Has the beneficiary had a trial and failure of Enbrel or Humira or a clinical reason beneficiary cannot try Enbrel or Humira? Yes___ No___

Request for FDA Approved Diagnosis Not Listed Above:

1. Diagnosis: _____
2. Is the beneficiary on another injectable biologic immunomodulator? Yes___ No___
3. Has the beneficiary been considered and screened for the presence of latent tuberculosis infection? Yes___ No___
4. Has the beneficiary been tested with Hep B SAG and Core Ab? Yes___ No___

Signature of Prescriber: _____ Date: _____

***Prescriber signature mandatory**

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to: 1-877-234-4274, or call Pharmacy Prior Authorization: 1-866-885-1406