Priority Health Medicare prior authorization form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☐ **Medicare Part B** ☒ **Medicare Part D**
This request is: ☐ **Expedited request** ☐ **Standard request**

Your request will be expedited if you haven't gotten the prescription and Priority Health Medicare determines, or your prescriber tells us, that your life or health may be at risk by waiting.

Simponi / Simponi Aria® (golimumab)

Member

Last Name: _____ First Name: _____
ID #: _____ DOB: _____ Gender: _____
Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____
Provider Address: _____
Provider NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Product and Billing Information

☐ New request ☐ Continuation request - **Original therapy start date**: _____

Drug product:
- ☐ Simponi 50mg/0.5mL SmartJect
- ☐ Simponi 100mg/mL SmartJect
- ☐ Simponi 50mg/0.5mL prefilled syringe
- ☐ Simponi 100mg/mL prefilled syringe
- ☐ Simponi Aria 50 mg/4 mL IV infusion

Date of last dose (if applicable): _____
Date of next dose (if applicable): _____
Dose:_____ **Dose Frequency**:_____
Patient's weight: _____
Number of doses requested: _____

Place of administration:
- ☐ Self-administered
- ☐ Physician's office
- ☐ Outpatient infusion
  Facility: _____ NPI:_____ Fax:_____
- ☐ Home infusion
  Facility: _____ NPI:_____ Fax:_____

Billing:
- ☐ Physician to buy and bill
- ☐ Facility to buy and bill
- ☐ Specialty Pharmacy
  Pharmacy:_____ NPI:_____ Fax:_____

ICD-10 Diagnosis code(s): _____

All fields must be complete and legible for review. Your office will receive a response via fax.

Updated 01/2019
Last reviewed 01/2019

Precertification Requirements

The following requirements need to be met before this drug is covered by Priority Health Medicare. These requirements have been approved by the Centers for Medicare and Medicaid Services (CMS), but you may ask us for an exception if you believe one or more of these requirements should be waived.

Before this drug is covered, the patient must meet all of the following requirements:

1. Must be used for a medically-accepted indication*
2. For ankylosing spondylitis:
    - Must have presence of active disease for at least 4 weeks
    - Must have a BASDAI score of at least 4
    - Must have a therapeutic trial and clinical failure with Enbrel or Humira
3. For patients with rheumatoid arthritis or psoriatic arthritis:
    - Must have a therapeutic trial and clinical failure with Enbrel or Humira
4. Must have a negative TB test (must be done yearly)

Medically accepted indication*

This drug is only covered under Medicare Part D when it is used for a medically accepted indication. A medically accepted indication is a use of the drug that is *either*:

- approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)
- — *or* — supported by certain reference books. (These reference books are the American Hospital Formulary Service Drug Information and the DRUGDEX Information System.)

Priority Health Precertification Documentation

A. What is the patient's diagnosis?

☐ Ankylosing spondylitis

1. Does the patient have a BASDAI score of 4?

☐ Yes. BASDAI score: _____

☐ No. **Are you requesting an exception to the criteria?**

☐ Yes. ***Rationale for exception***: _____

☐ No

2. Has the patient had presence of active disease for at least 4 weeks?

☐ Yes

☐ No. **Are you requesting an exception to the criteria?**

☐ Yes. ***Rationale for exception***: _____

☐ No

3. Did the patient try and fail Enbrel or Humira?

☐ Yes.

☐ No. **Are you requesting an exception to the criteria?**

☐ Yes. ***Rationale for exception***: _____

☐ No

☐ Psoriatic arthritis

1. Did the patient try and fail Enbrel or Humira?

☐ Yes.

☐ No. **Are you requesting an exception to the criteria?**

☐ Yes. ***Rationale for exception***: _____

☐ No

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Last reviewed 01/2019

☐ Rheumatoid arthritis

1. Did the patient try and fail Enbrel or Humira?

☐ Yes.

☐ No. **Are you requesting an exception to the criteria?**

☐ Yes. ***Rationale for exception***: _____

☐ No

☐ Ulcerative colitis

☐ Other – the patient's condition is: _____

Rationale for Other use: _____

B. What is the date and result of the patient's most recent TB test?

☐ Negative **Date:** _____

☐ Positive

☐ Not completed. **Are you requesting an exception to the criteria?**

☐ Yes. ***Rationale for exception***: _____

☐ No

Additional information

NOTE: When approved, coverage duration is for 12 months

National and Local Coverage Determination Criteria

Priority Health Medicare applies CMS national coverage determination (NCD) and local coverage determination (LCD) criteria for Part B drugs. If no NCD or LCD criteria are available for the state in which the member is receiving the services, the medication must be being used for a medically-accepted diagnosis as defined in the Medicare Benefit Policy Manual Chapter 15 § 50.

WPS-Medicare LCD: None available

Priority Health Medicare Exception Request *(exceptions to the above criteria)*

Do you believe one or more of the prior authorization requirements should be waived? ☐ Yes ☐ No
If yes, you must provide a statement explaining the medical reason why the exception should be approved.

Would Simponi likely be the most effective option for this patient?
☐ Yes ☐ No
If yes, please explain why: _____

_____

_____

If the patient is currently using Simponi, would changing the patient's current regimen likely result in adverse effects for the patient?
☐ Yes ☐ No
If yes, please explain: _____

_____

_____

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Updated 01/2019
Last reviewed 01/2019