Prior Authorization Request Form for
golimumab **(Simponi)**

USFHP Pharmacy Prior Authorization Form

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

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:**

1. Humira is the Department of Defense's preferred targeted biologic agent. Has the patient tried Humira?	☐ Yes proceed to question **2**	☐ No proceed to question **4**
2. Has the patient had an inadequate response to Humira?	☐ Yes proceed to question **5**	☐ No proceed to question **3**
3. Has the patient experienced an adverse reaction to Humira that is not expected to occur with the requested agent?	☐ Yes proceed to question **5**	☐ No **STOP** **Coverage not approved**
4. Does the patient have a contraindication to Humira (adalimumab)?	☐ Yes proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Cases of worsening congestive heart failure (CHF) and new onset CHF have been reported with TNF blockers, including SIMPONI. Is the prescriber aware of this?	☐ Yes proceed to question **6**	☐ No **STOP** **Coverage not approved**

6. Is the patient 18 years of age or older?	☐ Yes proceed to question **7**	☐ No **STOP** **Coverage not approved**
7. What is the indication or diagnosis?	☐ moderate to severe active **rheumatoid arthritis** – proceed to question **8** ☐ active **psoriatic arthritis** – proceed to question **10** ☐ active **ankylosing spondylitis** – proceed to question **11** ☐ moderately to severely active **ulcerative colitis** – proceed to question **10** ☐ other indication or diagnosis – **STOP: coverage not approved. Sign & date below.**	
8. Will Simponi be used in combination with methotrexate?	☐ Yes proceed to question **9**	☐ No **STOP** **Coverage not approved**
9. Does the patient have an active prescription for methotrexate?	☐ Yes proceed to question **12**	☐ No **STOP** **Coverage not approved**
10. Has the patient had an inadequate response to non-biologic systemic therapy? (For example: methotrexate, aminosalicylates [e.g. sulfasalazine, mesalamine], corticosteroids, immunosuppressants [e.g. azathioprine], etc.)?	☐ Yes proceed to question **12**	☐ No **STOP** **Coverage not approved**
11. Has the patient had an inadequate response to at least two NSAIDS over a period of at least two months?	☐ Yes proceed to question **12**	☐ No **STOP** **Coverage not approved**
12. Does the patient have evidence of a negative TB test result in the past 12 months (or TB is adequately managed)?	☐ Yes proceed to question **13**	☐ No **STOP** **Coverage not approved**
13. Will the patient be receiving other targeted immunomodulatory biologics with Simponi, including but not limited to the following: Actemra, Cimzia, Cosentyx, Enbrel, Humira, Ilumya, Kevzara, Kineret, Olumiant, Orencia, Otezla, Remicade, Rituxan, Siliq, Stelara, Taltz, Tremfya or Xeljanz/Xeljanz XR?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

Prescriber Signature _____ Date _____

[24 April 2019]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: