

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM
SIMPONI (golimumab)

Patient name: _____ Medicaid ID #: _____

Prescriber Name: _____ Prescriber NPI#: _____ Contact person: _____

Prescriber Phone#: _____ Extension/Option: _____ Fax#: _____

Pharmacy: _____ Pharmacy Phone#: _____ Pharmacy Fax #: _____

Requested Medication: _____ Strength: _____ Frequency/Day: _____

All information to be legible, complete and correct or form will be returned

FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF MEDICAL NECESSITY AND THE COMPLETED FORM TO 855-828-4992 note the new fax number

CRITERIA:

Rheumatoid Arthritis or Psoriatic Arthritis

- Age requirement: 18 years and older
- Diagnosis of moderate to severe Rheumatoid Arthritis, Psoriatic Arthritis
- History of treatment, incomplete response or intolerance to Methotrexate, or one other DMARD or second line drug (azathioprine, sulphadiazine, leflunomide, penicillamine, hydroxychloroquine, etc.)
- The number of swollen joints, must be 6 or more **(WRITE SPECIFIC NUMBER IN NOTES OR LETTER)**
- The number of tender joints must be 9 or more **(WRITE SPECIFIC NUMBER IN NOTES OR LETTER)**
- Negative TB skin test or history of treatment for latent TB infection.
- Absence of active bacterial or viral infection, malignancy, or immunosuppressive condition.
- Rheumatology consultation within the last 60 days.
- Simponi may not be given with other biologic agents such as Interferon, experimental medications or combination.
- Documented failure on or intolerance to a preferred product (Humira, Enbrel, or Cimzia).

Ankylosing Spondylitis

- Age requirement: 18 years and older.
- Diagnosis of Ankylosing Spondylitis
- Absence of active bacterial or viral infection, malignancy, or immunosuppressive condition.
- Negative TB skin test or history of treatment for latent TB infection.
- Rheumatology consultation within the last 60 days.
- Simponi may not be given with other biologic agents such as Interferon, experimental medications, or combinations.
- Documented failure on or intolerance to a preferred product (Humira, Enbrel, or Cimzia).

NOTES:

Available as a Non-Traditional Medicaid Benefit.

AUTHORIZATION:

1 year

RE-AUTHORIZATION:

An updated letter of medical necessity or progress notes showing improvement or maintenance with medication.

9/21/10

<http://health.utah.gov/medicaid/pharmacy>