



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:
Simponi

Phone: 215-991-4300 Fax back to: 866-240-3712

HEALTH PARTNERS manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name: Member Number: Date of Birth: Group Number: Address: City, State, Zip: Member Phone:	Prescriber Name: Fax: Phone: Office Contact: NPI: State Lic ID: Address: City, State, Zip:
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Drug Name: Expedited/Urgent

Directions:

Patient belongs to (please check one): HEALTH PARTNERS KIDZPARTNERS

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign:

Q1. What is the requested duration of therapy? 6 Months or less More than 6 months
Q2. Is the patient 18 years of age or older? Yes No
Q3. Does the patient have a diagnosis of moderate to severe active rheumatoid arthritis, active psoriatic arthritis, or active ankylosing spondylitis? Yes No
Q4. Is the prescribing physician a Rheumatologist or Dermatologist (in case of psoriasis)? Yes No
Q5. Has the patient been evaluated for active or latent tuberculosis infection with a tuberculin skin test prior to the initiation of therapy? Yes No
Q6. If latent infection is diagnosed, has the patient received appropriate prophylaxis in accordance with the CDC and prevention guidelines should be instituted? Yes No
Q7. Is the patient being treated for any other active infection? Yes No
Q8. If yes, please explain.
Q9. For Rheumatoid Arthritis: Is the patient being prescribed Simponi in combination with methotrexate? Yes No
Q10. Has the patient tried and failed to achieve a therapeutic response with Enbrel or Humira or is there any



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Prescriber Name:

contraindication for patient to try Enbrel or Humira?

Yes No

Q11. Was the patient compliant with Enbrel or Humira?

Yes No

Q12. Additional Information / Comments

Physician Signature

Date

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