CHORUS COMMUNITY HEALTH PLANS

Prior Authorization Form: **Simponi**

If this is an urgent request, please call Chorus Community Health Plans Pharmacy Services.
Otherwise, please return completed form – Phone: 844-201-4677 or Fax: 844-201-4675

Please type or print neatly. Incomplete responses may delay this request.

Office Contact:	Provider Specialty:	
Provider First Name:	Provider Last Name:	
Provider Phone #:	Provider Fax #:	Provider NPI #:

Patient Name:	CCHP Member ID #:	Patient DOB:	Patient Age:

Drug Requested:	Strength:	Frequency:	Quantity Dispensed (including units):

Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.

New medication **Ongoing medication**	If ongoing, please provide start date:	If ongoing, did the member show improvement while on therapy?	**Yes** **No**

Diagnosis:

Date of diagnosis:

Please indicate place of administration:

Physician's Office **Hospital/Facility** **Patient Home** **Other**

Please provide hospital/facility information:
Name: ____________________
Phone #: ____________________
Address: ____________________
____

Will the drug be: (select one)
Billed directly by the provider via JCODE
JCODE: ____________________
Billed by a pharmacy and delivered to the provider
Billed by a pharmacy and delivered to the patient

Please complete the following for all diagnoses:

Please indicate disease severity Mild Moderate Severe

Date of most recent tuberculosis skin test: ____________ Result of tuberculosis skin test: **Positive**

Does the member currently have evidence of infection? **Yes** **No**

Is the member currently using another TNF-blocking or biologic agent in combination with Simponi? **Yes** **No**
If yes, please provide name of medication: ____________________

Please indicate past medication(s) tried and failed:

(Simponi, when administered subcutaneously, requires prior drug therapy of both preferred TNF products.)

Medication Name	Start Date	End Date	Strength	Frequency	List adverse reactions/side effects/
Methotrexate					
Hydroxychloroquine					
Leflunomide					
Minocycline					
Sulfasalazine					
Azathioprine					

6-Mercaptopurine					
Cyclosporine					
Cimzia					
ENBREL**					
HUMIRA**					
Remicade					
Please indicate past medication(s) tried and failed:					
Medication Name	Start Date	End Date	Strength	Frequency	Reason for failure, discontinuation
Non-Steroidal Anti-Inflammatory Drugs (please provide names):					
Other (please provide names):					

Please indicate past medication(s) tried and failed:		
Rheumatoid Arthritis	Is the member's disease currently active?	**Yes** **No**
	Will the member be taking methotrexate in combination with Simponi?	**Yes** **No**
Ankylosing Spondylitis	Is the member's disease currently active?	**Yes** **No**
Psoriatic Arthritis	Is the member's disease dominant axial?	**Yes** **No**
	Is the member's disease dominant peripheral?	**Yes** **No**

Please provide any additional clinical information which should be considered in the space below:

**Enbrel and Humira are the preferred subcutaneous TNF products for together with CCHP