Wellpoint

Simponi, Simponi Aria (golimumab) Prior Authorization of Benefits (PAB) Form

CONTAINS CONFIDENTIAL PATIENT INFORMATION

Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 844-474-3341.

1. Patient information	**2. Physician information**
Patient name: _____	Prescribing physician: _____
Patient ID #: _____	Physician address: _____
Patient DOB: _____	Physician phone #: _____
Date of Rx: _____	Physician fax #: _____
Patient phone #: _____	Physician specialty: _____
Patient email address: _____	Physician DEA: _____
	Physician NPI #: _____
	Physician email address: _____

3. Medication	**4. Strength**	**5. Directions**	**6. Quantity per 30 days**
Simponi, Simponi Aria (golimumab)	_____	_____	Specify: _____

7. Diagnosis: _____

8. Approval criteria: (Check all boxes that apply. Note: Any areas not filled out are considered not applicable to your patient and may affect the outcome of this request.)

□ Yes □ No	Is the medication being provided and billed at the physician's office?
□ Yes □ No	Patient has had a diagnosis of rheumatoid arthritis in the last 730 days.
□ Yes □ No	Patient has had a diagnosis of ankylosing spondylitis, psoriatic arthritis and/or ulcerative colitis in the last 730 days.
□ Yes □ No	Patient has had one claim for methotrexate in the last 60 days.
□ Yes □ No	Patient has a history of heart failure in the last 365 days.
□ Yes □ No	Patient has a history of demyelinating disease (multiple sclerosis, optic neuritis, and/or Guillain-Barre syndrome) in the last 365 days.
□ Yes □ No	Patient has a history of hematologic abnormalities in the last 180 days.
□ Yes □ No	Patient has had a serious active infection (including hepatitis B virus and/or tuberculosis) in the last 180 days.
□ Yes □ No	Patient has had one claim for a contraindicated drug in the last 30 days. (PLEASE NOTE: Contraindicated drugs include: Cimzia, Enbrel, Humira, Kineret.)
□ Yes □ No	Patient has failed a 30-day treatment trial with at least one preferred agent(s) within the past 180 days. (PLEASE NOTE: The preferred agents include Enbrel and Humira.)

□ Yes □ No	Patient has a documented allergy or contraindication to preferred agents in this class. (PLEASE NOTE: The preferred agents include Enbrel and Humira.)
□ Yes □ No	Patient is being treated for stage-four advanced, metastatic cancer and associated conditions.

For the Texas Medicaid *Preferred Drug List,* please refer to the Texas Medicaid Vendor Drug Program website at: **http://www.txvendordrug.com/formulary/preferred-drugs.shtml**.

9. Physician signature

_____ _____

Prescriber or authorized signature Date

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations and exclusions. The submitting provider certifies that the information provided is true, accurate and complete and the requested services are medically indicated and necessary to the health of the patient.
Note: Payment is subject to member eligibility. Authorization does not guarantee payment.