



**SIMPONI® (golimumab)
PRIOR REVIEW/CERTIFICATION FAXBACK FORM**

**INCOMPLETE FORMS MAY DELAY PROCESSING
ALL NC PROVIDERS MUST PROVIDE THEIR 5-DIGIT BCBSNC PROVIDER ID# BELOW**

PRESCRIBER INFORMATION		PATIENT INFORMATION
PHYSICIAN NAME	PROVIDER ID/TAX ID (if out of state must have tax ID)	PATIENT NAME
CONTACT PERSON/PRACTICE NAME		PATIENT'S BCBSNC ID
PRACTICE PHONE	PRACTICE FAX	PATIENT'S DATE OF BIRTH
PRACTICE ADDRESS	CITY	STATE ZIP

Please answer the following questions: Dx code: _____

- Has the patient been screened for the presence of latent TB infection? Yes No
- Has the patient **previously used either etanercept (Enbrel®) or adalimumab (Humira®)** and such drug was ineffective in treating the patient's condition or was not tolerated? Yes No
- Will the patient be receiving treatment with more than one biologic agent at the same time? (e.g., Enbrel®, Humira®, Kineret®, Cimzia®, Remicade®, Orencia® or Rituxan®)? Yes No
- For which of the following conditions is Simponi being prescribed? *Please check one and answer the associated questions.*
 - Ankylosing Spondylitis**
 - Moderate to Severe Rheumatoid Arthritis or Active Psoriatic Arthritis**
 - Has the patient experienced a therapeutic failure/inadequate response with methotrexate (MTX) or has a contraindication? Yes No

OR

 - Is the patient being treated for rapidly progressive and advancing disease? Yes No

Other Pertinent Information: _____

****PLEASE NOTE: If you are prescribing greater than 50 mg of Simponi every 30 days, please complete and sign*
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Please certify the following by signing and dating below:

I certify that I have been authorized to request prior review and certification for the above requested service(s). I further certify that my patient's medical records accurately reflect the information provided. I understand that BCBSNC may request medical records for this patient at any time in order to verify this information. I further understand that if BCBSNC determines this information is not reflected in my patient's medical records, BCBSNC may request a refund of any payments made and/or pursue any other remedies available.

Prescriber's Signature (Required): _____ Date: _____

For BCBSNC members, fax form to 1-800-795-9403



**COMPLETE PAGE 2 ONLY IF REQUESTING A QUANTITY LIMIT
EXCEPTION FOR SIMPONI**

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PRACTICE PHONE	PRACTICE FAX	PATIENT'S DATE OF BIRTH
PRACTICE ADDRESS	CITY	STATE ZIP

If you are requesting a quantity above the amount listed, check the appropriate box and provide the medical necessity of the increased dosage requested.

***Please note:** This medication requires a **prior authorization** before a quantity limit override can be considered. Before submitting a request for a quantity level override, please ensure that a prior approval authorization has been submitted and/or approved (page 1). Otherwise, this request will deny.*

Dx Code: _____

Requested drug dose:

greater than 50 mg of Simponi every **30 days**

Provide dosage requested and a description of medical necessity / rationale for this request:

Please certify the following by signing and dating below:

I certify that I have been authorized to request prior review and certification for the above requested service(s). I further certify that my patient's medical records accurately reflect the information provided. I understand that BCBSNC may request medical records for this patient at any time in order to verify this information. I further understand that if BCBSNC determines this information is not reflected in my patient's medical records, BCBSNC may request a refund of any payments made and/or pursue any other remedies available.

Prescriber's Signature (Required): _____ Date: _____

For BCBSNC members, fax form to 1-800-795-9403