



**BlueCross BlueShield
of North Carolina**

SIMPONI™ PRIOR REVIEW AND 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:

1. 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

2. Has the patient been screened for the presence of latent TB?..... Yes No

3. Please check the appropriate diagnosis and answer the related questions:

Ankylosing Spondylitis – (Skip questions 3a and 3b, go directly to question 4)

Rheumatoid Arthritis or Psoriatic Arthritis

3a. Has the patient experienced a therapeutic failure/inadequate response
with Methotrexate (MTX) or has a contraindication?..... Yes No

OR

3b. Is the patient being treated for rapidly progressive and advancing disease?..... Yes No

4. I certify that the above-referenced patient with a diagnosis of rheumatoid arthritis, psoriatic arthritis or ankylosing spondylitis 1) has previously used an alternative formulary drug and the alternative drug has been detrimental to the patient's health or has been ineffective in treating the same condition and, in my opinion as the prescribing physician, is likely to be detrimental to the patient's health or ineffective in treating the condition again; OR 2) formulary alternatives are contraindicated in this patient; OR 3) the patient is being treated for rapidly progressive and advancing disease; OR 4) therapeutic alternatives are not available..... Yes No

Other Pertinent Information: _____

I certify that the above information is accurate and **is documented in the patient's medical record**. I further understand that BCBSNC may request medical records at any time to verify the above-referenced information.

Prescriber's Signature Required: _____ Date: _____

Fax completed form to 1-800-795-9403