Jefferson Health Plans

# *2024 PRIOR AUTHORIZATION REQUEST FORM*

Individual and Family Plans

## Simponi

**Fax back to: (833) 605-4407**

Phone: (215) 991-4300

Jefferson Health Plans 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 (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.**

| **Patient Name:** | **Prescriber Name:** |
|---|---|
| Member Number: | Fax: Phone: |
| Date of Birth: | Office Contact: |
| Line of Business: □ Exchange - PA | NPI: State Lic ID: |
| Address: | Address: |
| City, State ZIP: | City, State ZIP: |
| Primary Phone: | **Specialty/facility name (if applicable):** |

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

| | |
|---|---|
| Drug Name: | |
| Strength: | |
| Directions / SIG: | |

**Please attach any pertinent medical history including labs and information for this member that may support approval.**

**Please answer the following questions and sign.**

Q1. Is this an initial or continuation request?

- ☐ For Initial - Go to 2.
- ☐ For Continuation for RA - Go to 15.
- ☐ For Continuation for PsA - Go to 16.
- ☐ For Continuation for AS or nr-axSpA - Go to 17.
- ☐ For Continuation for UC - Go to 18.

Q2. Is the medication being prescribed by or in consultation with a rheumatologist (for RA, AS, nr-axSpA, PsA), dermatologist (for PsA) or gastroenterologist (for UC)?

☐ Yes ☐ No

Q3. Does the patient have moderately to severely active Rheumatoid Arthritis (RA)?

☐ Yes ☐ No

Q4. Does the patient have active Psoriatic arthritis (PsA)?

☐ Yes ☐ No

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Q5. Does the patient have active Ankylosing spondylitis (AS) or active non-radiographic axial spondyloarthritis (nr-axSpA)?

☐ Yes ☐ No

Q6. Does the patient have moderately to severely active Ulcerative colitis (UC)?

☐ Yes ☐ No

Q7. Has the patient previously received a biologic or targeted synthetic drug (e.g., Rinvoq, Otezla) indicated for RA with chart notes, medical record documentation, or claims history supporting previous medications tried? Please include the response to therapy.

☐ Yes ☐ No

Q8. Will the requested medication be prescribed in combination with methotrexate or leflunomide, or is there a clinical reason not to use methotrexate or leflunomide? Please provide reason, if applicable.

☐ Yes ☐ No

Q9. Has the patient been tested for RF, Anti-CCP and C-reactive protein (CRP) and/or erythrocyte sedimentation rate (ESR)? Please attach documentation.

☐ Yes ☐ No

Q10. Has the patient previously received a biologic or targeted synthetic drug (e.g., Rinvoq, Otezla) indicated for PsA with chart notes, medical record documentation, or claims history supporting previous medications tried? Include response to therapy.

☐ Yes ☐ No

Q11. Does the patient have mild to moderate disease and meets one of the following: A) The patient has had an inadequate response to methotrexate, leflunomide, or another conventional synthetic drug (e.g., sulfasalazine) administered at an adequate dose and duration. B) The patient has an intolerance or contraindication to methotrexate, leflunomide, or another conventional synthetic drug (e.g., sulfasalazine). C) The patient has enthesitis or predominantly axial disease? Attach chart notes, medical record documentation, or claims history supporting

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previous medications tried. Include response to therapy or documentation of clinical reason to avoid therapy.

☐ Yes ☐ No

Q12. Does the patient have severe disease?

☐ Yes ☐ No

Q13. Has the patient previously received a biologic or targeted synthetic drug (e.g., Rinvoq, Otezla) indicated for AS or nr-axSpA with chart notes, medical record documentation, or claims history supporting previous medications tried? Include response to therapy.

☐ Yes ☐ No

Q14. Has the patient experienced an inadequate response to at least two non-steroidal anti-inflammatory drugs (NSAIDs) or has an intolerance or contraindication to two or more NSAIDs? Attach chart notes, medical record documentation, or claims history supporting previous medications tried. Include response to therapy or documentation of clinical reason to avoid therapy.)

☐ Yes ☐ No

Q15. For continuation of therapy for RA, has the patient achieved or maintained a positive clinical response as evidenced by disease activity improvement of at least 20% from baseline in tender joint count, swollen joint count, pain, or disability? Please attach chart notes or medical records attached.

☐ Yes ☐ No

Q16. 16. For continuation of therapy for PsA, has the patient achieved or maintained positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition when there is improvement in any of the following from baseline: A) Number of swollen joints; B) Number of tender joints; C) Dactylitis; D) Enthesitis; E) Axial disease; F) Skin and/or nail involvement? Please attach chart notes or medical records attached.

☐ Yes ☐ No

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Q17. For continuation of therapy for AS and nr-axSpA, has the patient achieved or maintained positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition when there is improvement in any of the following from baseline: A) Functional status; B) Total spinal pain; C) Inflammation (e.g., morning stiffness)? Must attach chart notes or medical records attached.

☐ Yes ☐ No

Q18. For continuation of therapy for UC, has the patient achieved or maintained remission? Must attach chart notes or medical records attached.

☐ Yes ☐ No

Q19. Has the patient achieved or maintained a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition when there is improvement in any of the following from baseline: A) Stool frequency; B) Rectal bleeding; C) Urgency of defecation?
Must attach chart notes or medical records attached.

☐ Yes ☐ No

Q20. Additional Information:

_____ _____

Prescriber Signature Date

2024 Prior Authorization Request