



SIMPONI® (golimumab) - Prior Authorization/Prescription/Patient Enrollment Form

Complete form in its entirety and fax to number listed below

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PATIENT INFORMATION

Last Name		First Name	Middle Initial
Date of Birth	Sex M <input type="checkbox"/> F <input type="checkbox"/>	Medicaid ID #	
Allergies: <input type="checkbox"/> NKA or _____			
Street Address			City
State	County	Zip Code	
Home Phone		Cell Phone	
Parent/Guardian		Day Telephone	Night Telephone
Emergency Contact		Relationship	Telephone

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PRESCRIBER INFORMATION

Prescriber's Name		NPI Number	DEA Number
Telephone Number	Fax Number	Hospital/Clinic Name	
Street Address			City
State	County	Zip Code	
Contact Person at Office		Prescriber Specialty	



Fax Completed Form to:
Fax Number: 800-218-3221
Phone Number: 866-843-3604

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Department of Vermont Health Access SIMPONI® (golimumab) PRIOR AUTHORIZATION REQUEST

Patient Diagnosis:
 Rheumatoid Arthritis Psoriatic Arthritis Ankylosing Spondylitis Ulcerative Colitis

If requesting prescriber is not a Rheumatologist, Dermatologist or Gastroenterologist, has one of these specialties been consulted on this case? Yes No

Specialist name: _____ Specialist Type: _____

Initial Request (please complete remainder of form below)
 Subsequent Request: Response/tolerability to Simponi: _____

Please explain outcomes of therapy with Enbrel and/or Humira (DVHA preferred products):

Therapy (and dates)	Reason for discontinuation
_____	_____
_____	_____

List previous medications/therapies tried and failed for this condition:
(include NSAIDs, DMARDs, TNF Blockers: oral and injectable)

Therapy (and dates)	Reason for discontinuation
_____	_____
_____	_____
_____	_____

Prescriber Additional Comments:

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PRESCRIPTION

Dosage Form and Quantity:

Simponi 50 mg/0.5 ml prefilled syringe **OR** prefilled autoinjector Dispense Qty: 1
Sig: Administer 50 mg (1 syringe/autoinjector) subcutaneously once monthly.
Refill X: _____ (50 mg dose for RA, PsA or AS)

Simponi 100 mg/1 ml prefilled syringe **OR** prefilled autoinjector Dispense Qty: **3 or 1**
 Sig: Loading Dose: Administer 200 mg (2 syringe/autoinjector) subcutaneously at Week 0 and then 100 mg (1 syringe/autoinjector) subcutaneously at Week 2.
 Sig: Administer 100 mg (1 syringe/autoinjector) subcutaneously once monthly.
Refill X: _____

Deliver product to: Patient's home MD office Clinic

Prescriber's Signature: _____ **Date:** _____