VERMONT

Department of Vermont Health Access
NOB 1 South, 280 State Drive
Waterbury, Vermont 05671-1010

~Simponi ~

Prior Authorization Request Form

In order for beneficiaries to receive Medicaid coverage for medications that require prior authorization, the prescriber must complete and fax this form to Change Healthcare. Please complete this form in its entirety and sign and date below. Incomplete requests will be returned for additional information. For questions, please contact the Change Healthcare helpdesk at 1-844-679-5363.

Submit request via Fax: 1-844-679-5366

Prescribing physician:
Name: _____
Physician NPI: _____
Specialty: _____
Phone#: _____
Fax#: _____
Address: _____
Contact Person at Office: _____

Beneficiary:
Name: _____
Medicaid ID#: _____
Date of Birth: _____ Sex: _____
Patient's Phone: _____
Pharmacy Name_____
Pharmacy NPI: _____
Pharmacy Phone: _____Pharmacy Fax: _____

The following MUST be completed for MEDICAL BENEFIT requests:
HCPCS J-code or other code: _____
Administering Provider/Facility: Name_____ NPI#_____ Medicaid ID#_____

Patient Diagnosis:

☐ Rheumatoid Arthritis ☐ Psoriatic Arthritis ☐ Ankylosing Spondylitis ☐ Ulcerative Colitis

List previous medications/therapies tried and failed for this condition: (include oral/injectable, topical, phototherapy etc.)

Name of medication	Type of failure	Date
_____	_____	_____
_____	_____	_____
_____	_____	_____

Dosage Form and Quantity:

☐ Simponi 50mg/0.5ml ☐prefilled syringe OR ☐prefilled autoinjector Dispense Qty: __1__

☐ Sig: Administer 50mg (1 syringe/autoinjector) subcutaneously once monthly (50mg dose for RA, PsA, or AS)

☐ Simponi 100mg/1ml ☐prefilled syringe OR ☐prefilled autoinjector Dispense Qty: __3 OR 1__
☐ Sig: Loading Dose: Administer 200mg (2 syringe/autoinjector) subcutaneously at Week 0 and then 100mg subcutaneously at Week 2 then 100mg subcutaneously once monthly
☐ Sig: Administer 100mg (1 syringe/autoinjector) subcutaneously once monthly

☐ Simponi Aria IV Solution 50mg/4mL ☐ 2mg/kg IV at weeks 0 and 4, then every 8 weeks thereafter

Patient Weight: _____

Prescribers Additional Comments:

_____

By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in your medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.

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

CHANGE HEALTHCARE