



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# \_\_\_\_\_

Please check box if this drug is being provided under the DVHA's 340B Drug program and requires the TB modifier

**Patient Diagnosis:**

- Rheumatoid Arthritis     Psoriatic Arthritis     Ankylosing Spondylitis

**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:

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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:** \_\_\_\_\_

