

**Health New England**  
**Medication Request Form (MRF) /Prescription Request**  
**Simponi® (golimumab)**

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Contacted:
Physician:
Pharmacy:
Patient:

**Prior Authorization**

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Approved:
Quantity approved:
PA from and thru date:
PA #
Denied:
Returned:

**Instructions:**

This form is to be used by participating physicians and pharmacy providers to obtain coverage of Simponi®. Please complete this form and fax to ICORE Healthcare at (866)-364-2673. If you have any questions regarding this process, please contact ICORE Healthcare at (800) 775-5138.

**Medication Request Information (please complete each section of this form prior to transmittal):**

Patient Information (all required)	Physician Information (all required)
<b>Patient Name:</b>	<b>Physician Name:</b>
	<b>Specialty:</b>
<b>Patient Cell Phone #: (    )    -</b>	<b>NPI#:</b>
<b>Patient HNE ID#:</b>	<b>HNE Provider #:</b>
<b>Patient Date of Birth:</b>	<b>DEA #:</b>
<b>Diagnosis:</b>	<b>Telephone #: (    )    -</b>
<b>Allergies:</b>	<b>Fax #: (    )    -</b>

**Drug Information**

**Requested Drug/Strength/Form: Simponi® 50mg / 0.5ml Syringe**

<b>Dose, Directions, and length of treatment (please be specific):</b>	<b>Quantity (per month):</b>	<b>Refills:</b>
<input type="checkbox"/> Initial Treatment <input type="checkbox"/> Retreatment : 50 mg Subcutaneously	1 dose per month	

<b>Physician Signature:</b>	<b>Date:</b>
-----------------------------	--------------

**Indication:**

Rheumatoid arthritis (RA) in combination with methotrexate

Psoriatic arthritis either alone or in combination with methotrexate

Ankylosing spondylitis either alone or in combination with methotrexate

**Documentation of Medical Criteria:**

Patient seen by a Rheumatologist within the previous 12 months

Request is for continuation of therapy

Patient is intolerant to or failed therapy of at least one (1) DMARD or immunomodulator (including sulfasalazine, NSAIDs, hydroxychloroquine, aurothioglucose, auranofin, gold sodium thiomalate, azathioprine, d-penicillamine, cyclosporine, infliximab, etanercept, leflunomide, or anakinra).

Patient failed or experienced intolerable side effects to Enbrel® and/or Humira®

Active infections have been excluded (required). (including but not limited to chronic or localized infections, histoplasmosis, cytomegalovirus, tuberculosis, HIV)

Pregnancy has been excluded or if female is of child-bearing age appropriate contraception is being utilized (use with caution)

The patient will not be concurrently receiving, Humira® (adalimumab), Kineret® (anakinra), Cimzia® (certolizumab), Enbrel® (etanercept), Remicade® (infliximab), or Orencia® (abatacept))

**Other Pertinent History (relative or pertaining to this request):**