# Medical drug benefit
# Prior authorization request

WellSense HEALTH PLAN

## Simponi Aria

Version20 Effective: 07/11/2023

Phone: 877-417-1839 (NH Medicaid)
Fax: 866-539-7185

* Some plans might not accept this form for Medicare or Medicaid requests

| **This form is being used for:** | |
|---|---|
| Check if Expedited Review/Urgent Request: | ☐ (In checking this box, I attest to the fact that this request meets the definition and criteria for expedited review and is an urgent request.) |

| **1. Patient Information** | |
|---|---|
| Patient Name: | DOB: |
| Member ID #: | |

| **2. Prescriber Information** | |
|---|---|
| Prescribing Clinician: | Phone #: |
| Specialty: | Secure Fax #: |
| NPI #: | DEA/xDEA: |
| Prescriber Point of Contact Name (POC) (if different than provider): | |
| POC Phone #: | POC Secure Fax #: |
| POC Email (not required): | |
| Prescribing Clinician or Authorized Representative Signature: | Date: |

| **3. Requested dosing** |
|---|
| Please document the requested dosing: |

## 4. Concurrent use

Will the member be using the requested medication concurrently with a biologic or a targeted synthetic DMARD?

☐ Yes

☐ No

## 5. Ulcerative colitis

Does the member have ulcerative colitis?

☐ Yes

☐ No

## 6. Diagnosis

Please choose the appropriate diagnosis:

☐ Ankylosing Spondylitis (proceed to Q9)

☐ Juvenile idiopathic arthritis (proceed to Q7)

☐ Psoriatic arthritis (proceed to Q9)

☐ Rheumatoid arthritis (proceed to Q8)

☐ Other, please indicate diagnosis below and include supporting clinical documentation for use in this indication and attached applicable chart notes in faxed request.

## 7. Juvenile idiopathic arthritis

Please choose **all** of the following that apply: (Proceed to Q9)

☐ Member has tried one other medication for this condition (e.g. methotrexate, sulfasalazine, or leflunomide, or an NSAID)

☐ Member has an aggressive disease

☐ Other, please specify:

## 8. For rheumatoid arthritis

Please choose **all** of the following that apply (proceed to Q9):

☐ Member has tried one conventional synthetic DMARD for at least 3 months (e.g. methotrexate, leflunomide, hydroxychloroquine, and sulfasalazine)

☐ Other (please specify)

## 9. Prescriber's specialty

Please indicate what specialty the prescriber is (select any that apply):

☐ Rheumatologist

☐ Other (please indicate what specialty):

## 10. Initial or Continuing Therapy

Is the request for initial or continuing therapy?

☐ Initial (Proceed to Q13)

☐ Continuation (Proceed to Q11)

## 11. Continuation of therapy

Has the member had a response to therapy?

☐ Yes (proceed to Q12)

☐ No

## 12. Appropriate response to therapy

Please choose the appropriate response to therapy



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| | |
|---|---|
| ☐ Decreased pain or stiffness | ☐ Decreased duration of morning stiffness or fatigue |
| ☐ Decreased itching or burning | ☐ Decreased stool frequency |
| ☐ Decreased blood in stool | ☐ Decreased joint pain or morning stiffness |
| ☐ Decreased soft tissue swelling in joints or tendon sheaths | ☐ Improvement in limitation of motion |
| ☐ Improved function or activities of daily living | ☐ Improved laboratory values |
| ☐ Improvements in C-reactive protein | ☐ Reduced dosage of corticosteroids |
| ☐ Other, please specify: | |

## 13. HCPCS Codes

Please document the applicable HCPCS codes (e.g. J codes or Q codes) being requested, including the number of units and number of visits *(using the space below):*

- ☐ HCPCS / Qcodes:
- ☐ Number of units:
- ☐ Number of visits:

**Providers should consult the health plan's coverage policies, member benefits, and medical necessity guidelines to complete this form. Providers may attach any additional data relevant to medical necessity criteria.**