Blue Cross Blue Shield/Blue Care Network of Michigan
Medication Authorization Request Form
SIMPONI ARIA® (golimumab) J1602

Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

This form is to be used by participating physicians to obtain coverage for SIMPONI ARIA®. For commercial members only, please complete this form and submit via fax to 1-877-325-5979. If you have any questions regarding this process, please contact BCBSM Provider Relations and Servicing or the Medical Drug Helpdesk at 1-800-437-3803 for assistance.

PATIENT INFORMATION	PHYSICIAN INFORMATION
Name	**Name**
ID Number	**Specialty**
D.O.B. ☐Male ☐Female **Pt weight (in kg)** **Date recorded:**_____	**Address**
Diagnosis	**City /State/Zip**
Drug Name	**Phone/Fax: P**: ( ) - **F**: ( ) -
Dose and Quantity	**NPI**
Directions	**Contact Person**
Date of Service(s)	**Contact Person Phone / Ext.**

STEP 1: DISEASE STATE INFORMATION

1. Is this request for: ☐ Initiation ☐ Continuation *Date patient started therapy:* _____
2. Site of administration? ☐ Provider office/Home infusion ☐ Other: _____
   ☐ Hospital outpatient facility (go to #3) *Reason for Hospital Outpatient administration:* _____
3. **Please specify location of administration if hospital outpatient infusion: _____**
4. **Please provide the NPI number for the place of administration: _____**

5. **Initiation AND Continuation of therapy:**
   a. Please check patient's diagnosis:
      ☐ Rheumatoid arthritis (RA)
      ☐ Polyarticular juvenile idiopathic arthritis
      ☐ Psoriatic arthritis
      ☐ Ankylosing spondylitis
      ☐ Other, list diagnosis: _____
   b. Has the patient tried and failed therapy with at least one conventional therapy?
      ☐ Methotrexate, Date started: _____ Date ended: _____
      ☐ Sulfasalazine, Date started: _____ Date ended: _____
      ☐ Hydroxychloroquine, Date started: _____ Date ended: _____
      ☐ Leflunomide, Date started: _____ Date ended: _____
      ☐ Cyclosporine, Date started: _____ Date ended: _____
      ☐ Other: _____, Date started: _____ Date ended: _____
   c. **For RA indication:** Will the patient use Methotrexate along with Simponi Aria? ☐ yes ☐ no, Provide rationale: _____
   d. Will the patient be receiving Simponi Aria with other biologic agents (for example: Remicade, Humira, Stelara, Cosentyx, Entyvio, or Tremfya, etc.) or targeted DMARD medications (for example: Otezla)?
      ☐ Yes, Comment: _____ ☐ No

6. **Continuation Request: Simponi Aria start date: _____**
   a. Have the patient's signs and symptoms improved with Simponi Aria?
      ☐ Yes ☐ No, Comment: _____

Please add any other supporting medical information necessary for our review

Coverage will not be provided if the prescribing physician's signature and date are not reflected on this document.

☐ Request for expedited review: I certify that applying the standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function

Physician's Name	**Physician Signature**	**Date**

Step 2: Checklist	☐ Form Completely Filled Out ☐ Attached Chart Notes	☐ Prior Treatments with traditional DMARD
Step 3: Submit	**By Fax: BCBSM Specialty Pharmacy Mailbox 1-877-325-5979**	**By Mail: BCBSM Specialty Pharmacy Program P.O. Box 312320, Detroit, MI 48231-2320**

01/21/14; 10/19/2015; 11/9/2016; 12/28/2016; 8/11/2017;12/5/2017; 2/2/2018; 7/24/2018, 9/18/2018; 3/7/2019; 12/3/2021