



PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Simponi

Fax back to: (833) 605-4407

Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	Prescriber Name:
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: <input type="checkbox"/> Exchange - PA	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	Specialty/facility name (if applicable):

REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval.

Please answer the following questions and sign.

Q1. Is this an initial or continuation request? For initial, go to 2.

- For continuation for RA, go to 21.
- For continuation for PsA go to 22.
- For continuation for AS or nr-axSpA go to 23.
- For continuation for UC go to 24.
- For continuation of immune checkpoint inhibitor-related toxicity go to 26.

Q2. Is the medication being prescribed by or in consultation with a rheumatologist (for RA, AS, nr-axSpA, PsA, immune checkpoint inhibitor-related toxicity), dermatologist (for PsA), gastroenterologist (for UC), or oncologist/hematologist for immune checkpoint inhibitor-related toxicity?

- Yes No

Q3. Does the patient have moderately to severely active Rheumatoid Arthritis (RA)? If YES, go to 8. If NO, go to 4.

- Yes No



PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Simponi

Fax back to: (833) 605-4407

Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	Prescriber Name:
Q4. Does the patient have active Psoriatic arthritis (PsA)? If YES, go to 14. If NO, go to 5. <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q5. Does the patient have active Ankylosing spondylitis (AS) or active non-radiographic axial spondyloarthritis (nr-axSpA)? If YES, go to 17. If NO, go to 6. <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q6. Does the patient have moderately to severely active Ulcerative colitis (UC)? If YES, go to 27. If NO, go to 7. <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q7. Does the patient have immune checkpoint inhibitor-related toxicity? If YES, go to 19. <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q8. For moderately to severely active RA, has the patient tested positive for Rheumatoid factor (RF), anti-cyclic citrullinated peptide (anti-CCP) OR has been tested for RF, Anti-CCP, and C-reactive protein (CRP) and/or erythrocyte sedimentation rate (ESR)? Please attach documentation. <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q9. For RA, has the patient within the past 120 days received a biologic or targeted synthetic drug (e.g., Rinvoq, Otezla) indicated for RA with chart notes, medical record documentation, or claims history supporting previous medications tried? Include response to therapy. If YES, go to 13. If NO, go to 10. <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q10. The member has failed to achieve a low disease activity after a 3-month trial of methotrexate (MTX) monotherapy at a maximum titrated dose of at least 15 mg per week and meets any of the following conditions. If YES, go to 13. If NO, go to 11.	



PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Simponi

Fax back to: (833) 605-4407

Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:

Prescriber Name:

- Member has had a documented inadequate response to MTX in combination with or at least one other conventional synthetic drug (i.e., hydroxychloroquine and/or sulfasalazine) after a 3-month trial at a maximum tolerated dose(s).
- Member has experienced a documented intolerable adverse event to hydroxychloroquine or sulfasalazine.
- Member has a documented contraindication to hydroxychloroquine (see Appendix) and sulfasalazine (e.g., porphyria, intestinal or urinary obstruction).
- Member has moderate to high disease activity.

Q11. The member was unable to tolerate a 3-month trial of MTX monotherapy at a maximum titrated dose of at least 15 mg per week and meets any of the following conditions. If YES, go to 13. If NO, go to 12.

- Member has had a documented inadequate response to MTX in combination with at least one other conventional synthetic drug (i.e., hydroxychloroquine and/or sulfasalazine) after a 3-month trial at a maximum tolerated dose(s).
- Member has stopped taking MTX and has had a documented inadequate response to another conventional synthetic drug (i.e., leflunomide, hydroxychloroquine, and/or sulfasalazine) alone or in combination after a 3-month trial at a maximum tolerated dose(s).
- Member has experienced a documented intolerable adverse event to leflunomide, hydroxychloroquine, or sulfasalazine.
- Member has a documented contraindication to leflunomide, hydroxychloroquine (see Appendix), and sulfasalazine (e.g., porphyria, intestinal or urinary obstruction).
- Member has moderate to high disease activity.

Q12. The member has experienced a documented intolerable adverse event or has a documented contraindication to MTX (see Appendix), discontinues MTX, and meets any of the following conditions:

- Member has had a documented inadequate response to another conventional synthetic drug (i.e., leflunomide, hydroxychloroquine, and/or sulfasalazine) alone or in combination after a 3-month trial at a maximum tolerated dose(s).
- Member has experienced a documented intolerable adverse event to leflunomide, hydroxychloroquine, or sulfasalazine.
- Member has a documented contraindication to leflunomide, hydroxychloroquine (see Appendix), and sulfasalazine (e.g., porphyria, intestinal or urinary obstruction).



PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Simponi

Fax back to: (833) 605-4407

Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	Prescriber Name:
<input type="checkbox"/> Member has moderate to high disease activity.	
Q13. Will the requested medication be prescribed in combination with methotrexate or leflunomide, or is there a clinical reason not to use methotrexate or leflunomide? Please provide reason, if applicable. If YES, go to 27.	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Q14. For PsA, has the patient previously received a biologic or targeted synthetic drug (e.g., Rinvoq, Otezla) indicated for PsA with chart notes, medical record documentation, or claims history supporting previous medications tried? Include response to therapy. If YES, go to 27. If NO, go to 15.	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Q15. Does the patient have mild to moderate disease and meets one of the following?: (Attach chart notes, medical record documentation, or claims history supporting previous medications tried. Include response to therapy or documentation of clinical reason to avoid therapy.) If YES, go to 27. If NO, go to 16.	
<input type="checkbox"/> The patient has had an inadequate response to methotrexate, leflunomide, or another conventional synthetic drug (e.g., sulfasalazine) administered at an adequate dose and duration.	
<input type="checkbox"/> The patient has an intolerance or contraindication to methotrexate, leflunomide, or another conventional synthetic drug (e.g., sulfasalazine).	
<input type="checkbox"/> The patient has enthesitis or predominantly axial disease.	
Q16. Does the patient have severe disease? If YES, go to 27.	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Q17. Has the patient previously received a biologic or targeted synthetic drug (e.g., Rinvoq, Otezla) indicated for AS or nr-axSpA with chart notes, medical record documentation, or claims history supporting previous medications tried? Include response to therapy. If YES, go to 27. If NO, go to 18.	



PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Simponi

Fax back to: (833) 605-4407

Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	Prescriber Name:
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q18. Has the patient experienced an inadequate response to at least two non-steroidal anti-inflammatory drugs (NSAIDs) or has an intolerance or contraindication to two or more NSAIDs. (Attach chart notes, medical record documentation, or claims history supporting previous medications tried. Include response to therapy or documentation of clinical reason to avoid therapy.) If YES, go to 27.	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q19. For immune checkpoint inhibitor-related toxicity, Has the patient experienced an inadequate response to corticosteroids or a conventional synthetic drug (e.g., methotrexate, sulfasalazine, leflunomide, hydroxychloroquine)? If YES, go to 27 If NO, go to 20.	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q20. Has the patient experienced an intolerance or contraindication to corticosteroids and a conventional synthetic drug (e.g., methotrexate, sulfasalazine, leflunomide, hydroxychloroquine). If YES, go to 27.	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q21. For continuation of therapy for RA, has the patient achieved or maintained a positive clinical response as evidenced by disease activity improvement of at least 20% from baseline in tender joint count, swollen joint count, pain, or disability (chart notes or medical records attached). If YES, go to 27.	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q22. For continuation of therapy for PsA, has the patient achieved or maintained positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition when there is improvement in any of the following from baseline (chart notes or medical records attached):	
If YES, go to 27.	
<input type="checkbox"/> Number of swollen joints	
<input type="checkbox"/> Number of tender joints	

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document

Simponi

Fax back to: (833) 605-4407

Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	Prescriber Name:
----------------------	-------------------------

- Dactylitis
- Enthesitis
- Axial disease
- Skin and/or nail involvement
- Functional status
- C-reactive protein (CRP)

Q23. For continuation of therapy for AS and nr-axSpA, has the patient achieved or maintained positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition when there is improvement in any of the following from baseline (chart notes or medical records attached):

If YES, go to 27.

- Functional status
- Total spinal pain
- Inflammation (e.g., morning stiffness)
- Swollen joints
- Tender joints
- C-reactive protein (CRP)

Q24. For continuation of therapy for UC, has the patient achieved or maintained remission (chart notes or medical records attached)? If YES, go to 27. If NO, go to 25.

- Yes No

Q25. Has the patient achieved or maintained a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition when there is improvement in any of the following from baseline (chart notes or medical records attached):

If YES, go to 27.

- Stool frequency
- Rectal bleeding
- Urgency of defecation



PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Simponi

Fax back to: (833) 605-4407

Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	Prescriber Name:
<input type="checkbox"/> C-reactive protein (CRP) <input type="checkbox"/> Fecal calprotectin (FC) <input type="checkbox"/> Appearance of the mucosa on endoscopy, computed tomography enterography (CTE), magnetic resonance enterography (MRE), or intestinal ultrasound <input type="checkbox"/> Improvement on a disease activity scoring tool (e.g., Ulcerative Colitis Endoscopic Index of Severity [UCEIS], Mayo score)	
Q26. For immune checkpoint inhibitor-related toxicity, has the patient achieved or maintained a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q27. Has the member had a documented negative TB test (which can include a tuberculosis skin test [TST] or an interferon-release assay [IGRA]) within 6 months of initiating therapy for persons who are naive to biologic drugs or targeted synthetic drugs associated with an increased risk of TB? If YES, go to 30. If NO, go to 28. <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q28. If TB test was positive, has active TB been ruled out (e.g., chest x-ray)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q29. If latent TB is present, has treatment been initiated before starting the requested medication? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q30. Is the member using the requested medication concurrently with another biologic or targeted synthetic drug? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q31. Additional Information:	



PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Simponi

Fax back to: (833) 605-4407

Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	Prescriber Name:
----------------------	-------------------------

Prescriber Signature

Date

v2026