

**Physician's Prior Authorization Questionnaire
Simponi™**

Patient:

ID#:

DOB:

Patient Address:

Simponi™ is covered under certain clinical conditions. The following information will help determine if this patient is eligible for coverage of treatment with this drug.

1. What is the patient's diagnosis? *(Please do not use codes.)* _____

2. Is the disease: Mild Moderate Severe

3. Will the patient be taking other biological DMARDs at the same time as Simponi™? Yes No

4. Will the patient be taking any other medications for this diagnosis at the same time as Simponi™?
 Yes No

If Yes, please list: _____

*Quantity limits will be applied according to the dosing listed in the
manufacturer's prescribing information.*

Coverage will not be available for more than one (1) month's supply at a time.

Simponi™ will be shipped to the patient from our Specialty Pharmacy.

Physician's Signature

Date

Please **Print** Physician's Name & Specialty

Phone Number

Fax Number

Thank you for your assistance and should you have any questions or wish to discuss, please feel free to contact the pharmacy department at (501) 378-3392. For your convenience, you may fax your response(s) back to (501) 378-6980.

Forms are also available online at www.usableadmin.com/providers/PharmacyForms.aspx