

## MEDICARE FORM

## Simponi Aria® (golimumab) Infusion **Medication Precertification Request**

For Ohio MMP:

FAX.

1-855-734-9389

PHONE: 1-855-364-0974

please use other form.

For other lines of business:

Page 1 of 2

Note: Simponi Aria is preferred for MA plans and non-preferred for (All fields must be completed and legible for precertification review.) MAPD plans. Preferred products Please indicate: ☐ Start of treatment: Start date / vary based on indication. See section G below. Continuation of therapy: Date of last treatment / / Phone: \_\_\_\_ Precertification Requested By: A. PATIENT INFORMATION First Name: Last Name DOB. State: ZIP: Address: City: Home Phone: Work Phone: Cell Phone: Email: Current Weight: \_\_\_\_\_ lbs or \_\_\_\_\_ kgsHeight: \_\_\_\_\_ inches or \_\_\_\_\_ cms | Allergies: **B. INSURANCE INFORMATION** Aetna Member ID #: Does patient have other coverage? Group #: \_\_\_\_\_ If yes, provide ID#: \_\_\_\_\_ Carrier Name: \_\_\_\_ Insured: Insured: **Medicare**: ☐ Yes ☐ No If yes, provide ID #: **Medicaid**: ☐ Yes ☐ No If yes, provide ID #: C. PRESCRIBER INFORMATION First Name: Last Name: (Check One): M.D. D.O. N.P. P.A. Address: City: State: ZIP: Phone: Fax: St Lic #: NPI#: DEA #: UPIN: Provider Email: Office Contact Name: Phone: Specialty (Check one): ☐ Dermatologist ☐ Rheumatologist Other: D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION Place of Administration: Dispensing Provider/Pharmacy: Patient Selected choice ☐ Self-administered ☐ Physician's Office ☐ Physician's Office ☐ Retail Pharmacy Outpatient Infusion Center Phone: \_\_\_\_\_ ☐ Specialty Pharmacy Other Center Name: Name: Home Infusion Center Phone: Agency Name: City: \_\_\_\_\_ State: \_\_\_\_ ZIP: \_\_\_\_\_ Administration code(s) (CPT): Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Address: State: ZIP: City: **TIN:** \_\_\_\_\_\_ PIN: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E. PRODUCT INFORMATION Request is for Simponi Aria (golimumab): Dose: Frequency: **F. DIAGNOSIS INFORMATION** – Please indicate primary ICD Code and specify any other where applicable. Secondary ICD Code: G. CLINICAL INFORMATION - Required clinical information must be completed in its entirety for all precertification requests. For All Requests (clinical documentation required for all requests): Note: Simponi Aria is a preferred product for MA Plans. Enbrel. Humira, Keyzara, Otezla, Rinyog, Skyrizi, and Xelianz/Xelianz XR are the preferred products for MAPD plans. Preferred products vary based on indication. ☐ Yes ☐ No Has the patient had prior therapy with Simponi Aria (golimumab) within the last 365 days? ☐ Yes ☐ No Has the patient had a trial and failure, intolerance, or contraindication to any of the following? (select all that apply) ☐ Enbrel (etanercept) ☐ Humira (adalimumab) ☐ Kevzara (sarilumab) ☐ Otezla (apremilast) ☐ Rinvoq (upadacitinib) ☐ Skyrizi (risankizumab-rzaa) ☐ Xeljanz/Xeljanz XR (tofacitinib) Please explain if there are any other medical reason(s) that the patient cannot use any of the following preferred products when indicated for the patient's diagnosis (select all that apply). ☐ Enbrel (etanercept) ☐ Humira (adalimumab) ☐ Kevzara (sarilumab) ☐ Otezla (apremilast) ☐ Rinvoq (upadacitinib) ☐ Skyrizi (risankizumab-rzaa) ☐ Xeljanz/Xeljanz XR (tofacitinib)

☐ Yes ☐ No Will the requested drug be used in combination with any other biologic or targeted synthetic disease-modifying anti-rheumatic drug (DMARD)

Continued on next page

(e.g., Olumiant, Xeljanz)?



## **MEDICARE FORM**

## Simponi Aria® (golimumab) Infusion Medication Precertification Request

Page 2 of 2

(All fields must be completed and legible for precertification review.)

For Ohio MMP:

**FAX:** 1-855-734-9389 **PHONE:** 1-855-364-0974

For other lines of business:

please use other form.

Note: Simponi Aria is preferred for MA plans and non-preferred for MAPD plans. Preferred products vary based on indication. See section G.

Patient First Name	Patient Last Name	Patient Phone	Patient DOB
G. CLINICAL INFORMATION - Required clinical information must be completed for ALL precertification requests.			
Yes   No			
Please select: ☐ treatment initiated ☐ treatment completed  For initiation Requests;			
Ankylosing spondylitis			
☐ Yes ☐ No Has the patient been diagnosed with active ankylosing spondylitis (AS)?			
☐ Yes ☐ No Has the patient previously received a biologic indicated for active ankylosing spondylitis?			
Yes No Has the patient experienced an inadequate response with at least TWO nonsteroidal anti-inflammatory drugs (NSAIDs), or has an intolerance or contraindication to at least two NSAIDs?			
Psoriatic arthritis			
Yes No Has the patient been diagnosed with active psoriatic arthritis (PsA)?			
Rheumatoid arthritis			
Yes No Has the patient been diagnosed with moderately to severely active rheumatoid arthritis (RA)?			
Yes No Is the requested medication being prescribed in combination with methotrexate?			
Please indicate a clinical reason for the patient to not use methotrexate:  History of intolerance or adverse event Alcoholism, alcoholic liver disease or other chronic liver disease  Elevated liver transaminases Interstitial pneumonitis or clinically significant pulmonary fibrosis  Renal impairment Pregnancy or planning pregnancy Breastfeeding Blood dyscrasias (e.g., thrombocytopenia, leukopenia, significant anemia)  Myelodysplasia Hypersensitivity Significant drug interaction Other No clinical reason not to use methotrexate or leflunomide			
For Other or No clinical reason not to use methotrexate or leflunomide:			
☐ Yes ☐ No Has the patient previously received a biologic or targeted synthetic disease modifying drug (e.g., Xeljanz) indicated for moderately to severely active rheumatoid arthritis?			
Yes No Has the patient experienced an inadequate response after at least 3 months of treatment with methotrexate titrated to 20 mg per week?			
	Has the patient experienced intolerance to methotrexate  Yes No Does the patient have a contraindication: Please indicate the contraindication: Alcoholism, alcoholic liver diseas Transaminases Interstitial pneu Renal impairment Pregnancy Blood dyscrasias (e.g., thrombod Myelodysplasia Hypersensiti	tion to methotrexate?  History of intolerance e or other chronic liver dis monitis or clinically signific y or planning pregnancy ytopenia, leukopenia, signitity USignificant drug i	sease
For Continuation Requests:			
☐ Yes ☐ No ☐ Unknown Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program? ☐ Yes ☐ No ☐ Has the patient achieved or maintained positive clinical response as evidenced by low disease activity or improvement in signs and symptoms since starting treatment with the requested drug?			
H. ACKNOWLEDGEMENT			
Request Completed By (Signature Required	t):	r	Date://
Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.			

The plan may request additional information or clarification, if needed, to evaluate requests.