aetna®

MEDICARE FORM

Simponi Aria® (golimumab) Infusion Medication Precertification Request

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

For Medicare Advantage Part B:
Phone: 1-866-503-0857 (TTY: 711)
FAX: 1-844-268-7263

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 below.

Please indicate: ☐ Start of treatment: Start date ____/____/____
☐ Continuation of therapy: Date of last treatment ____/____/____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:	Last Name:	DOB:	
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	Email:
Current Weight: ____ lbs or ____ kgs Height: ____ inches or ____ cms		Allergies:	

B. INSURANCE INFORMATION

Aetna Member ID #: _____
Group #: _____
Insured: _____

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
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:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____
City: _____ State: _____ ZIP: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____
NPI: _____

Dispensing Provider/Pharmacy: *Patient Selected choice*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Other _____
Name: _____
Address: _____
City: _____ State: _____ ZIP: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____
NPI: _____

E. PRODUCT INFORMATION

Request is for Simponi Aria (golimumab):
Dose: _____ **Frequency:** _____ **HCPCS Code:** _____

F. DIAGNOSIS INFORMATION – Please indicate primary ICD Code and specify any other where applicable.

Primary ICD Code: _____ Secondary ICD Code: _____ Other 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, Kevzara, Otezla, Rinvoq, Skyrizi, Stelara, Tremfya and Xeljanz/ Xeljanz 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) ☐ Stelara (ustekinumab) ☐ Tremfya (guselkumab) ☐ 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) ☐ Stelara (ustekinumab) ☐ Tremfya (guselkumab) ☐ 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) (e.g., Olumiant, Xeljanz)?

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

G. CLINICAL INFORMATION *(continued)* – Required clinical information must be completed in its entirety for all precertification requests.

☐ Yes ☐ No Has the patient received a biologic or targeted synthetic DMARD (e.g., Rinvoq, Xeljanz) in the past?
- ☐ Yes ☐ No Has the patient been tested for TB with a PPD test, interferon-release assay (IGRA) or chest x-ray within 6 months of initiating a biologic therapy?
  - (Check all that apply): ☐ PPD test ☐ interferon-gamma assay (IGRA) ☐ chest x-ray
  - Please enter the results of the TB test: ☐ positive ☐ negative ☐ unknown
  - ***If positive,*** Does the patient have latent or active TB? ☐ latent ☐ active ☐ unknown
  - ***If latent TB,*** ☐ Yes ☐ No Has treatment for latent tuberculosis (TB) infection been initiated or completed?
    - Please select: ☐ treatment initiated ☐ treatment completed
- ☐ Yes ☐ No Does the patient have risk factors for TB?
  - ☐ Yes ☐ No Has the patient been tested for tuberculosis (TB) within the previous 12 months?
    - (Check all that apply): ☐ PPD test ☐ interferon-gamma assay (IGRA) ☐ chest x-ray
    - Please enter the results of the TB test: ☐ positive ☐ negative ☐ unknown
    - ***If positive,*** Does the patient have latent or active TB? ☐ latent ☐ active ☐ unknown
    - ***If latent TB,*** ☐ Yes ☐ No Has treatment for latent tuberculosis (TB) infection been initiated or completed?
      - Please select: ☐ treatment initiated ☐ treatment completed

For initiation Requests:

Ankylosing spondylitis

☐ Yes ☐ No Has the patient been diagnosed with active ankylosing spondylitis (AS)?

Articular juvenile idiopathic arthritis (Juvenile rheumatoid arthritis)

☐ Yes ☐ No Has the patient been diagnosed with active articular juvenile arthritis?

Immune checkpoint inhibitor-related toxicity

☐ Yes ☐ No Has the patient been diagnosed with immunotherapy-related inflammatory arthritis?

☐ Yes ☐ No Is the disease refractory or severe?
- ☐ Yes ☐ No Has the disease responded to systemic corticosteroids?

Non-radiographic axial spondyloarthritis

☐ Yes ☐ No Has the patient been diagnosed with active non-radiographic axial spondyloarthritis?

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?
  - ☐ Yes ☐ No Has the patient experienced intolerance to methotrexate?
    - ☐ Yes ☐ No Does the patient have a contraindication to methotrexate?
      - Please indicate the contraindication: ☐ 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

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G. CLINICAL INFORMATION *(continued)* – Required clinical information must be completed in its entirety for all precertification requests.

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):* _____ **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.