Simponi Aria® (golimumab) Infusion Medication Precertification Request

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

Aetna Precertification Notification
Phone: 1-866-752-7021
FAX: 1-888-267-3277

For Medicare Advantage Part B:
Please Use Medicare Request Form

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: _____

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

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.

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):

☐ Yes ☐ No Will the requested drug be used in combination with any other biologic (e.g., Humira) or targeted synthetic drug (DMARD) (e.g., Olumiant, Otezla, Xeljanz)?

☐ Yes ☐ No Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic drug (e.g., Olumiant, Xeljanz) associated with an increased risk of tuberculosis?

→ ☐ Yes ☐ No Has the patient had a tuberculosis (TB) test (e.g., tuberculosis skin test [PPD], interferon-release assay [IGRA], chest x-ray) within 6 months of initiating therapy?

→ (Check all that apply): ☐ PPD test ☐ interferon-gamma assay (IGRA) ☐ chest x-ray

Please enter the results of the tuberculosis (TB) test: ☐ positive ☐ negative ☐ unknown

If positive, please indicate which applies to the patient:
☐ latent TB and treatment for latent TB has been initiated
☐ latent TB and treatment for latent TB has been completed
☐ latent TB and treatment for latent TB has not been initiated
☐ active TB

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G. CLINICAL INFORMATION - Required clinical information must be completed for ALL precertification requests.

☐ Yes ☐ No Is this infusion request in an outpatient hospital setting?

→ ☐ Yes ☐ No Has the patient experienced an adverse event with the requested product that has not responded to conventional interventions (e.g., acetaminophen, steroids, diphenhydramine, fluids, other pre-medications or slowing of infusion rate) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after an infusion?

☐ Yes ☐ No Has the patient developed antibodies to infliximab which increases the risk for infusion related reactions?

☐ Yes ☐ No Does the patient have severe venous access issues that require the use of special interventions only available in the outpatient hospital setting?

☐ Yes ☐ No Does the patient have significant behavioral issues and/or physical or cognitive impairment that would impact the safety of the infusion therapy AND the patient does not have access to a caregiver?

→ Please provide a description of the behavioral issue or impairment: _____

☐ Yes ☐ No Is the patient medically unstable which may include respiratory, cardiovascular, or renal conditions that may limit the member's ability to tolerate a large volume or load or predispose the member to a severe adverse event that cannot be managed in an alternate setting without appropriate medical personnel and equipment?

→ Please provide a description of the condition: ☐ Cardiopulmonary: _____
☐ Respiratory: _____
☐ Renal: _____
☐ Other: _____

For initiation Requests (clinical documentation required for all requests):

Ankylosing spondylitis and axial spondyloarthritis

Please indicate loading dose at weeks 0 and 4: _____ Please indicate maintenance dose: _____ frequency: _____weeks

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

→ Please indicate: ☐ Active ankylosing spondylitis (AS) ☐ Active axial spondyloarthritis

☐ Yes ☐ No Is the requested drug being prescribed by or in consultation with a rheumatologist?

☐ Yes ☐ No Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic drug (e.g., Rinvoq, Xeljanz) that is indicated for active ankylosing spondylitis or active axial spondyloarthritis?

→ ☐ 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?

Articular Juvenile Idiopathic Arthritis

Please indicate loading dose at weeks 0 and 4: _____ Please indicate maintenance dose: _____ frequency: _____weeks

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

☐ Yes ☐ No Is the requested drug being prescribed by or in consultation with a rheumatologist?

Please select which of the following applies to the patient: ☐ Oligoarticular juvenile idiopathic arthritis ☐ Polyarticular juvenile idiopathic arthritis

☐ Yes ☐ No Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic drug (e.g., Xeljanz) that is indicated for active articular juvenile idiopathic arthritis?

→ ☐ Yes ☐ No Has the patient had an inadequate response to methotrexate or another conventional synthetic drug (e.g., leflunomide, sulfasalazine, hydroxychloroquine) administered at an adequate dose and duration?

→ ☐ Yes ☐ No Has the patient had an inadequate response to a trial of scheduled non-steroidal anti-inflammatory drugs (NSAIDs) and/or intra-articular glucocorticoids (e.g., triamcinolone hexacetonide)?

→ ☐ Yes ☐ No Does the patient have one of the following risk factors for poor outcome: a) involvement of ankle, wrist, hip, sacroiliac joint, and/or temporomandibular joint (TMJ), b) presence of erosive disease or enthesitis, c) delay in diagnosis, d) elevated levels of inflammation markers, or e) symmetric disease?

☐ Yes ☐ No Does the patient have any of the following risk factors for disease severity and potentially a more refractory disease course: a) positive rheumatoid factor, b) positive anti-cyclic citrullinated peptide antibodies, or c) pre-existing joint damage?

☐ Yes ☐ No Does the patient meet any of the following: a) high-risk joints are involved (e.g., cervical spine, wrist, or hip), b) high disease activity, or c) high risk for disabling joint disease?

Psoriatic arthritis

Please indicate loading dose at weeks 0 and 4: _____ Please indicate maintenance dose: _____ frequency: _____weeks

☐ Yes ☐ No Is the requested drug being prescribed by or in consultation with a rheumatologist or dermatologist?

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

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☐ Yes ☐ No Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic drug (e.g., Rinvoq, Otezla) that is indicated for active psoriatic arthritis?

- ☐ Yes ☐ No Does the patient have mild to moderate disease?
  - ☐ Yes ☐ No Does the patient have severe disease?
- ☐ Yes ☐ No Does the patient have enthesitis or predominantly axial disease?
  - ☐ Yes ☐ No Has the patient had an inadequate response to methotrexate, leflunomide, or another conventional synthetic drug (e.g., sulfasalazine) administered at an adequate dose and duration?
    - ☐ Yes ☐ No Has the patient had an intolerance to methotrexate, leflunomide, or another conventional synthetic drug (e.g., sulfasalazine)?
      - ☐ Yes ☐ No Does the patient have a contraindication to methotrexate or leflunomide?
        - ☐ Yes ☐ No Does the patient have a contraindication to another conventional synthetic drug (e.g., sulfasalazine)?

Please indicate the contraindication:
☐ History of intolerance or adverse event ☐ Renal impairment ☐ Hypersensitivity
☐ Blood dyscrasias (e.g., thrombocytopenia, leukopenia, significant anemia)
☐ Breastfeeding ☐ Elevated liver transaminases ☐ Myelodysplasia
☐ Interstitial pneumonitis or clinically significant pulmonary fibrosis
☐ Pregnancy or currently planning pregnancy ☐ Significant drug interaction
☐ Clinical diagnosis of alcohol use disorder, alcoholic liver disease or other chronic liver disease
☐ Other: _____

Rheumatoid arthritis

Please indicate loading dose at weeks 0 and 4: _____ Please indicate maintenance dose: _____ frequency: _____weeks

☐ Yes ☐ No Has the patient been diagnosed with moderately to severely active rheumatoid arthritis (RA)?

☐ Yes ☐ No Is the requested drug being prescribed by or in consultation with a rheumatologist?

☐ Yes ☐ No Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic drug (e.g., Rinvoq, Xeljanz) indicated for moderately to severely active rheumatoid arthritis?

- ☐ Yes ☐ No Does the patient meet either of the following: a) the patient was tested for the rheumatoid factor (RF) biomarker and the RF biomarker test was positive, or b) the patient was tested for the anti-cyclic citrullinated peptide (anti-CCP) biomarker and the anti-CCP biomarker test was positive?
  - ☐ Yes ☐ No Has the patient been tested for all of the following biomarkers: a) rheumatoid factor (RF), b) anti-cyclic citrullinated peptide (anti-CCP), and c) C-reactive protein (CRP) and/or erythrocyte sedimentation rate (ESR)?
- ☐ Yes ☐ No Is the requested medication being prescribed in combination with methotrexate or leflunomide?

Please indicate a clinical reason for the patient to not use methotrexate or leflunomide: ☐ History of intolerance or adverse event ☐ Clinical diagnosis of alcohol use disorder, alcoholic liver disease or other chronic liver disease ☐ Elevated liver transaminases ☐ Interstitial pneumonitis or clinically significant pulmonary fibrosis ☐ Renal impairment ☐ Pregnancy or currently planning pregnancy ☐ Breastfeeding ☐ Blood dyscrasias (e.g., thrombocytopenia, leukopenia, significant anemia) ☐ Myelodysplasia ☐ Hypersensitivity ☐ Significant drug interaction ☐ Other, please explain: _____

☐ Yes ☐ No Does the patient have other reason or no clinical reason not to use methotrexate or leflunomide?

- ☐ Yes ☐ No Has the patient experienced an inadequate response after at least 3 months of treatment with methotrexate at a dose greater than or equal to 15 mg per week?
  - ☐ Yes ☐ No Has the patient experienced an intolerance to methotrexate or leflunomide?
    - ☐ Yes ☐ No Does the patient have a contraindication to methotrexate or leflunomide?

Please indicate the contraindication: ☐ History of intolerance or adverse event ☐ Clinical diagnosis of alcohol use disorder, alcoholic liver disease or other chronic liver disease ☐ Elevated liver transaminases ☐ Interstitial pneumonitis or clinically significant pulmonary fibrosis ☐ Renal impairment ☐ Pregnancy or currently planning pregnancy ☐ Breastfeeding ☐ Blood dyscrasias (e.g., thrombocytopenia, leukopenia, significant anemia) ☐ Myelodysplasia ☐ Hypersensitivity ☐ Significant drug interaction ☐ Other, please explain: _____

☐ Yes ☐ No Is the requested medication being prescribed in combination with methotrexate or leflunomide?

Please indicate a clinical reason for the patient to not use methotrexate or leflunomide: ☐ History of intolerance or adverse event ☐ Clinical diagnosis of alcohol use disorder, alcoholic liver disease or other chronic liver disease ☐ Elevated liver transaminases ☐ Interstitial pneumonitis or clinically significant pulmonary fibrosis ☐ Renal impairment ☐ Pregnancy or currently planning pregnancy ☐ Breastfeeding ☐ Blood dyscrasias (e.g., thrombocytopenia, leukopenia, significant anemia) ☐ Myelodysplasia ☐ Hypersensitivity ☐ Significant drug interaction ☐ Other, please explain: _____
☐ 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 (clinical documentation required for all requests):

Please indicate maintenance dose: _____ frequency: _____weeks

☐ Yes ☐ No Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program?

For All Conditions (Exception Rheumatoid arthritis)

☐ Yes ☐ No Has the patient achieved or maintained positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition since starting treatment with the requested drug?

Ankylosing spondylitis and axial spondyloarthritis

☐ Yes ☐ No Is the requested drug being prescribed by or in consultation with a rheumatologist?

Please indicate which of the following the patient has experienced an improvement in from baseline:

☐ functional status ☐ total spinal pain ☐ inflammation (e.g., morning stiffness) ☐ none of the above

Articular Juvenile Idiopathic Arthritis

☐ Yes ☐ No Is the requested drug being prescribed by or in consultation with a rheumatologist?

Please indicate which of the following the patient has experienced an improvement in from baseline:

☐ number of joints with active arthritis (e.g., swelling, pain, limitation of motion) ☐ number of joints with limitation of movement
☐ functional ability ☐ none of the above

Psoriatic arthritis

☐ Yes ☐ No Is the requested drug being prescribed by or in consultation with a rheumatologist or dermatologist?

Please indicate which of the following the patient has experienced an improvement in from baseline:

☐ number of swollen joints ☐ number of tender joints ☐ dactylitis ☐ enthesitis ☐ axial disease ☐ skin and/or nail involvement ☐ none of the above

Rheumatoid arthritis

☐ Yes ☐ No Is the requested drug being prescribed by or in consultation with a rheumatologist?

☐ Yes ☐ No Has the patient achieved or maintained positive clinical response since starting treatment with the requested drug?

→ ☐ Yes ☐ No Has the patient experienced substantial disease activity improvement (e.g., at least 20% from baseline) in tender joint count, swollen joint count, pain, or disability?

→ Please indicate the percent of disease activity improvement from baseline in tender joint count, swollen joint count, pain, or disability: _____%

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.