Simponi Aria® (golimumab) Infusion Medication Precertification Request

(All fields must be completed and legible for Precertification Review.)

Aetna Precertification Notification
503 Sunport Lane, Orlando, FL 32809
Phone: 1-866-503-0857
FAX: 1-888-267-3277

For Medicare Advantage Part B:
FAX: 1-844-268-7263

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** ☐ **Gastroenterologist** ☐ **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 ☐ Mail Order
☐ Other: __________
Name: __________
Address: __________
Phone: __________ Fax: __________
TIN: __________ PIN: __________

E. PRODUCT INFORMATION

Request is for Simponi Aria: 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 initiation requests* (clinical documentation required):**

☐ Yes ☐ No Will golimumab (Simponi Aria) be used concomitantly with apremilast, tofacitinib, or other biologic DMARDs (e.g., adalimumab, certolizumab)?
☐ 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 date and results of the TB test: Date: ____/____/____ Results: ☐ Positive ☐ Negative ☐ Unknown
If positive, Does the patient have latent or active TB? ☐ Latent ☐ Active
If latent TB, ☐ Yes ☐ No Will TB treatment be started before initiation of therapy with golimumab (Simponi Aria)?

Ankylosing spondylitis

☐ Yes ☐ No Is there evidence that the disease is active?
☐ Yes ☐ No Has the patient had an inadequate response to two or more non-steroidal anti-inflammatory drugs (NSAIDs)?
→ Please provide the names and date ranges: NSAID #1: __________ Date range: ____/____/____ to ____/____/____
NSAID #2: __________ Date range: ____/____/____ to ____/____/____

Psoriatic Arthritis

☐ Yes ☐ No Does the patient have active **axial** psoriatic arthritis?
☐ Yes ☐ No Was the treatment with 2 or more non-steroidal anti-inflammatory drugs (NSAIDs) ineffective?
→ Provide the names and date ranges: NSAID #1: __________ Date range: ____/____/____ to ____/____/____
NSAID #2: __________ Date range: ____/____/____ to ____/____/____
☐ Yes ☐ No Does the patient have active **non-axial** psoriatic arthritis?
→ ☐ Yes ☐ No Was the treatment with methotrexate ineffective? ***If yes***, Date range: ____/____/____ to ____/____/____
☐ Yes ☐ No Was the treatment with methotrexate not tolerated or contraindicated? ☐ not tolerated ☐ contraindicated
→ ☐ Yes ☐ No Was a trial with at least 1 conventional disease-modifying anti-rheumatic drug (DMARD) (other than methotrexate) ineffective?
Name: __________ Date range: ____/____/____ to ____/____/____

Continued on next page

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Aetna Precertification Notification
Phone: 1-855-240-0535
FAX: 1-877-269-9916

For Medicare Advantage Part B:
FAX: 1-844-268-7263

Patient First Name	Patient Last Name	Patient Phone	Patient DOB

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

Rheumatoid Arthritis

Please indicate the severity of the patient's rheumatoid arthritis: ☐ Mild ☐ Moderate ☐ Severe

☐ Yes ☐ No Is there evidence that the disease is active?

☐ Yes ☐ No Will the patient use golimumab (Simponi Aria) in combination with methotrexate?

For continuation requests

☐ Yes ☐ No Will golimumab (Simponi Aria) be used concomitantly with apremilast, tofacitinib, or other biologic DMARDs (e.g., adalimumab, certolizumab)?

☐ Yes ☐ No Is there clinical documentation supporting disease stability?

☐ Yes ☐ No Is there clinical documentation supporting disease improvement?

☐ Yes ☐ No Does the patient have any risk factors for TB?

→ ☐ Yes ☐ No Has the patient had a TB test within the past year?
(check all that apply): ☐ PPD test ☐ interferon-gamma assay (IGRA) ☐ chest x-ray
Please enter the date and results of the TB test: Date: ____/____/____ Results: ☐ Positive ☐ Negative ☐ Unknown

☐ Yes ☐ No Is this continuation request a result of the patient receiving samples of golimumab (Simponi Aria)? (Sampling of golimumab (Simponi Aria) does not guarantee coverage under the provisions of the pharmacy benefit.)

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.