MEDICARE FORM
Simponi Aria® (golimumab) Infusion Medication Precertification Request

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

For Medicare Advantage Part B:
For other lines of business:
Please use commercial 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.

Would you like to use electronic prior authorization? Consider using **Availity**, our electronic prior authorization portal. Learn more about **Availity** from the links in the table below.

For phone or fax requests, refer to the table below for routing information. To determine which box to use, refer to the patient's Aetna ID card. State specific special needs and Medicare-Medicaid Plans may be designated on the front of the ID card or in the website URL on the back of the card. If you don't see your specific plan listed, call the number on the back of the member's ID card to confirm routing information.

For Aetna Medicare Advantage and **Allina Health Aetna Medicare Members** send request to: **Phone:** 1-866-503-0857 **(TTY:** 711**)** **Fax:** 1-844-268-7263 **Availity:** https://www.aetna.com/health-care-professionals/resource-center/availity.html
For Aetna Medicare FIDE (HMO-DSNP) **Virginia Dual Eligible Special Needs Plans** send request to: **Phone:** 1-855-463-0933 **Fax:** 1-833-280-5224 **Availity:** https://www.aetnabetterhealth.com/virginia-hmosnp/providers/portal
For Aetna Medicare FIDE (HMO-DSNP) **New Jersey Dual Eligible Special Needs Plans** send request to: **Phone:** 1-844-362-0934 **Fax:** 1-833-322-0034 **Availity:** https://www.aetnabetterhealth.com/new-jersey-hmosnp/providers/portal.html
For Aetna Medicare FIDE (HMO D-SNP) **Illinois Dual Eligible Special Needs Plans** send request to: **Phone:** 1-866-600-2139 **FAX:** 1-855-320-8445 **Availity:** https://www.aetnabetterhealth.com/illinois/providers/portal
For Aetna Medicare HIDE (HMO D-SNP) **Michigan Dual Eligible Special Needs Plans** send request to: **Phone:** 1-855-676-5772 **Fax:** 1-844-241-2495 **Availity:** https://www.aetnabetterhealth.com/michigan/providers/portal.html

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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: _____
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): 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. Bimzelx, Enbrel, Hadlima, Pyzchiva SC, Rinvoq, Skyrizi SC, Stelara SC, Tremfya SC, Tyenne SC, Xeljanz/Xeljanz XR, and Yesintek SC are the preferred products for MAPD plans. Preferred products vary based on indication.

☐ Yes ☐ No Has the patient received a dose of Simponi Aria (golimumab) through insurance in the last 365 days?
This does not include samples or doses ad/ministered without prior authorization.

☐ No Has the patient had a documented inadequate response to two or more of the following? (if yes, select all that apply below)
Medical records (e.g., chart notes) documenting an inadequate response to a trial of two or more preferred products must be available upon request.
☐ Bimzelx (bimekizumab-bkzx) ☐ Enbrel (etanercept) ☐ Hadlima (adalimumab-bwwd) ☐ Pyzchiva SC (ustekinumab-ttwe)
☐ Rinvoq (upadacitinib) ☐ Skyrizi SC (risankizumab-rzaa) ☐ Stelara SC (ustekinumab) ☐ Tremfya SC (guselkumab)
☐ Tyenne SC (tocilizumab-aazg) ☐ Xeljanz/Xeljanz XR (tofacitinib) ☐ Yesintek SC (ustekinumab-kfce)
→ When was the member's inadequate response to the preferred drug(s)? _____
→ Please describe the nature of the inadequate response of the preferred drug(s) _____

☐ No Has the patient had a document intolerable adverse event to two or more of the following? (if yes, select all that apply below)
Medical records (e.g., chart notes) documenting an intolerable adverse event to two or more preferred products must be available upon request.
☐ Bimzelx (bimekizumab-bkzx) ☐ Enbrel (etanercept) ☐ Hadlima (adalimumab-bwwd) ☐ Pyzchiva SC (ustekinumab-ttwe)
☐ Rinvoq (upadacitinib) ☐ Skyrizi SC (risankizumab-rzaa) ☐ Stelara SC (ustekinumab) ☐ Tremfya SC (guselkumab)
☐ Tyenne SC (tocilizumab-aazg) ☐ Xeljanz/Xeljanz XR (tofacitinib) ☐ Yesintek SC (ustekinumab-kfce)
→ When was the member's intolerable adverse event to the preferred drug(s)? _____
→ Please describe the nature of the intolerable adverse event to the preferred drug(s) _____

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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.

Please explain if there are any contraindications or 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).

☐ Bimzelx (bimekizumab-bkzx) ☐ Enbrel (etanercept) ☐ Hadlima (adalimumab-bwwd) ☐ Pyzchiva SC (ustekinumab-ttwe) ☐ Rinvoq (upadacitinib)
☐ Skyrizi SC (risankizumab-rzaa) ☐ Stelara SC (ustekinumab) ☐ Tremfya SC (guselkumab) ☐ Tyenne SC (tocilizumab-aazg)
☐ Xeljanz/Xeljanz XR (tofacitinib) ☐ Yesintek SC (ustekinumab-kfce)

☐ 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)?

☐ 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

Initiation Requests (clinical documentation required);

Ankylosing spondylitis

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

Articular juvenile idiopathic arthritis

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

Immune checkpoint inhibitor-related inflammatory arthritis

☐ Yes ☐ No Is the disease moderate or severe?

☐ Yes ☐ No Has the patient had an inadequate response to corticosteroids or a conventional synthetic drug (e.g., methotrexate, sulfasalazine, leflunomide, hydroxychloroquine)?

→ ☐ Yes ☐ No Does the patient have an intolerance or contraindication to 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)?

For initiation Requests *continued*;

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

Continuation Requests (clinical documentation required):

☐ Yes ☐ No Is the patient receiving benefit from therapy?

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.