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:
Phone: 1-866-503-0857
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** ☐ **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 disease-modifying anti-rheumatic 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 DMARD (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, Does the patient have latent or active tuberculosis TB? ☐ latent ☐ active ☐ unknown
If latent tuberculosis 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 tuberculosis (TB) (e.g., persons with close contact to people with infectious TB disease; persons who have recently immigrated from areas of the world with high rates of TB [e.g., Africa, Asia, Eastern Europe, Latin America, Russia]; children less than 5 years of age who have a positive TB test; groups with high rates of TB transmission [e.g., homeless persons, injection drug users, persons with HIV infection], or persons who work or reside with people who are at an increased risk for active TB [e.g., hospitals, long-term care facilities, correctional facilities, homeless shelters])?

→ ☐ 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 tuberculosis (TB) test: ☐ positive ☐ negative ☐ unknown
If positive, Does the patient have latent or active tuberculosis (TB)? ☐ latent ☐ active ☐ unknown
If latent tuberculosis TB, ☐ Yes ☐ No Has treatment for latent tuberculosis (TB) infection been initiated or completed?
→ Please select: ☐ treatment initiated ☐ treatment completed

Continued on next page

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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

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)?

☐ Yes ☐ No Has the patient ever received (including current utilizers) a biologic (e.g., Humira) 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?

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?

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 disease-modifying antirheumatic drug (DMARD) (e.g., Xeljanz) indicated for active articular juvenile idiopathic arthritis?

→ ☐ Yes ☐ No Has the patient had an inadequate response to methotrexate or another non-biologic DMARD administered at an adequate dose and duration?

→ Please indicate which of the following risk factors the patient has:
☐ positive rheumatoid factor ☐ positive anti-cyclic citrullinated peptide antibodies ☐ pre-existing joint damage
☐ no risk factors

Please indicate which of the following applies to the patient:
☐ high-risk joints are involved (e.g., cervical spine, wrist, or hip) ☐ high disease activity
☐ high risk for disabling joint disease ☐ none of the above

Psoriatic 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 psoriatic arthritis (PsA)?

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

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 Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic disease modifying drug (e.g., Rinvoq, Xeljanz) indicated for moderately to severely active rheumatoid arthritis?

→ ☐ Yes ☐ No Has the patient been tested for the rheumatoid factor (RF) biomarker?
Please indicate the test result: ☐ positive ☐ negative ☐ not completed

☐ Yes ☐ No Has the patient been tested for the anti-cyclic citrullinated peptide (anti-CCP) biomarker?
Please indicate the test result: ☐ positive ☐ negative ☐ not completed

☐ Yes ☐ No Has the patient been tested for the C-reactive protein (CRP) and/or erythrocyte sedimentation rate (ESR) biomarker(s)?
Please indicate the test result: ☐ positive ☐ negative ☐ not completed

☐ Yes ☐ No Has the patient been tested for the erythrocyte sedimentation rate (ESR) biomarker?
Please indicate the test result: ☐ positive ☐ negative ☐ not completed

☐ 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 ☐ 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?

→ ☐ 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 20 mg per week?

→ ☐ Yes ☐ No Has the patient experienced an intolerance to methotrexate?

→ ☐ Yes ☐ No Does the patient have a contraindication to methotrexate?

→ 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?

→ Please indicate a clinical reason for the patient to not use methotrexate: ☐ 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

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

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

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

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 ☐ skin and/or nail involvement ☐ none of the above

Rheumatoid arthritis

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

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

Continued on next page

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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.