



# MEDICARE FORM

## Simponi Aria® (golimumab) Infusion Medication Precertification Request

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

For Michigan MMP:  
FAX: 1-844-241-2495  
PHONE: 1-855-676-5772

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 #: _____		Does patient have other coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Group #: _____		If yes, provide ID#: _____ Carrier Name: _____	
Insured: _____		Insured: _____	
Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, provide ID #: _____ Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No	
		If yes, provide ID #: _____	

### C. PRESCRIBER INFORMATION

First Name:		Last Name:		(Check One): <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> N.P. <input type="checkbox"/> 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

<b>Place of Administration:</b> <input type="checkbox"/> Self-administered <input type="checkbox"/> Physician's Office <input type="checkbox"/> Outpatient Infusion Center Phone: _____ Center Name: _____ <input type="checkbox"/> Home Infusion Center Phone: _____ Agency Name: _____ <input type="checkbox"/> Administration code(s) (CPT): _____ Address: _____ City: _____ State: _____ ZIP: _____ Phone: _____ Fax: _____ TIN: _____ PIN: _____ NPI: _____		<b>Dispensing Provider/Pharmacy: Patient Selected choice</b> <input type="checkbox"/> Physician's Office <input type="checkbox"/> Retail Pharmacy <input type="checkbox"/> Specialty Pharmacy <input type="checkbox"/> Other _____ Name: _____ Address: _____ City: _____ State: _____ ZIP: _____ Phone: _____ Fax: _____ TIN: _____ PIN: _____ NPI: _____	
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### 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 for all requests):**

Note: Simponi Aria is a preferred product for MA Plans. Enbrel, Humira, Otezla, Rinvoq, Skyrizi, 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, intolerance, or contraindication to any of the following? (select all that apply)

Enbrel (etanercept)  Humira (adalimumab)  Otezla (apremilast)  Rinvoq (upadacitinib)  Skyrizi (risankizumab-rzaa)  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)  Otezla (apremilast)  Rinvoq (upadacitinib)  Skyrizi (risankizumab-rzaa)  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
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### G. CLINICAL INFORMATION - Required clinical information must be completed 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)?

Yes  No Has the patient previously received a biologic 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?

##### 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

#### 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.