PriorityHealth

Pharmacy Prior Authorization Form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☒ **Commercial (Traditional)** ☒ **Commercial Individual (Optimized)**
☐ **Medicaid**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Simponi® or Simponi Aria® (golimumab)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____

Provider Address: _____

Provider NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Product Information

☐ New request ☐ Continuation request (required every 2 years for infusion only)

Drug product:
☐ Simponi 50mg/0.5mL SmartJect
☐ Simponi 100mg/mL SmartJect
☐ Simponi 50mg/0.5mL prefilled syringe
☐ Simponi 100mg/mL prefilled syringe
☐ **Simponi Aria 50 mg/4 mL IV infusion**

Dose:_____ **Dose Frequency**:_____
Start date (or date of next dose): _____
Date of last dose (if applicable): _____
Date of next dose: _____
Body Weight: _____

Place of administration:
☐ Self-administered
☐ Physician's office
☐ Outpatient infusion
Facility: _____ NPI:_____ Fax:_____
☐ Home infusion
Facility: _____ NPI:_____ Fax:_____

Billing:
☐ Physician to buy and bill
☐ Facility to buy and bill
☐ Specialty Pharmacy
Pharmacy:_____ NPI:_____ Fax:_____

ICD-10 Diagnosis code(s): _____

Note: Simponi Aria is covered for rheumatoid arthritis, ankylosing spondylitis, and psoriatic arthritis.

All fields must be complete and legible for review. Your office will receive a response via fax.

Updated 01/2018
Last reviewed 03/2018

PriorityHealth

SIMPONI COVERAGE POLICY

- Before Simponi is covered, the patient must meet all of the General Criteria for Simponi and all of the Specific Criteria for the treatment diagnosis. If these criteria are not met, the prescriber must provide an explanation of why an exception to the criteria is necessary.
- Coverage for a diagnosis not listed below will be considered on a case by case basis. Please provide rationale for use and all pertinent patient information.
- Simponi will not be covered in combination with another biologic drug.
- Please provide rationale when requesting any dose or dosing interval not listed in the FDA label.

Criteria

General Criteria for ALL Diagnoses:

a) Patient has evidence of a negative TB test result in the past 12 months (or TB is adequately managed); AND
b) Patient does not have moderate to severe heart failure (or heart failure is adequately managed); AND
c) Prescriber is a specialist or has consulted with a specialist for the disease being treated.

Specific Criteria for Individual Diagnoses:

1. Ankylosing Spondylitis
   a) Patient has tried at least TWO of the following: Cosentyx, Enbrel, or Humira, each for a period of at least 3 months

2. Psoriatic Arthritis
   a) Patient has tried at least ONE conventional systemic DMARD (such as methotrexate, leflunomide, sulfasalazine, or azathioprine) for a period of at least 3 months, AND
   b) Patient has tried at least TWO of the following: Cosentyx, Enbrel, Humira, Xeljanz/XR, or Stelara, each for a period of at least 3 months.

3. Rheumatoid Arthritis
   a) Patient has tried at least ONE conventional systemic DMARD (such as methotrexate, leflunomide, hydroxychloroquine, or sulfasalazine) for a period of at least 3 months; AND
   b) Patient has tried at least TWO of the following: Actemra, Enbrel, Humira, or Xeljanz/XR, each for a period of at least 3 months.

4. Ulcerative Colitis
   a) Patient has tried Humira or Xeljanz/XR for a period of at least 3 months.

Note: Authorization for indications, dosing, or a route of administration not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the appropriateness of the drug, the dosing of the drug, or the route of administration to be used for the identified indication.

Priority Health Precertification Documentation

A. What condition is this drug being requested for?

- ☐ Ankylosing spondylitis
- ☐ Psoriatic arthritis
- ☐ Rheumatoid arthritis
- ☐ Ulcerative colitis
- ☐ Other – the patient's condition is: _____

Rationale for use: _____

B. Which of the following has the patient had a documented therapeutic trial with?

- ☐ Methotrexate Dates of therapy: _____
- ☐ Leflunomide Dates of therapy: _____
- ☐ Hydroxychloroquine Dates of therapy: _____
- ☐ Sulfasalazine Dates of therapy: _____
- ☐ Actemra Dates of therapy: _____
- ☐ Cosentyx Dates of therapy: _____
- ☐ Enbrel Dates of therapy: _____
- ☐ Humira Dates of therapy: _____
- ☐ Stelara Dates of therapy: _____
- ☐ Xeljanz/XR Dates of therapy: _____
- ☐ Other Drug: _____ Dates of therapy: _____

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C. Has the patient had a negative TB test result in the past 12 months?

☐ Yes Date: _____

☐ No, rationale for use: _____

D. Does the patient have moderate to severe heart failure?

☐ Yes Date: _____

☐ No, rationale for use: _____

E. Will the patient be receiving other biologic therapy in combination with Simponi?

☐ No ☐ Yes, rationale for use: _____

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