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 Advantage **Virginia Dual Eligible Special Needs Plans** (HMO D-SNP) send request to:
Phone: 1-855-463-0933
Fax: 1-833-280-5224
Availity: https://www.aetnabetterhealth.com/virginia-hmosnp/providers/portal

For Aetna Assure Premier Plus Medicare Advantage **New Jersey Dual Eligible Special Needs Plans** (HMO D-SNP) 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 Better Health of **Illinois Premier Medicare Medicaid Plan** (MMP) send request to:
Phone: 1-866-600-2139
FAX: 1-855-320-8445
Availity: https://www.aetnabetterhealth.com/illinois/providers/portal

For Aetna Better Health of **Ohio Premier Medicare Medicaid Plan** (MMP) send request to:
Phone: 1-855-364-0974
Fax: 1-855-734-9389
Availity: https://www.aetnabetterhealth.com/ohio/providers/portal

For Aetna Better Health of **Michigan Premier Medicare Medicaid Plan** (MMP) 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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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: _____
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):
Dose: _____ **Frequency:** _____ **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. Cosentyx SC, Enbrel, Humira, Idacio, Rinvoq, Skyrizi, Stelara, Tremfya, Tyenne SC 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?

☐ No Has the patient had a trial and failure of any of the following? (if yes, select all that apply below)
☐ Cosentyx SC (secukinumab) ☐ Enbrel (etanercept) ☐ Humira (adalimumab) ☐ Idacio (adalimumab-aacf) ☐ Rinvoq (upadacitinib)
☐ Skyrizi (risankizumab-rzaa) ☐ Stelara (ustekinumab) ☐ Tremfya (guselkumab) ☐ Tyenne SC (tocilizumab-aazg)
☐ Xeljanz/Xeljanz XR (tofacitinib)
→ When was the member's trial and failure of the preferred drug? _____
→ Please describe the nature of the failure of the preferred drug _____

☐ No Has the patient had an adverse reaction to any of the following? (if yes, select all that apply below)
☐ Cosentyx SC (secukinumab) ☐ Enbrel (etanercept) ☐ Humira (adalimumab) ☐ Idacio (adalimumab-aacf) ☐ Rinvoq (upadacitinib)
☐ Skyrizi (risankizumab-rzaa) ☐ Stelara (ustekinumab) ☐ Tremfya (guselkumab) ☐ Tyenne SC (tocilizumab-aazg)
☐ Xeljanz/Xeljanz XR (tofacitinib)
→ When was the member's adverse reaction to the preferred drug? _____
→ Please describe the nature of the adverse reaction to the preferred drug _____

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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).

☐ Cosentyx SC (secukinumab) ☐ Enbrel (etanercept) ☐ Humira (adalimumab) ☐ Idacio (adalimumab-aacf) ☐ Rinvoq (upadacitinib)
☐ Skyrizi (risankizumab-rzaa) ☐ Stelara (ustekinumab) ☐ Tremfya (guselkumab) ☐ Tyenne SC (tocilizumab-aazg)
☐ 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)?

☐ 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)?

Articular juvenile idiopathic arthritis (Juvenile rheumatoid arthritis)

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

Immune checkpoint inhibitor-related toxicity

☐ Yes ☐ No Has the patient been diagnosed with immunotherapy-related inflammatory arthritis?
☐ Yes ☐ No Is the disease refractory or severe?
→ ☐ Yes ☐ No Has the disease responded to systemic 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)?

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G. CLINICAL INFORMATION *(continued)* – Required clinical information must be completed in its entirety for all precertification requests.

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

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? Chart notes or medical record documentation supporting benefit from therapy must be submitted upon request.

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.