Updated: 06/2018
PARP Approved: 07/2018

Gateway Health
Prior Authorization Criteria
Simponi/Simponi Aria (golimumab)

All requests for Simponi/Simponi Aria (golimumab) require a prior authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Drug Name Prior Authorization Criteria:

For all requests for Simponi Aria/Simponi (golimumab) all of the following criteria must be met:

- Member is an adult age of 18 years of older.
- Medication must be prescribed by or in association with rheumatologist, gasteroenterologist, or dermatologist.

Coverage may be provided with a diagnosis of **moderately active Rheumatoid Arthritis** and the following criteria is met:

- Member must have a history of trial and failure, contraindication, or intolerance of at least 3 months of treatment with methotrexate or another DMARD.
- Medication will be used in combination with Methotrexate (if not contraindicated or member does not have intolerance to methotrexate).
- Member must have a history of trial and failure, contraindication, or intolerance to Enbrel* or Humira*.

Coverage may be provided with a diagnosis of **Active Psoriatic Arthritis** and the following criteria is met:

- Member has moderately to severely active psoriatic arthritis which must include documentation of either active psoriatic lesions or documented history of psoriasis.
- Member must have a history of trial and failure, contraindication, or intolerance to ALL of the following:
  - Member without axial disease:
    - Four- week trial each of at least 2 NSAIDs.
    - Eight week trial of methotrexate or other DMARD
  - Member with axial disease
    - Four- week trial each of at least 2 NSAIDs.
  - Member with psoriatic arthritis with enthesitis
    - Four- week trial each of at least 2 NSAIDs.
- Member must have a history of trial and failure, contraindication, or intolerance to Enbrel*or Humira*.

Coverage may be provided with a diagnosis of **Ankylosing Spondylitis** and the following criteria is met:

- Member must have a history of trial and failure, contraindication, or intolerance to ALL of the following:
  - Four- week trial each of at least 2 NSAIDs
- Member must have a history of trial and failure, contraindication, or intolerance to Enbrel* or Humira*.

Coverage may be provided with a diagnosis of **Ulcerative Colitis** and the following criteria is met:

- Prescribed medication is Simponi.
- Member must have a history of trial and failure, contraindication, or intolerance to Steroids (*i.e.,* prednisone, Entocort®) for at least three to four weeks.
- Member must have a history of trial and failure, contraindication, or intolerance to Immunomodulators (*i.e.,* Azathioprine, 6-Mercaptopurine, Methotrexate) for at least 3 months.
- Member must have a history of trial and failure, contraindication, or intolerance to Aminosalicylates, 5-ASAs (*i.e.,* Sulfasalazine, Pentasa®, Asacol®, Colazal®) for at least 4 to 6 weeks.
- Member must have a history of trial and failure, contraindication, or intolerance to Humira*.

Initial Duration of Approval: 12 months

Reauthorization criteria

- Reauthorization benefit will be approved if there is documented, significant improvement with prior courses of treatment

Reauthorization Duration of approval: 12 months

*Enbrel and Humira both require prior authorization. Members that are currently established on Simponi/Simponi Aria will not be required to change to a preferred/formulary product.

When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.