Updated: 11/2020
DMMA Approved: 12/2020

Request for Prior Authorization for Simponi Aria/Simoni (golimumab)
Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158

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

Simponi Aria/Simponi (golimumab) Prior Authorization Criteria:

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

- Medication must be prescribed by or in association with rheumatologist, gastroenterologist, or dermatologist.
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines.
- Must be age-appropriate according to FDA-approved labeling, nationally recognized compendia, or evidence-based practice guidelines

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 to BOTH of the following:
  - 3 months of methotrexate or another DMARD.
  - 3 months of treatment with either Enbrel (etanercept)* OR Humira (adalimumab)*
- Medication will be used in combination with Methotrexate (if not contraindicated or member does not have intolerance to methotrexate).
- **Initial Duration of Approval:** 6 months
- **Reauthorization criteria**
  - Member must have positive clinical response involving the following clinical/ laboratory parameters: Number of swollen joints, number of tender joints, patient's assessment of pain, member's global assessment of disease activity, HAQ score, and/or CRP (C-Reactive Protein).
- **Reauthorization Duration of approval:** 12 months

Coverage may be provided with a diagnosis of **polyarticular Juvenile Idiopathic Arthritis (pJIA)** and the following criteria is met:

- Member must have a history of trial and failure, contraindication, or intolerance to a three-month trial with BOTH of the following:
  - DMARD (ie. MTX, leflunomide)
  - Enbrel (etanercept)* OR Humira (adalimumab)*
- **Initial Duration of Approval:** 6 months
- **Reauthorization Criteria**
  - Reauthorization benefit will be approved if there is documented, significant improvement in AJC (active joint count) with prior courses of treatment.
- **Reauthorization Duration of Approval:** 12 months

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

- Member has moderately to severely active psoriatic arthritis indicated by the presence of at least ONE of the following:
  - Erosive Disease
  - Elevated Markers of inflammation attributable to psoriatic arthritis
  - Long-term damage that interferes with function (i.e., joint deformities)
  - Highly active disease that causes a major impairment in quality of life
  - Active PsA at many sites including dacylitis, enthesitis
  - Function-limiting PsA at a few sites
  - Rapidly progressive disease.
- Member must have a history of trial and failure, contraindication, or intolerance to BOTH of the following:
  - A four- week trial each of at least 2 NSAIDs
  - 3 months of treatment with either Enbrel (etanercept)* OR Humira (adalimumab)*
- **Initial Duration of Approval:** 6 months
- **Reauthorization criteria**
  - Reauthorization benefit will be approved if there is evidence of positive clinical response involving the following clinical/laboratory parameters: Number of swollen joints, number of tender joints, patient's assessment of pain, member's global assessment of disease activity, HAQ score, and/or CRP (C-Reactive Protein).
- **Reauthorization Duration of approval:** 12 months

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 BOTH of the following:
  - A four- week trial each of at least 2 NSAIDs
  - 3 months of treatment with either Enbrel (etanercept)* OR Humira (adalimumab)*
- **Initial Duration of Approval:** 6 months
- **Reauthorization criteria**
  - Reauthorization benefit will be approved if there is evidence of positive clinical response involving the following clinical/laboratory parameters: Patient global assessment, back pain, BASFI (Bath Ankylosing Spondylitis Functional Index), CRP, Modified Schober's test, chest expansion, occiput-to-wall measurement.
- **Reauthorization Duration of approval:** 12 months

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 conventional treatments including ONE of the following for at least 3 months:

  - Aminosalicylates, 5-ASAs (*i.e.*, Sulfasalazine, Pentasa®, Asacol®, Colazal®)
  - Steroids (*i.e.*, prednisone)
  - Immunomodulators (*i.e.*, Azathioprine, 6-Mercaptopurine, Methotrexate)
- Member must have a history of trial and failure, contraindication, or intolerance of at least 2 months of treatment with Humira (adalimumab)*
- **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 (etanercept) and Humira (adalimumab) require prior authorization.

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

Drugs are authorized in generic form unless the branded product is on the preferred drug list or the prescriber has indicated in writing that the branded product is medically necessary. If only the branded product is on the preferred drug list, the generic form will be considered non-preferred and shall not require the prescriber to indicate in writing that the branded product is medically necessary.

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SIMPONI ARIA/SIMPONI (GOLIMUMAB)
PRIOR AUTHORIZATION FORM – PAGE 1 of 2

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX:** (855) 476-4158
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (844) 325-6251 Monday through Friday 8:30am to 5:00pm

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:
Health Options ID:	Member weight: _____pounds or _____kg

REQUESTED DRUG INFORMATION

Medication:	Strength:
Frequency:	Duration:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:

Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? ☐ Yes ☐ No

Billing Information

This medication will be billed: ☐ at a pharmacy **OR** ☐ medically, JCODE:_____

Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

Diagnosis:

☐ **Rheumatoid Arthritis (RA)**
- Which of the following have been tried (please clarify in the section below):
  - ☐ 3 months of treatment with methotrexate or another DMARD?
  - ☐ 3 months of Enbrel or Humira
- Will the medication be used in combination with methotrexate? ☐ Yes ☐ No

☐ **Polyarticular Juvenile Idiopathic Arthritis (pJIA)**
- Which of the following have been tried (please clarify in the section below):
  - ☐ 3 months of treatment with methotrexate or another DMARD?
  - ☐ 3 months of Enbrel or Humira

☐ **Psoriatic Arthritis (PsA)**
- Does the member have moderately to severely active psoriatic arthritis defined by ANY of the following?
  - ☐ Erosive Disease
  - ☐ Elevated Markers of inflammation attributable to psoriatic arthritis
  - ☐ Long-term damage that interferes with function (i.e., joint deformities)
  - ☐ Highly active disease that causes a major impairment in quality of life
  - ☐ Active PsA at many sites including dacylitis, enthesitis
  - ☐ Function-limiting PsA at a few sites
  - ☐ Rapidly progressive disease
- Which of the following have been tried (please clarify in the section below):
  - ☐ 4 week trial with 2 different NSAIDs
  - ☐ 3 months of Enbrel or Humira

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SIMPONI ARIA/SIMPONI (GOLIMUMAB)
PRIOR AUTHORIZATION FORM (CONTINUED) – PAGE 2 OF 2

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX:** (855) 476-4158
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (844) 325-6251 Monday through Friday 8:30am to 5:00pm

MEMBER INFORMATION

Member Name:	DOB:
Health Options ID:	Member weight: _____pounds or_____kg

MEDICAL HISTORY (Complete for ALL requests)

☐ **Ankylosing Spondylitis (AS)**
- Which of the following have been tried (please clarify in the section below):
  - ☐ 4 week trial with 2 different NSAIDs
  - ☐ 3 months of Enbrel or Humira

☐ **Ulcerative Colitis (UC)**
- Which of the following have been tried (please clarify in the section below):
  - ☐ Aminosalicylates, 5-ASAs (*i.e.*, Sulfasalazine, Pentasa, Asacol, Colazal)
  - ☐ Steroids (*i.e.*, prednisone)
  - ☐ Immunomodulators (*i.e.*, Azathioprine, 6-Mercaptopurine, Methotrexate)
  - ☐ Humira

☐ **Other _____ICD-10: _**

CURRENT or PREVIOUS THERAPY

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

REAUTHORIZATION

For Rheumatoid Arthritis and Psoriatic Arthritis:
Does the prescriber attest that member has positive clinical response involving the following clinical laboratory/ parameters: number of swollen joints, number of tender joints, patient's assessment of pain, member's global assessment of disease activity, HAQ score, and/or CRP (C-Reactive Protein)? ☐ Yes ☐ No

For Polyarticular Juvenile Idiopathic Arthritis (pcJIA):
Has there been improvement in the active joint count (AJC) as a result of treatment? ☐ Yes ☐ No

For Ankylosing Spondylitis:
Does the prescriber attest that member has positive clinical response involving the following clinical laboratory/ parameters: patient global assessment, back pain, BASFI (Bath Ankylosing Spondylitis Functional Index, CRP, Modified Schober's test, chest expansion, occiput-to-wall measurement? ☐ Yes ☐ No

For Ulcerative Colitis:
Does the prescriber attest that member has documented, positive clinical response to therapy? ☐ Yes ☐ No

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date