



Simponi® (golimumab) Injectable Medication Precertification Request

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(Please complete all fields and return both pages for precertification review)

Aetna Precertification Notification

Phone: 1-855-240-0535

FAX: 1-877-269-9916

For Medicare Advantage Part B:

FAX: 1-844-268-7263

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): Rheumatologist Gastroenterologist Other: _____

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration: <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: _____	Dispensing Provider/Pharmacy: (Patient selected choice) <input type="checkbox"/> Outpatient Infusion Center <input type="checkbox"/> Physician's Office <input type="checkbox"/> Specialty Pharmacy <input type="checkbox"/> Mail Order <input type="checkbox"/> Retail Pharmacy <input type="checkbox"/> Other: _____ Name: _____ Address: _____ Phone: _____ Fax: _____ TIN: _____ PIN: _____
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E. PRODUCT INFORMATION

Request is for: Simponi (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 Initiation requests (clinical documentation required for all requests):

Yes No Will Simponi (golimumab) be used concomitantly with apremilast, tofacitinib, or other biologic DMARDs (e.g., adalimumab, infliximab)?
 Yes No Has the patient been tested for TB with a PPD test, interferon-release assay (IGRAs) or chest x-ray within 6 months of initiation 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
If latent TB, Yes No Will TB treatment be started before initiation of therapy with Simponi (golimumab)?

Ankylosing Spondylitis

Yes No Is there evidence that the disease is active?
 Yes No Has the patient had an ineffective response to 2 or more non-steroidal anti-inflammatory drugs (NSAIDs)?
→ Please provide the names and length of treatment:
NSAID #1: _____
Please indicate length of treatment: Less than 1 month 1 month 2 months 3 months or greater
NSAID #2: _____
Please indicate length of treatment: Less than 1 month 1 month 2 months 3 months or greater

Psoriatic Arthritis

Yes No Is there evidence that the disease is active?
 Yes No Does the patient have axial psoriatic arthritis?
→ Yes No Was the treatment with 2 or more non-steroidal anti-inflammatory drugs (NSAIDs) ineffective?
→ Please provide the names and length of treatment:
NSAID #1: _____
Please indicate length of treatment: Less than 1 month 1 month 2 months 3 months or greater
NSAID #2: _____
Please indicate length of treatment: Less than 1 month 1 month 2 months 3 months or greater

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB
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G. CLINICAL INFORMATION (continued)- Required clinical information must be completed in its entirety for all precertification requests.

Yes No Does the patient have **non-axial** psoriatic arthritis?

Yes No Does the patient have severe disease at presentation, defined as severe disability at onset with erosive disease involving multiple joints?

Yes No Was the treatment with methotrexate ineffective?

Yes No Was treatment with methotrexate not tolerated or contraindicated?
Please select: not tolerated contraindicated

Yes No Was treatment with another conventional DMARD ineffective?
Please select: cyclophosphamide cyclosporine
 hydroxychloroquine Leflunomide
 sulfasalazine Other: Please explain: _____

Please indicate length of treatment:
 Less than 1 month 1 month
 2 months 3 months or greater

Indicate length of therapy: Less than 1 month 1 month 2 months 3 months or greater

Rheumatoid Arthritis

Please indicate the severity of the patient's rheumatoid arthritis: Mild Moderate Severe

Yes No Is there evidence that the disease is active?

Yes No Was treatment with methotrexate ineffective?

Yes No Was treatment with methotrexate not tolerated or contraindicated?
Please select: not tolerated contraindicated

Yes No Was treatment with another conventional DMARD ineffective?
Please select: azathioprine cyclosporine hydroxychloroquine leflunomide sulfasalazine

Please indicate length of treatment: Less than 1 month 1 month
 2 months 3 months or greater

Please indicate length of the methotrexate therapy: Less than 1 month 1 month 2 months 3 months or greater

Yes No Will the patient use Simponi (golimumab) concomitantly with methotrexate?

Ulcerative Colitis

Yes No Is the patient hospitalized with active fulminant ulcerative colitis?

Please indicate the severity of the patient's ulcerative colitis: Mild Moderate Severe

Yes No Is there evidence that the disease is active?

Yes No Is the patient refractory to immunosuppression with corticosteroids (e.g., hydrocortisone, methylprednisolone, prednisone)?

Yes No Does the patient require continuous immunosuppression with corticosteroids (e.g., hydrocortisone, methylprednisolone, prednisone)?

Name and dose: Name: _____ Dose: _____

Please indicate the route: Oral IV

Length of time on therapy: Less than 10 days 10 to 29 days 30 days or greater

Name and dose: Name: _____ Dose: _____

Please indicate the route: Oral IV

Length of time on therapy: Less than 10 days 10 to 29 days 30 days or greater

Yes No Was treatment with immunosuppressant agent (e.g., azathioprine, 6-mercaptopurine) ineffective?

Yes No Was treatment with immunosuppressant agent (e.g., azathioprine, 6-mercaptopurine) not tolerated or contraindicated?
 not tolerated contraindicated

Provide the name of the drug(s): _____

Please indicate length of treatment: Less than 1 month 1 month 2 months 3 months or greater

Yes No Was treatment with 5-aminosalicylic acid agents (e.g., balsalazide, mesalamine, sulfasalazine) ineffective?

Yes No Was treatment with 5-aminosalicylic acid agents (e.g., balsalazide, mesalamine, sulfasalazine) not tolerated or contraindicated?
 not tolerated contraindicated

Provide the name of the drug(s): _____

Please indicate length of treatment: Less than 1 month 1 month 2 months 3 months or greater

Please select the symptoms the patient exhibit: more than 10 stools per day continuous bleeding abdominal pain distension
 acute, severe toxic symptoms, including fever and anorexia

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

For Continuation requests (clinical documentation required for all requests):

Please indicate the length of time on Simponi (golimumab)? _____

Yes No Has the patient received samples of Simponi (golimumab)? (Sampling of Simponi (golimumab) does not guarantee coverage under the provisions of the pharmacy benefit.)

Yes No Will Simponi (golimumab) be used concomitantly with apremilast, tofacitinib, or other biologic DMARDs (e.g., adalimumab, infliximab)?

Yes No Is there clinical documentation of disease stability or improvement? Disease stability Disease improvement

Yes No Does the patient have any risk factors for TB?

Yes No Has the patient had a TB test within the past 12 months?

 (chick all that apply): PPD test interferon-gamma assay (IGRA) chest x-ray

 Results: Positive Negative Unknown

For Rheumatoid arthritis Only:

Please indicate the severity of the patient's disease at baseline (pretreatment with Simponi (golimumab): Mild Moderate Severe

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.