AvMed

MEDICAL PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-877-535-1391**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If information provided is not complete, correct, or legible, authorization can be delayed**.

For Medicare Members: Medicare Coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determination (NCD) and Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable. They can be found at: https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx. Additional indications may be covered at the discretion of the health plan.

Drug Requested: Simponi® ARIA™ (golimumab) **(J-1602) (Medical) (Non-Preferred)**

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member AvMed #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight: _____ **Date:** _____

SIMPONI® ARIA™ DOSE: _____ **Frequency:** _____

❑ Standard Review. In checking this box, the timeframe does not jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain.

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

(Continued on next page)

DIAGNOSIS: Check diagnosis below that applies. .	
❑ **Moderate-to-severe Active Rheumatoid Arthritis** **Dosage:** : IV: 2 mg/kg at weeks 0, 4, and then every 8 weeks thereafter (in combination with methotrexate)	❑ **Active Psoriatic Arthritis** **Dosage: Children ≥2 years and Adolescents:** Simponi Aria: IV: 80 mg/m2/dose at weeks 0, 4, and then every 8 weeks thereafter. **Adults:** IV: 2 mg/kg at weeks 0, 4, and then every 8 weeks

❑ Prescriber is a **Rheumatologist**

AND

❑ Trial and failure of at least **ONE DMARD** therapy for at least **three (3) months** **(check each tried)**:

❑ methotrexate	❑ auranofin	❑ azathioprine
❑ hydroxychloroquine	❑ leflunomide	❑ sulfasalazine
❑ Other: _____		

AND

❑ Trial and failure, contraindication, or intolerance to **BOTH** of the following:

❑ Renflexis® **AND** ❑ Cimzia®

❑ Diagnosis - Active Ankylosing Spondylitis

Dosage: IV: 2 mg/kg at weeks 0, 4, and then every 8 weeks thereafter

❑ Prescribed by or in consultation with a **Rheumatologist**

AND

❑ Trial and failure, contraindication, or intolerance to **TWO** NSAIDs

AND

❑ Trial and failure, contraindication, or intolerance to **BOTH** of the following:

❑ Renflexis **AND** ❑ Cimzia

❑ Diagnosis - Polyarticular Juvenile Idiopathic Arthritis

Dosage: IV: 80 mg/m2/dose at weeks 0, 4, and then every 8 weeks thereafter

❑ Prescribed by or in consultation with a **Rheumatologist**

AND

❑ Trial and failure, contraindication, or intolerance to Renflexis®

(Continued on next page)

Medication being provided by (check box below that applies):

- ❑ **Location/site of drug administration:** _____

  NPI or DEA # of administering location: _____

  OR

- ❑ **Specialty Pharmacy – PropriumRx**

For urgent reviews: Practitioner should call AvMed Pre-Authorization Department if they believe a standard review would subject the member to adverse health consequences. AvMed's definition of urgent is a lack of treatment that could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

*****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****

***Approved by Pharmacy and Therapeutics Committee**: 1~~/16/2014~~; 11/19/2020
REVISED/UPDATED: ~~1/27/2014; 2/7/2014; 4/4/2014; 4/28/2014; 10/31/2014; 4/3/2015; 5/23/2015~~; ~~12/23/2015;~~ ~~1/29/2016;~~ ~~9/28/2016~~; ~~12/11/2016~~; ~~7/24/2017~~; ~~1/1/2018~~; ~~3/28/2018~~; ~~4/30/2018~~; ~~11/23/2018~~; ~~(Reformatted) 3/19/2019~~; ~~5/5/2019~~; ~~7/8/2019;9/28/2019~~; ~~10/9/2019;~~ ~~11/19/2020;~~ **4/1/2021**;