AvMed

PHARMACY 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 1-305-671-0200**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Simponi® (golimumab) SQ (Pharmacy)

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:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

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

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

Weight (if applicable): _____ **Date weight obtained:** _____

NOTE: The Health Plan considers the use of concomitant therapy with more than one biologic immunomodulator (e.g., Dupixent, Entyvio, Humira, Rinvoq, Stelara) prescribed for the same or different indications to be experimental and investigational. Safety and efficacy of these combinations has **NOT** been established and will **NOT** be permitted.

- ❑ Will the member be discontinuing a previously prescribed biologic if approved for requested medication?
  ❑ Yes **OR** ❑ No
- ❑ If yes, please list the medication that will be discontinued and the medication that will be initiated upon approval along with the corresponding effective date.

  Medication to be discontinued: _____ **Effective date:** _____

  Medication to be initiated: _____ **Effective date:** _____

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.

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❑ Diagnosis: Moderate-to-Severe Rheumatoid Arthritis

Dosing: SubQ: 50 mg once a month (in combination with methotrexate)

- ❑ Member has a diagnosis of moderate-to-severe **rheumatoid arthritis**
- ❑ Prescribed by or in consultation with a **Rheumatologis**t
- ❑ Member meets **ONE** of the following:
  - ❑ Member has tried and failed at least **ONE** of the following **DMARD** therapies for at least three **(3) months**:
    - ❑ hydroxychloroquine
    - ❑ leflunomide
    - ❑ methotrexate
    - ❑ sulfasalazine
  - ❑ Member has previously tried and failed another biologic medication other than the requested medication (e.g., adalimumab, tofacitinib, Rinvoq)
- ❑ Member meets **ONE** of the following:
  - ❑ Member tried and failed, has a contraindication, or intolerance to **TWO** of the **PREFERRED** biologics below **(verified by chart notes or pharmacy paid claims)**:

❑ Preferred adalimumab product	❑ Enbrel®
❑ Rinvoq®/Rinvoq® LQ	❑ Preferred tocilizumab product: Actemra® SC or Tyenne® SC
❑ generic tofacitinib/ER	

  - ❑ Member has been established on Simponi® SQ for at least 90 days **AND** prescription claims history indicates **at least a 90-day supply of Simponi SQ was dispensed within the past 130 days (verified by chart notes or pharmacy paid claims)**

❑ Diagnosis: Active Psoriatic Arthritis

Dosing: SubQ: 50 mg once a month (either alone or in combination with methotrexate or other non-biologic DMARDs)

- ❑ Member has a diagnosis of active **psoriatic arthritis**
- ❑ Prescribed by or in consultation with a **Rheumatologist or Dermatologist**
- ❑ Member meets **ONE** of the following:
  - ❑ Member has tried and failed at least **ONE** of the following **DMARD** therapies for at least **three (3) months**:
    - ❑ cyclosporine
    - ❑ leflunomide
    - ❑ methotrexate
    - ❑ sulfasalazine
  - ❑ Member has previously tried and failed another biologic medication other than the requested medication (e.g., adalimumab, Otezla, Skyrizi)

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- ❑ Member meets **ONE** of the following:
  - ❑ Member tried and failed, has a contraindication, or intolerance to **TWO** of the **PREFERRED** biologics below **(verified by chart notes or pharmacy paid claims)**:

❑ Preferred adalimumab product	❑ Enbrel®	❑ Otezla®/Otezla XR™
❑ Rinvoq®/ Rinvoq® LQ	❑ Skyrizi®	❑ Taltz®
❑ generic tofacitinib/ER/solution	❑ Tremfya®	❑ Preferred ustekinumab product

  - ❑ Member has been established on Simponi® SQ for at least 90 days **AND** prescription claims history indicates **at least a 90-day supply of Simponi SQ was dispensed within the past 130 days (verified by chart notes or pharmacy paid claims)**

❑ Diagnosis: Active Ankylosing Spondylitis

Dosing: SubQ: 50 mg once a month (either alone or in combination with methotrexate or other non-biologic DMARDs)

- ❑ Member has a diagnosis of active **ankylosing spondylitis**
- ❑ Prescribed by or in consultation with a **Rheumatologist**
- ❑ Member tried and failed, has a contraindication, or intolerance to **ONE** NSAID
- ❑ Member meets **ONE** of the following:
  - ❑ Member tried and failed, has a contraindication, or intolerance to **TWO** of the **PREFERRED** biologics below **(verified by chart notes or pharmacy paid claims)**:

❑ Preferred adalimumab product	❑ Enbrel®	❑ Rinvoq®
❑ Taltz®	❑ generic tofacitinib/ER	

  - ❑ Member has been established on Simponi® SQ for at least 90 days **AND** prescription claims history indicates **at least a 90-day supply of Simponi SQ was dispensed within the past 130 days (verified by chart notes or pharmacy paid claims)**

❑ Diagnosis: Moderate-to-Severe Active Ulcerative Colitis

- ❑ **Dosing: SubQ: Adults and pediatric patients 40 kg and greater -** Induction: 200 mg at week 0, then 100 mg at week 2, followed by maintenance therapy of 100 mg at week 6 and every 4 weeks thereafter
- ❑ **Dosing: SubQ: Pediatric patients at least 15 kg to less than 40 kg -** Induction: 100 mg at week 0, then 50 mg at week 2, followed by maintenance therapy of 50 mg at week 6 and every 4 weeks thereafter

- ❑ Member weighs at least 15 kg
- ❑ Member has a diagnosis of moderate-to-severe active **Ulcerative Colitis**
- ❑ Prescribed by or in consultation with a **Gastroenterologist**

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- ❑ Member meets **ONE** of the following unless member has a contraindication or intolerance:
  - ❑ Member has tried and failed corticosteroids
  - ❑ Member has tried and failed at least **ONE** of the following **DMARD**:
    - ❑ 5-aminosalicylates (balsalazide, olsalazine, sulfasalazine)
    - ❑ oral mesalamine (Apriso, Asacol/HD, Delzicol, Lialda, Pentasa)
    - ❑ Other immunosuppressant drug: _____
  - ❑ Member has previously tried and failed another biologic medication other than the requested medication (e.g., Skyrizi, Tremfya, ustekinumab)
- ❑ Member meets **ONE** of the following:
  - ❑ Member tried and failed, has a contraindication, or intolerance to **ONE** of the **PREFERRED** biologics below **(verified by chart notes or pharmacy paid claims):**

❑ Preferred adalimumab product	❑ Skyrizi®	❑ Tremfya®
❑ Preferred ustekinumab product	❑ Zymfentra™	

  - ❑ Member has been established on Simponi® SQ for at least 90 days **AND** prescription claims history indicates **at least a 90-day supply of Simponi SQ was dispensed within the past 130 days (verified by chart notes or pharmacy paid claims)**

Medication being provided by a Specialty Pharmacy – Proprium Rx

*****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:** ~~6/21/2010; 8/17/2023; 7/26/2024;~~ ~~11/21/2024;~~ ~~11/20/2025; 3/26/2026;~~ **9/24/2026**
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