SENTARA COMMUNITY PLAN
(MEDICAID)

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 1-844-305-2331**. 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**.

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

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

Member Name: _____

Member Sentara #: _____ **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:** _____

- ❑ 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.

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

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- ❑ Member has a diagnosis of moderate to severe active rheumatoid arthritis

OR

- ❑ Member has a diagnosis of psoriatic arthritis

AND

- ❑ Prescriber is a **Rheumatologist**

AND

- ❑ Trial and failure of at least **ONE DMARD** therapy **(check each tried)**:

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

AND

- ❑ Member has trial and failure of **TWO (2)** of the **PREFERRED** biologics below:

❑ Humira®	❑ Enbrel®	❑ Infliximab

❑ **Diagnosis - Active Ankylosing Spondylitis**
Dosage: IV: 2 mg/kg at weeks 0, 4, and then every 8 weeks thereafter

- ❑ Diagnosed with **active ankylosing spondylitis**

AND

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

AND

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

AND

Trial and failure, contraindication, or adverse reaction to methotrexate

AND

- ❑ Trial and failure of **TWO (2)** of the **PREFERRED** drugs below:

❑ Humira®	❑ Enbrel®	❑ Infliximab

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❑ **Diagnosis – Juvenile Rheumatoid Arthritis/ Juvenile Idiopathic Arthritis**
Dosage: IV: 80 mg/m2/dose at weeks 0, 4, and then every 8 weeks thereafter

- ❑ Member must be 2 years of age and older diagnosed with moderately or severely active **Juvenile Rheumatoid Arthritis or Idiopathic Arthritis**

AND

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

AND

- ❑ Member has at least five swollen joints

AND

- ❑ Member has three or more joints with limitation of motion and pain, tenderness or both

AND

- ❑ Member tried and failed **at least one (1)** previous **DMARD** therapy including but not limited to the following; check each tried:

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

AND

- ❑ Trial and failure of **TWO (2)** of the **PREFERRED** biologics below:

❑ Humira®	❑ Enbrel®

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 Sentara Health Pre-Authorization Department if they believe a standard review would subject the member to adverse health consequences. Sentara Health'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~~; ~~3/15/2021~~; ~~7/11/2022~~ **6/26/2023**