Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Simponi (golimumab) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 6 months; Continuation- 12 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Simponi (golimumab).** Please complete and fax this form back to Kaiser Permanente within 24 hours [fax: 1-866-331-2104]. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless this form is complete.**

KP-MAS Formulary can be found at: Pharmacy | Community Provider Portal | Kaiser Permanente

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Prescriber Information

Is the prescriber a Rheumatologist, Dermatologist, or Gastroenterologist? □ No □ Yes

If consulted with a specialist, specialist name and specialty: _____

Prescriber Name: _____ Specialty: _____ NPI: _____

Prescriber Address: _____

Prescriber Phone #: _____Prescriber Fax #: _____

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #_____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: _____
Sig: _____

Drug 2: Name/Strength/Formulation: _____
Sig: _____

5–Diagnosis/Clinical Criteria

1. Is this request for initial or continuing therapy?
□ Initial therapy □ Continuing therapy, state start date: _____

2. Indicate the patient's diagnosis for the requested medication: _____

Clinical Criteria:

Rheumatology:

1. Member has a diagnosis of active ankylosing spondylitis or nonradiographic axial spondyloarthritis
   □ No □ Yes

2. **AND** member has an intolerance to, contraindication to, or failed treatment with all of the following:
   a. Full anti-inflammatory dose of an NSAID taken on a regular continuing basis for at least 4 weeks, AND
   b. At least 2 anti-TNFs (adalimumab biosimilars (Amjevita preferred) or Humira, Enbrel, infliximab product)
   □ No □ Yes

OR

1. Member has a diagnosis of rheumatoid arthritis
   □ No □ Yes

2. **AND** member has an intolerance to, contraindication to, or failed treatment with all of the following:
   a. Xeljanz, Actemra, Orencia,
   b. **AND** at least 2 anti-TNFs (adalimumab biosimilars (Amjevita preferred) or Humira, Enbrel, infliximab product)
   □ No □ Yes

OR

1. Member has a diagnosis of psoriatic arthritis
   □ No □ Yes

2. **AND** member has an intolerance to, contraindication to, or failed treatment with all of the following:
   a. Xeljanz, Cosentyx, Orencia,
   b. **AND** at least 2 anti-TNFs (adalimumab biosimilars (Amjevita preferred) or Humira, Enbrel, infliximab product)
   □ No □ Yes

Gastroenterology:

1. Patient has a diagnosis of moderate to severe ulcerative colitis
   □ No □ Yes

2. **AND** patient has an intolerance to, contraindication to, or inadequate response to:
   a. Preferred anti-TNF agent [i.e. infliximab product (Inflectra preferred) or adalimumab product (Amjevita preferred)], AND
   b. At least one of the following:
      i. Entyvio (vedolizumab)
      ii. Xeljanz (tofacitinib)
   □ No □ Yes

For continuation of therapy, please respond to <u>additional questions</u> below:

1. Patient has documented a clinically significant benefit from medication
   □ No □ Yes

2. **AND** specialist follow-up occurred in past 12 months since last review
   □ No □ Yes

6 – Prescriber Sign-Off

Additional Information –

1. **Please submit chart notes/medical records for the patient that are applicable to this request.**
2. **If member has not tried preferred agent(s) please provide rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:**

_____

_____

_____

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Prescriber Signature:	**Date:**

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