Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

Simponi Aria
(golimumab intravenous)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication requested:
☐ Simponi Aria 50mg

Dose and Quantity: Duration of therapy: J-Code:

Frequency of administration: ICD10:

Height (ft, in): Weight (lb or kg):

Is this a new start or continuation of therapy? If your patient has already begun treatment with drug samples of Simponi Aria, please choose "new start therapy". ☐ new start of therapy ☐ continuation of therapy

If continued therapy:
Is there documentation of a beneficial response to this medication? ☐ Yes ☐ No
(if no) Please provide clinical support for the continued use:

Please provide the dates your patient has received Simponi Aria:

Besides the drug being requested, other biological drugs include Actemra, adalimumab (Amjevita, Humira), Adbry, Cibinqo, Cimzia, Cosentyx, Enbrel, Entyvio, Ilumya, infliximab (Avsola, Inflectra, Remicade, Renflexis), Kevzara, Kineret, Olumiant, Orencia, Otezla, Rinvoq, rituximab (Riabni, Rituxan, Rituxan Hycela, Ruxience, Truxima), Rituxan, Siliq, Simponi/Simponi Aria, Skyrizi, Sotyktu, Stelara, Taltz, Tremfya, Tysabri, Xeljanz, Zeposia. Which of the following best describes your patient's situation?

☐ The patient is NOT taking any other biological at this time, nor will they in the future. The requested drug is the only biological the patient is/will be using.
☐ The patient is currently on another biological, but this drug will be stopped and the requested drug will be started.
☐ The patient is currently on another biological, and the requested drug will be added. The patient may continue to take both drugs together.
☐ The patient is currently on BOTH the requested drug AND another biological.
☐ other

(if other/more than Simponi Aria) Please provide the clinical rationale for concurrent use.

(Please note: there are different preferred products depending on your patient's plan. Please refer to the applicable Cigna health care professional resource

[e.g. cignaforhcp.com] to determine benefit availability and the terms and conditions of coverage)

Where will this medication be obtained?

☐ Accredo Specialty Pharmacy**
☐ Hospital Outpatient
☐ Retail pharmacy
☐ Other (please specify):
☐ Home Health / Home Infusion vendor
☐ Physician's office stock (billing on a medical claim form)

***Cigna's nationally preferred specialty pharmacy*

***Medication orders can be placed with Accredo via E-prescribe - Accredo (1620 Century Center Pkwy, Memphis, TN 38134-8822 | NCPDP 4436920), Fax 888.302.1028, or Verbal 866.759.1557*

Facility and/or doctor dispensing and administering medication:

Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

Where will this drug be administered?

☐ Patient's Home
☐ Hospital Outpatient
☐ Physician's Office
☐ Other (please specify):

***NOTE:** Per some Cigna plans, infusion of medication MUST occur in the least intensive, medically appropriate setting.*

Is this patient a candidate for re-direction to an alternate setting (such as alternate infusion site, physician's office, home) with assistance of a Specialty Care Options Case Manager? ☐ Yes ☐ No (provide medical necessity rationale):

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

Diagnosis related to use:

☐ ankylosing spondylitis (AS)
☐ polyarticular juvenile idiopathic arthritis (PJIA)
☐ psoriatic arthritis (PsA)
☐ rheumatoid arthritis (RA)
☐ ulcerative colitis (UC)
☐ other (Please specify):

Clinical Information:

(if AS, PJIA, RA) Is the requested medication being prescribed by, or in consultation with, a rheumatologist? ☐ Yes ☐ No

(if PsA) Is the requested medication being prescribed by, or in consultation with, a rheumatologist or dermatologist? ☐ Yes ☐ No

(if AS, RA) Has your patient already tried a biologic or targeted synthetic DMARD (tsDMARD) for their condition? ☐ Yes ☐ No

(if no and AS) The covered alternatives are non-steroidal anti-inflammatory drugs (NSAIDs). For the alternatives tried, please include drug name and strength, date(s) taken and for how long, and what the documented results were of taking each drug, including any intolerances or adverse reactions your patient experienced. For the alternatives NOT tried, please provide details why your patient can't try that drug.

Per the information provided above, which of the following is true for your patient in regards to the covered alternatives?
☐ The patient tried one of the alternatives, but it didn't work.
☐ The patient tried one of the alternatives, but they did not tolerate it.
☐ The patient cannot try one of these alternatives because of a contraindication to this drug.
☐ Other

(if no and RA) The covered alternatives are conventional synthetic disease-modifying anti-rheumatic drugs (csDMARDs). For the alternatives tried, please include drug name and strength, date(s) taken and for how long, and what the documented results were of taking each drug, including any intolerances or adverse reactions your patient experienced. For the alternatives NOT tried, please provide details why your patient can't try that drug.

Per the information provided above, which of the following is true for your patient in regards to the covered alternatives?
☐ The patient tried one of the alternatives, but it didn't work.
☐ The patient tried all of the alternatives, but they did not tolerate any of them.
☐ The patient cannot try any of these alternatives because of a contraindication to each one.
☐ Other

Additional pertinent information: *Please include any alternatives tried, with drug name, date(s) taken and for how long, and what the documented results were of taking this drug, including any intolerances or adverse reactions your patient experienced.*

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

Save Time! Submit Online at: www.covermymeds.com/main/prior-authorization-forms/cigna/ or via SureScripts in your EHR.

Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

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