Simponi Aria (golimumab injection for intravenous use)

Line(s) of Business: 
HMO; PPO; QUEST Integration
Akamai Advantage

Effective Date:

POLICY

A. INDICATIONS
   The indications below including FDA-approved indications and compendial uses are considered a
   covered benefit provided that all the approval criteria are met and the member has no exclusions to
   the prescribed therapy.

   FDA-Approved Indication
   - Moderately to severely active rheumatoid arthritis in combination with methotrexate

B. CRITERIA FOR INITIAL APPROVAL
   1. Moderately to severely active rheumatoid arthritis (RA)
      Initial authorization of 6 months may be granted for members who meet all of the following
      criteria:
      i. Member has tried a disease modifying anti-rheumatic drug (DMARD)
      ii. Simponi must be prescribed in combination with methotrexate (MTX) unless the
          member has a clinical reason not to use MTX.

C. RE-AUTHORIZATION/CONTINUATION OF THERAPY
   Members who have had Simponi Aria previously authorized by HMSA/CVS are subject to the
   continuation criteria below for approval. Members without previous authorization are required to
   meet criteria for initial authorization in section B. above.

   Authorization of 12 months may be granted for members who achieve or maintain positive clinical
   response as evidenced by low disease activity, improvement in signs and symptoms or maintenance
   of improvement in signs and symptoms.

D. DOSAGE AND ADMINISTRATION
   Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted
   compendia, and/or evidence-based practice guidelines.

E. IMPORTANT REMINDER
   The purpose of this Medical Policy is to provide a guide to coverage. This Medical Policy is not
   intended to dictate to providers how to practice medicine. Nothing in this Medical Policy is intended
   to discourage or prohibit providing other medical advice or treatment deemed appropriate by the
   treating physician.
Benefit determinations are subject to applicable member contract language. To the extent there are any conflicts between these guidelines and the contract language, the contract language will control.

This Medical Policy has been developed through consideration of the medical necessity criteria under Hawaii’s Patients’ Bill of Rights and Responsibilities Act (Hawaii Revised Statutes §432E-1.4), generally accepted standards of medical practice and review of medical literature and government approval status. HMSA has determined that services not covered under this Medical Policy will not be medically necessary under Hawaii law in most cases. If a treating physician disagrees with HMSA’s determination as to medical necessity in a given case, the physician may request that CVS/caremark reconsider the application of the medical necessity criteria to the case at issue in light of any supporting documentation.

F. REFERENCES