



Medical Policy Manual **Approved Rev: Do Not Implement until 7/31/24**

Golimumab (Simponi ARIA®)

IMPORTANT REMINDER

We develop Medical Policies to provide guidance to Members and Providers. This Medical Policy relates only to the services or supplies described in it. The existence of a Medical Policy is not an authorization, certification, explanation of benefits or a contract for the service (or supply) that is referenced in the Medical Policy. For a determination of the benefits that a Member is entitled to receive under his or her health plan, the Member's health plan must be reviewed. If there is a conflict between the medical policy and a health plan or government program (e.g., TennCare), the express terms of the health plan or government program will govern.

POLICY

I. 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.

A. FDA-Approved Indications

1. Adult patients with moderately to severely active rheumatoid arthritis (RA) in combination with methotrexate
2. Active psoriatic arthritis (PsA) in patients 2 years of age and older
3. Adult patients with active ankylosing spondylitis (AS)
4. Active polyarticular juvenile idiopathic arthritis (pJIA) in patients 2 years of age and older

B. Compendial Uses

1. **Non-radiographic** axial spondyloarthritis
2. Oligoarticular juvenile idiopathic arthritis
3. **Immune checkpoint inhibitor-related toxicities - inflammatory arthritis**

All other indications are considered experimental/investigational and not medically necessary.

II. DOCUMENTATION

Submission of the following information is necessary to initiate the prior authorization review:

A. Rheumatoid arthritis (RA)

1. Initial requests:
 - i. Chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy. If therapy is not advisable, documentation of clinical reason to avoid therapy.
 - ii. Laboratory results, chart notes, or medical record documentation of biomarker testing (i.e., rheumatoid factor [RF], anti-cyclic citrullinated peptide [anti-CCP], and C-reactive protein [CRP] and/or erythrocyte sedimentation rate [ESR]) (if applicable).
2. Continuation requests: Chart notes or medical record documentation supporting positive clinical response.

B. Psoriatic arthritis (PsA), ankylosing spondylitis (AS), **non-radiographic** axial spondyloarthritis (**nr-axSpA**), and **immune checkpoint inhibitor-related toxicity**



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1. Initial requests: Chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy. If therapy is not advisable, documentation of clinical reason to avoid therapy.
 2. Continuation requests: Chart notes or medical record documentation supporting positive clinical response.
- C. Articular juvenile idiopathic arthritis (JIA)**
1. Initial requests: Chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy.
 2. Continuation requests: Chart notes or medical record documentation supporting positive clinical response.

III. PRESCRIBER SPECIALTIES

This medication must be prescribed by or in consultation with one of the following:

- A. Rheumatoid arthritis, ankylosing spondylitis, **non-radiographic** axial spondyloarthritis, and articular juvenile idiopathic arthritis: rheumatologist
- B. Psoriatic arthritis: rheumatologist or dermatologist
- C. **Immune checkpoint inhibitor-related toxicity: oncologist, hematologist, or rheumatologist**

IV. CRITERIA FOR INITIAL APPROVAL

A. Rheumatoid arthritis (RA)

1. Authorization of 12 months may be granted for adult members who have previously received a biologic or targeted synthetic drug (e.g. Rinvoq, Xeljanz) indicated for moderately to severely active rheumatoid arthritis. The requested medication must be prescribed in combination with methotrexate or leflunomide unless the member has a clinical reason not to use methotrexate or leflunomide (see Appendix A).
2. Authorization of 12 months may be granted for adult members for treatment of moderately to severely active RA when all of the following criteria are met:
 - i. Member meets either of the following criteria:
 - a. Member has been tested for either of the following biomarkers and the test was positive:
 1. Rheumatoid factor (RF)
 2. Anti-cyclic citrullinated peptide (anti-CCP)
 - b. Member has been tested for ALL of the following biomarkers:
 1. RF
 2. Anti-CCP
 3. C-reactive protein (CRP) and/or erythrocyte sedimentation rate (ESR)
 - ii. Member is prescribed the requested medication in combination with methotrexate or leflunomide or has a clinical reason not to use methotrexate or leflunomide (see Appendix A).
 - iii. Member meets either of the following criteria:
 - a. Member has experienced an inadequate response to at least a 3-month trial of methotrexate despite adequate dosing (i.e., titrated to at least 15 mg/week).
 - b. Member has an intolerance or contraindication to methotrexate (see Appendix A).

B. Psoriatic arthritis (PsA)

1. Authorization of 12 months may be granted for members 2 years of age and older who have previously received a biologic or targeted synthetic drug (e.g., Rinvoq, Otezla) indicated for active psoriatic arthritis.



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2. Authorization of 12 months may be granted for members 2 years of age and older for treatment of active psoriatic arthritis when either of the following criteria is met:
 - i. Member has mild to moderate disease and meets one of the following criteria:
 - a. Member has had an inadequate response to methotrexate, leflunomide, or another conventional synthetic drug (e.g., sulfasalazine) administered at an adequate dose and duration.
 - b. Member has an intolerance or contraindication to methotrexate or leflunomide (see Appendix A), or another conventional synthetic drug (e.g., sulfasalazine).
 - c. Member has enthesitis or predominantly axial disease.
 - ii. Member has severe disease.

C. Ankylosing spondylitis (AS) and non-radiographic axial spondyloarthritis (nr-axSpA)

1. Authorization of 12 months may be granted for adult members who have previously received a biologic or targeted synthetic drug (e.g., Rinvoq, Xeljanz) indicated for active ankylosing spondylitis or active non-radiographic axial spondyloarthritis.
2. Authorization of 12 months may be granted for adult members for treatment of active ankylosing spondylitis or active non-radiographic axial spondyloarthritis when any of the following criteria is met:
 - i. Member has experienced an inadequate response to at least two non-steroidal anti-inflammatory drugs (NSAIDs).
 - ii. Member has an intolerance or contraindication to two or more NSAIDs.

D. Articular juvenile idiopathic arthritis (JIA)

1. Authorization of 12 months may be granted for members 2 years of age and older who have previously received a biologic or targeted synthetic drug (e.g., Xeljanz) indicated for active articular juvenile idiopathic arthritis.
2. Authorization of 12 months may be granted for members 2 years of age and older for treatment of active articular juvenile idiopathic arthritis when any of the following criteria is met:
 - i. Member has had an inadequate response to methotrexate or another conventional synthetic drug (e.g., leflunomide, sulfasalazine, hydroxychloroquine) administered at an adequate dose and duration.
 - ii. Member has had an inadequate response to a trial of scheduled non-steroidal anti-inflammatory drug (NSAID) and/or intra-articular glucocorticoids (e.g., triamcinolone hexacetonide) and one of the following risk factors for poor outcome:
 - a. Involvement of ankle, wrist, hip, sacroiliac joint, and/or temporomandibular joint (TMJ)
 - b. Presence of erosive disease or enthesitis
 - c. Delay in diagnosis
 - d. Elevated levels of inflammation markers
 - e. Symmetric disease
 - iii. Member has risk factors for disease severity and potentially a more refractory disease course (see Appendix B) and the member also meets one of the following:
 - a. High-risk joints are involved (e.g., cervical spine, wrist, or hip).
 - b. High disease activity.
 - c. Is judged to be at high risk for disabling joint disease.

E. Immune checkpoint inhibitor-related toxicity

Authorization of 12 months may be granted for treatment of immune checkpoint inhibitor-related toxicity when the member has severe immunotherapy-related inflammatory arthritis and meets either of the following:

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1. Member has experienced an inadequate response to corticosteroids.
2. Member has an intolerance or contraindication to corticosteroids.

V. CONTINUATION OF THERAPY

A. Rheumatoid arthritis (RA)

Authorization of 12 months may be granted for all adult members (including new members) who are using the requested medication for moderately to severely active rheumatoid arthritis and who achieve or maintain a positive clinical response as evidenced by disease activity improvement of at least 20% from baseline in tender joint count, swollen joint count, pain, or disability.

B. Psoriatic arthritis (PsA)

Authorization of 12 months may be granted for all members 2 years of age and older (including new members) who are using the requested medication for psoriatic arthritis and who achieve or maintain a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition when there is improvement in any of the following from baseline:

1. Number of swollen joints
2. Number of tender joints
3. Dactylitis
4. Enthesitis
5. Axial disease
6. Skin and/or nail involvement

C. Ankylosing spondylitis (AS) and **non-radiographic axial spondyloarthritis (axSpA)**

Authorization of 12 months may be granted for all adult members (including new members) who are using the requested medication for ankylosing spondylitis or **non-radiographic axial spondyloarthritis** and who achieve or maintain a positive clinical response with the requested medication as evidenced by low disease activity or improvement in signs and symptoms of the condition when there is improvement in any of the following from baseline:

1. Functional status
2. Total spinal pain
3. Inflammation (e.g., morning stiffness)

D. Articular juvenile idiopathic arthritis (JIA)

Authorization of 12 months may be granted for all members 2 years of age and older (including new members) who are using the requested medication for active articular juvenile idiopathic arthritis and who achieve or maintain a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition when there is improvement in any of the following from baseline:

1. Number of joints with active arthritis (e.g., swelling, pain, limitation of motion)
2. Number of joints with limitation of movement
3. Functional ability

E. **Immune checkpoint inhibitor-related toxicity**

Authorization of 12 months may be granted for all members (including new members) who are using the requested medication for immunotherapy-related inflammatory arthritis and who achieve or maintain a positive clinical response with the requested medication as evidenced by low disease activity or improvement in signs and symptoms of the condition.

VI. OTHER



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For all indications: Member has had a documented negative tuberculosis (TB) test (which can include a tuberculosis skin test [PPD], an interferon-release assay [IGRA], or a chest x-ray)* within 6 months of initiating therapy for persons who are naïve to biologic drugs or targeted synthetic drugs associated with an increased risk of TB.

* If the screening testing for TB is positive, there must be further testing to confirm there is no active disease. Do not administer the requested medication to members with active TB infection. If there is latent disease, TB treatment must be started before initiation of the requested medication.

For all indications: Member cannot use the requested medication concomitantly with any other biologic drug or targeted synthetic drug **for the same indication**.

VII. DOSAGE AND ADMINISTRATION

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

VIII. APPENDICES

Appendix A: Examples of **clinical reasons to avoid pharmacologic treatment with methotrexate or leflunomide**

1. Clinical diagnosis of alcohol use disorder, alcoholic liver disease or other chronic liver disease
2. **Drug interaction**
3. **Risk of treatment related toxicity**
4. Pregnancy or currently planning pregnancy
5. Breastfeeding
6. **Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension)**
7. Hypersensitivity
8. History of intolerance or adverse event

Appendix B: Risk factors for Articular Juvenile Idiopathic Arthritis

1. Positive rheumatoid factor
2. Positive anti-cyclic citrullinated peptide antibodies
3. Pre-existing joint damage

MEDICATION QUANTITY LIMITS

Drug Name	Diagnosis	Maximum Dosing Regimen
Simponi Aria (Golimumab)	Ankylosing Spondylitis or Axial Spondyloarthritis	Route of Administration: Intravenous ≥18 Years Initial: 2mg/kg on weeks 0 and 4 Maintenance: 2mg/kg every 8 weeks
Simponi Aria (Golimumab)	Immune Checkpoint Inhibitor-Related Toxicity	Route of Administration: Intravenous ≥18 Years Initial: 2mg/kg on weeks 0 and 4 Maintenance: 2mg/kg every 8 weeks
Simponi Aria (Golimumab)	Polyarticular Juvenile Idiopathic Arthritis or	Route of Administration: Intravenous 2-17 Years Initial: 80mg/m ² on weeks 0 and 4



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	Oligoarticular Juvenile Idiopathic Arthritis	Maintenance: 80mg/m ² every 8 weeks
Simponi Aria (Golimumab)	Psoriatic Arthritis	Route of Administration: Intravenous <u>2-17 Years</u> Initial: 80mg/m ² on weeks 0 and 4 Maintenance: 80mg/m ² every 8 weeks <u>≥18 Years</u> Initial: 2mg/kg on weeks 0 and 4 Maintenance: 2mg/kg every 8 weeks
Simponi Aria (Golimumab)	Rheumatoid Arthritis	Route of Administration: Intravenous <u>≥18 Years</u> Initial: 2mg/kg on weeks 0 and 4 Maintenance: 2mg/kg every 8 weeks

APPLICABLE TENNESSEE STATE MANDATE REQUIREMENTS

BlueCross BlueShield of Tennessee's Medical Policy complies with Tennessee Code Annotated Section 56-7-2352 regarding coverage of off-label indications of Food and Drug Administration (FDA) approved drugs when the off-label use is recognized in one of the statutorily recognized standard reference compendia or in the published peer-reviewed medical literature.

ADDITIONAL INFORMATION

For appropriate chemotherapy regimens, dosage information, contraindications, precautions, warnings, and monitoring information, please refer to one of the standard reference compendia (e.g., the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) published by the National Comprehensive Cancer Network®, Drugdex Evaluations of Micromedex Solutions at Truven Health, or The American Hospital Formulary Service Drug Information).

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EFFECTIVE DATE 7/31/2024

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