

## Payer Policy Summary Sheet for SIMPONI™ (golimumab)

Insurer \_\_\_\_\_ Plan Type (e.g., PPO, HMO) \_\_\_\_\_

Major Employers Utilizing Plan \_\_\_\_\_

### Product Access Requirements

Prior Authorization Policy \_\_\_\_\_

PA Valid for \_\_\_\_\_ Months or \_\_\_\_\_ Injections

Pre-Formulary Exception Requirements:  Letter of Medical Necessity  
 Biologic Step or Fail First Policy  
 Other

**Specialty Pharmacy:**

Optional:  Yes  No      Mandatory:  Yes  No

Preferred SPP: \_\_\_\_\_

Delivery Policies/Site Options: \_\_\_\_\_

Tier Level: \_\_\_\_\_ Monthly Co-pay: \_\_\_\_\_

**Retail Pharmacy:**

Optional:  Yes  No      Mandatory:  Yes  No

Preferred Retail Pharmacy: \_\_\_\_\_

Tier Level: \_\_\_\_\_ Monthly Co-pay: \_\_\_\_\_

### Injection Training Information

Is a Separate Prior Authorization Required for Injection Training?  Yes  No

Prior Authorization Policy \_\_\_\_\_

PA Valid for \_\_\_\_\_ Months or \_\_\_\_\_ Injections

**In Prescriber's Office:**

Practice/Facility:  In Network  Out of Network

Injection Service Coding Requirements:

CPT 90772

Other \_\_\_\_\_

**Alternate Site of Care:**

Another Physician's Office \_\_\_\_\_

Hospital Outpatient Department \_\_\_\_\_

Alternate Healthcare Facility \_\_\_\_\_

Other \_\_\_\_\_

Other Comments \_\_\_\_\_

### Key Contact at Payer

Name \_\_\_\_\_

Name \_\_\_\_\_

Phone \_\_\_\_\_

Phone \_\_\_\_\_

Fax \_\_\_\_\_

Fax \_\_\_\_\_

Email \_\_\_\_\_

Email \_\_\_\_\_

**Before prescribing SIMPONI™, please see Full Prescribing Information, including Boxed Warning, Warnings and Precautions, Adverse Reactions, and Medication Guide, available at [www.simponi.com](http://www.simponi.com).**