blue california
Promise Health Plan

golimumab (Simponi Aria)

Medical Benefit Drug Policy

Drug Details

USP Category: IMMUNOLOGICAL AGENTS
Mechanism of Action: monoclonal antibody tumor necrosis factor (TNF) blocking agent.
HCPCS:
J1602:Injection, golimumab, 1 mg, for intravenous use
How Supplied:
50 mg/4 mL solution (single-dose vial)

Condition(s) listed in policy *(see coverage criteria for details)*

- Ankylosing Spondylitis (AS)
- Polyarticular Juvenile Idiopathic Arthritis (pJIA)
- Psoriatic Arthritis (PsA)
- Rheumatoid Arthritis (RA)

Any condition not listed in this policy requires a review to confirm it is medically necessary. For conditions that have not been approved for intended use by the Food and Drug Administration (i.e., off-label use), the criteria outlined in the California Code of Regulations (CCR), Title 22, Section 51303 and 51313 must be met.

Special Instructions and Pertinent Information

Provider must submit documentation (such as office chart notes, lab results or other clinical information) to ensure the member has met all medical necessity requirements.

The member's specific benefit may impact drug coverage. Other utilization management processes, and/or legal restrictions may take precedence over the application of this clinical criteria.

Coverage Criteria
The following condition(s) require Prior Authorization/Preservice.

Ankylosing Spondylitis (AS)
Meets medical necessity if all the following are met:

Initial:

1. Prescribed by or in consultation with a rheumatologist
2. Meets ONE of the following:
   a. Inadequate response with a trial of any two-prescription strength NSAIDs
   b. Intolerable GI adverse events after a trial of a prescription strength NSAID in combination with a PPI
   c. Unable to take NSAIDs due to history of GI bleed
3. Not being used in combination with other targeted immunomodulators (e.g., anti-TNFs, interleukin inhibitors, JAK inhibitors)

4. Patient has had an inadequate response or intolerable side effect with preferred infliximab (Avsola, Inflectra, or Renflexis), or contraindication to all infliximab products

Reauthorization:

1. Patient is responding to therapy
2. ***Effective 2/1/2026 and after:*** Not being used in combination with other targeted immunomodulators (e.g., anti-TNFs, interleukin inhibitors, JAK inhibitors)

Covered Doses:
Up to 2 mg/kg given intravenously at weeks 0 and 4, then every 8 weeks

Coverage Period:
one year

ICD-10:
M45.0-M45.9

Polyarticular Juvenile Idiopathic Arthritis (pJIA)

Meets medical necessity if all the following are met:

Initial:

1. Prescribed by or in consultation with a rheumatologist
2. Inadequate response or intolerance to a disease modifying anti-rheumatic drug (DMARD) or documented medical reason why methotrexate cannot be used
3. Not being used in combination with other targeted immunomodulators (e.g., anti-TNFs, interleukin inhibitors)
4. Inadequate response or intolerable side effect with at least two of the following: anti-TNFs, or JAK inhibitors

Reauthorization:

1. Patient is responding to therapy
2. ***Effective 2/1/2026 and after:*** Not being used in combination with other targeted immunomodulators (e.g., anti-TNFs, interleukin inhibitors)

Covered Doses:
Up to 80 mg/m^2 given intravenously at weeks 0 and 4, and every 8 weeks thereafter

Coverage Period:
one year

ICD-10:
M08.00-M08.40

Psoriatic Arthritis (PsA)

Meets medical necessity if all the following are met:

Initial:

1. Prescribed by or in consultation with a rheumatologist

2. Inadequate response, intolerance, or contraindication to one or more disease modifying anti-rheumatic drugs (DMARDs), or has a medical reason why methotrexate, sulfasalazine, and leflunomide cannot be used
3. Not being used in combination with other targeted immunomodulators (e.g., anti-TNFs, interleukin inhibitors, JAK inhibitors)
4. Inadequate response or intolerable side effect with preferred infliximab (Avsola, Inflectra or Renflexis) or contraindication to all infliximab products

Reauthorization:

1. Patient is responding to therapy
2. ***Effective 2/1/2026 and after:*** Not being used in combination with other targeted immunomodulators (e.g., anti-TNFs, interleukin inhibitors, JAK inhibitors)

Covered Doses:
Up to 2 mg/kg given intravenously at weeks 0 and 4, then every 8 weeks

Coverage Period:
one year

ICD-10:
L40.50-L40.59

Rheumatoid Arthritis (RA)
Meets medical necessity if all the following are met:
Initial:

1. Prescribed by or in consultation with a rheumatologist
2. Inadequate response, intolerable side effect, or contraindication to a DMARD (e.g., methotrexate, hydroxychloroquine, leflunomide, and sulfasalazine)
3. Not used in combination with other targeted immunomodulators (e.g., anti-TNFs, interleukin inhibitors, JAK inhibitors)
4. Inadequate response or intolerable side effect with preferred infliximab (Avsola, Inflectra or Renflexis) or contraindication to all infliximab products

Reauthorization:

1. Patient is responding to therapy
2. ***Effective 2/1/2026 and after:*** Not being used in combination with other targeted immunomodulators (e.g., anti-TNFs, interleukin inhibitors, JAK inhibitors)

Covered Doses:
Up to 2 mg/kg given intravenously at weeks 0 and 4, then every 8 weeks

Coverage Period:
one year

ICD-10:
(X=0-9) M05.XXX, M06.0XX, M06.2XX, M06.3XX, M06.8XX, M06.9

References

1. AHFS. Available by subscription at http://www.lexi.com
2. DrugDex. Available by subscription at http://www.micromedexsolutions.com/home/dispatch
3. Fraenkel L, Bathon JM, England BR, et al. 2021 American College of Rheumatology Guideline for the Treatment of Rheumatoid Arthritis. Arthritis Care Res (Hoboken). 2021;73(7):924-939.
4. MCG™ Care Guidelines, 19th edition, 2015, Home Infusion Therapy, CMT: CMT-0009(SR)
5. Simponi Aria (golimumab) [Prescribing information]. Janssen Biotech Inc.,Horsham, PA. April 2025.
6. Singh JA, Guyatt G, Ogdie A, et al. 2018 American College of Rheumatology/National Psoriasis Foundation Guideline for the Treatment of Psoriatic Arthritis. Arthritis Rheum 2019; 71:5-32.
7. Ward, MM, Deodhar A, Gensler, LS, et al. 2019 Update of the American College of Rheumatology/Spondylitis Association of America/Spondyloarthritis Research and Treatment Network Recommendations for the Treatment of Ankylosing Spondylitis and Nonradiographic Axial Spondyloarthritis. Arthritis Rheumatol, 2019;71(10):1599-1613.
8. Ringold S MD, MS, Angeles-Han S MD, MSc, Beukelman T MD, MSCE, et al. 2019 American College of Rheumatology/Arthritis Foundation Guideline for the Treatment of Juvenile Idiopathic Arthritis: Therapeutic Approaches for Non-Systemic Polyarthritis, Sacrolitis, and Enthesitis. Arthritis Rheum 2019 Jun;71(6):846-863.

Review History

Date of Last Annual Review: 4Q2025

Changes from previous policy version:

- Ankylosing Spondylitis, Polyarticular Juvenile Idiopathic Arthritis, Psoriatic Arthritis: Added reauthorization criteria
- Rheumatoid Arthritis: Clarified prerequisite requirement to include DMARDs for rheumatoid arthritis and added reauthorization criteria

Blue Shield of California Medication Policy to Determine Medical Necessity
Reviewed by P&T Committee