# Simponi Aria® (Golimumab) Injection for Intravenous Infusion (for Ohio Only)

**Policy Number**: CSOH2025D0051.C
**Effective Date**: March 1, 2025

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| Related Policies |
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| None |

## Application

This Medical Benefit Drug Policy only applies to the state of Ohio. Any requests for services that are stated as unproven or services for which there is a coverage or quantity limit will be evaluated for medical necessity using Ohio Administrative Code 5160-1-01

## Coverage Rationale

This policy refers only to Simponi Aria (golimumab) injection for intravenous infusion. Simponi, for self-administered subcutaneous injection, is obtained under the pharmacy benefit.

**Simponi Aria® (Golimumab) is proven and medically necessary for the treatment of certain conditions outlined within the InterQual® criteria.** For medical necessity clinical coverage criteria, refer to the current release of the InterQual® guideline for: Simponi Aria: CP: Specialty Rx Non-Oncology, Golimumab (Simponi Aria).

Click here to view the InterQual® criteria.

## Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

| HCPCS Code | Description |
|---|---|
| J1602 | Injection, golimumab, 1 mg, for intravenous use |

## Policy History/Revision Information

| Date | Summary of Changes |
|---|---|
| 03/01/2025 | **Coverage Rationale**<br>• Replaced coverage guidelines with language indicating:<br>  ○ This policy refers only to Simponi Aria (golimumab) injection for intravenous infusion; Simponi for self-administered subcutaneous injection is obtained under the pharmacy benefit |

| Date | Summary of Changes |
|---|---|
| | ○ Simponi Aria® (Golimumab) is proven and medically necessary for the treatment of certain conditions outlined within the InterQual® criteria; for medical necessity clinical coverage criteria, refer to the current release of the InterQual® CP: Specialty Rx Non-Oncology, Golimumab (Simponi Aria)<br>**Applicable Codes**<br>• Removed list of applicable ICD-10 diagnosis codes<br>**Supporting Information**<br>• Removed *Background*, *Clinical Evidence*, *FDA*, and *References* sections<br>• Archived previous policy version CSOH2024D0051.B |

# Instructions for Use

This Medical Benefit Drug Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the federal, state (Ohio Administrative Code [OAC]), or contractual requirements for benefit plan coverage must be referenced as the terms of the federal, state (OAC), or contractual requirements for benefit plan coverage may differ from the standard benefit plan. In the event of a conflict, the federal, state (OAC), or contractual requirements for benefit plan coverage govern. Before using this policy, please check the federal, state (OAC), or contractual requirements for benefit plan coverage. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Medical Benefit Drug Policy is provided for informational purposes. It does not constitute medical advice.

UnitedHealthcare may also use tools developed by third parties, such as the InterQual® criteria, to assist us in administering health benefits. The UnitedHealthcare Medical Benefit Drug Policies are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.