Priority Health Medicare prior authorization form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☐ **Medicare Part B** ☒ **Medicare Part D**

This request is: ☐ **Expedited request** ☐ **Standard request**

Your request will be expedited if you haven't gotten the prescription and Priority Health Medicare determines, or your prescriber tells us, that your life or health may be at risk by waiting.

Tremfya® (guselkumab)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____

Provider Address: _____

Provider NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Product and Billing Information

Drug product: ☐ Tremfya 100 mg/1mL syringe

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Dosage & dosing frequency: _____

Drug cost information

The wholesale acquisition cost for each 100 mg dose of Tremfya is $9,684. The annual cost of maintenance treatment with this drug is more than $63,000.

Prior authorization criteria

The following requirements need to be met before this drug is covered by Priority Health Medicare. These requirements have been approved by the Centers for Medicare and Medicaid Services (CMS), but you may ask us for an exception if you believe one or more of these requirements should be waived.

Before this drug is covered, the patient must meet all of the following requirements:

1. Must be age 18 or older
2. Must submit a negative TB test result from within the previous 12 months
3. Must be used for a medically-accepted indication*
4. For plaque psoriasis:
    - Must affect 5% or more of patient's body surface area (unless hands, feet, head, neck, or genitalia affected)
    - Must first try one non-biologic systemic drug
    - Must first try Enbrel or Humira

All fields must be complete and legible for review. Your office will receive a response via fax.

Updated 01/2019
Last reviewed 01/2019

Medically-accepted indication*

This drug is only covered under Medicare Part D when it is used for a medically accepted indication. A medically accepted indication is a use of the drug that is *either*:

- approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)
- — *or* — supported by certain reference books. (These reference books are the American Hospital Formulary Service Drug Information and the DRUGDEX Information System)

Additional information

When authorized, Priority Health will cover up to 100 mg (one syringe) at weeks 0 and 4, followed by 100 mg (one syringe) every 8 weeks for maintenance dosing.

Priority Health Precertification Documentation

A. What is the date and result of the patient's most recent TB test?

☐ Negative **Date:** _____
☐ Positive
☐ Not completed. **Are you requesting an exception to the criteria?**
  ☐ Yes. ***Rationale for exception***: _____
  ☐ No

B. What condition is this drug being requested for?

☐ Plaque psoriasis
☐ Other – the patient's condition is: _____
Rationale for Other use: _____

C. Does the patient have disease involvement of one or more of the following areas?

☐ hands
☐ feet
☐ head
☐ neck
☐ genitalia
☐ more than 5% body surface area

☐ None. **Are you requesting an exception to the criteria?**
  ☐ Yes. ***Rationale for exception***: _____
  ☐ No

D. Has the patient tried one of the following non-biologic systemic drugs?

☐ azathioprine
☐ methotrexate
☐ Soriatane
☐ cyclosporine
☐ Other: _____

☐ None. **Are you requesting an exception to the criteria?**
  ☐ Yes. ***Rationale for exception***: _____
  ☐ No

E. Did the patient first try Enbrel or Humira?

☐ Yes.
☐ No. **Are you requesting an exception to the criteria?**
  ☐ Yes. ***Rationale for exception***: _____
  ☐ No

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Priority Health Medicare Exception Request *(exceptions to the above criteria)*

Do you believe one or more of the prior authorization requirements should be waived? ☐ Yes ☐ No
If yes, you must provide a statement explaining the medical reason why the exception should be approved.

Would Tremfya likely be the most effective option for this patient?
☐ No
☐ Yes, because:_____

If the patient is currently using Tremfya, would changing the patient's current regimen likely result in adverse effects for the patient?
☐ No
☐ Yes, because:_____

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Updated 01/2019
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