PriorityHealth

Pharmacy Prior Authorization Form

For Prior Authorization, please fax to: 877 974-4411 toll free, or 616 942-8206

This form applies to: ☒ **Commercial (Traditional)** ☒ **Commercial (Individual/Optimized)**
☐ **Medicaid**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

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

☐ New request ☐ Continuation request

Drug product: ☐ Tremfya 100 mg/1 mL prefilled syringe

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Dose: _____ **Dose Frequency:** _____

ICD-10 Diagnosis code(s): _____

For first injection only (**if applicable):**

Place of administration:
☐ Physician's office
☐ Outpatient infusion
Facility: _____ NPI: _____ Fax: _____
☐ Home infusion
Agency: _____ NPI: _____ Fax: _____

Billing:
☐ Physician to buy and bill
☐ Facility to buy and bill
☐ Specialty Pharmacy
Pharmacy: _____ NPI: _____ Fax: _____

TREMFYA COVERAGE POLICY

- Before Tremfya is covered, the patient must meet all of the General Criteria for Tremfya and all of the Specific Criteria for the treatment diagnosis. If these criteria are not met, the prescriber must provide an explanation of why an exception to the criteria is necessary.
- Coverage for a diagnosis not listed below will be considered on a case by case basis. Please provide rationale for use and all pertinent patient information.
- Tremfya will not be covered in combination with another biologic drug.
- Please provide rationale when requesting any dose or dosing interval not listed in the FDA label.
- Please note, only the first injection will be covered under your medical benefit for administration by a healthcare professional. All subsequent injections are covered under the pharmacy benefit and are intended for self-administration.

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

Updated 01/2021
Last reviewed 01/2021

Criteria

General Criteria for ALL Diagnoses:

Prescriber is a specialist or has consulted with a specialist for the disease being treated.

Specific Criteria for Individual Diagnoses:

1. Plaque Psoriasis
    a. Patient has tried ALL of the following for a period of at least 3 months:
        i. One topical agent
        ii. One non-biologic traditional DMARD (e.g., methotrexate [MTX], cyclosporine, acitretin)
        iii. Phototherapy
2. Psoriatic arthritis
    a. Patient has tried at least ONE conventional synthetic DMARD (such as methotrexate, leflunomide, sulfasalazine, or azathioprine) for a period of at least 3 months

Note: Authorization for indications, dosing, or a route of administration not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the appropriateness of the drug, the dosing of the drug, or the route of administration to be used for the identified indication.

Priority Health Precertification Documentation

A. What condition is this drug being requested for?

- ☐ Plaque psoriasis
- ☐ Psoriatic arthritis
- ☐ Other – the patient's condition is: _____

Rationale for use: _____

B. Will the patient be receiving other biologic therapy in combination with Tremfya?

☐ No ☐ Yes, rationale for use: _____

C. Has the patient had a trial with one or more non-biologic systemic agents for a period of at least 3 months?

- ☐ No – rationale for use: _____
- ☐ Yes – Please mark the agent(s) tried and failed below

D. Which of the following has the patient had a documented therapeutic trial with?

- ☐ Methotrexate Dates of therapy: _____
- ☐ Cyclosporine Dates of therapy: _____
- ☐ Acitretin Dates of therapy: _____
- ☐ Other Drug: _____ Dates of therapy: _____

E. Has the patient had a trial with one or more topical agents for a period of at least 3 months?

- ☐ Yes
- ☐ No – rationale for use: _____

F. Has the patient had a trial with phototherapy for a period of at least 3 months?

- ☐ Yes, UVA
- ☐ Yes, UVB
- ☐ No – rationale for use: _____

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