PRIOR AUTHORIZATION REQUEST
Tremfya

PATIENT: Name_____
Address: _____
City, State, Zip_____
D.O.B. _____
Member ID:_____

Prescriber: Name_____
Address _____
City, State, Zip_____
Phone _____
Fax _____
NPI _____

Medication Requested:_____ Qty Requested: _____

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please answer the following questions

1. Will the requested medication be used in combination with a BIOLOGIC or with a targeted synthetic disease-modifying antirheumatic drug (DMARD) used for an inflammatory condition?
   - ☐ Biologic DMARD
   - ☐ Targeted synthetic DMARD
   - ☐ Conventional synthetic DMARD
   - ☐ No, the requested medication will NOT be used in combination with another BIOLOGIC or Targeted Synthetic disease-modifying antirheumatic drug (DMARD)
2. ☐ Yes ☐ No Is the patient currently receiving Tremfya?
3. What is the indication or diagnosis?
   - ☐ Plaque psoriasis
   - ☐ Psoriatic arthritis
   - ☐ All other indications or diagnoses – (Please Specify) _____
4. ☐ Yes ☐ No Has the patient tried at least one traditional systemic agent for psoriasis for at least 3 months, unless intolerant?
5. ☐ Yes ☐ No Has the patient already had a 3-month trial or previous intolerance to at least one biologic?
6. ☐ Yes ☐ No Does the patient have a contraindication to methotrexate (MTX), as determined by the prescriber?
7. ☐ Yes ☐ No Is the requested medication being prescribed by or in consultation with a dermatologist?
8. ☐ Yes ☐ No Has the patient had a response, as determined by the prescriber?
9. ☐ Yes ☐ No Is the requested medication being prescribed by or in consultation with a rheumatologist or a dermatologist?
10. ☐ Yes ☐ No Has the patient had a response, as determined by the prescriber?

If you have any questions, call: 800-753-2851

PRIOR AUTHORIZATION REQUEST
Tremfya

Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 877-251-5896

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

If you have any questions, call: 800-753-2851