maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

Tremfya

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

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 note that supporting clinical documentation is required for **ALL** PA requests.

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? [NOTE: Biologic DMARDs include Actemra (V or SC), Kevzara, Cosentyx, Kineret, Orencia (IV or SC), a rituximab product (for example, Rituxan, Truxima), Cimzia, Enbrel, Humira, an infliximab product (for example, Remicade, Inflectra, Renflexis), Simponi (Aria or SC), Ilumya, Siliq, Stelara (IV or SC), or (Taltz) and Targeted synthetic DMARDs include: Xeljanz/XR, Olumiant, Rinvoq, or Otezla.] [If yes, no further questions.]	Yes	No
2	Is the patient currently receiving Tremfya? [If no, skip to question 9.]	Yes	No

If you have any questions, call: 1-888-258-8250

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3	Has the patient been receiving medication samples for the requested medication? [If yes, skip to question 9.]	Yes	No
4	Does the patient have a previously approved prior authorization (PA) on file with the current plan? [NOTE: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If yes, skip to question 6.]	Yes	No
5	Has documentation been submitted to confirm that the patient has had a clinically significant response to therapy, as determined by the prescriber? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.] [If yes, skip to question 9.]	Yes	No
6	Has the patient been on established therapy for at least 3 months? [If no, skip to question 9.]	Yes	No
7	Has documentation been submitted to confirm that the patient has had a clinically significant response to therapy, as determined by the prescriber? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
8	What is the indication or diagnosis? [] Plaque psoriasis (If checked, no further questions) [] Psoriatic arthritis (If checked, no further questions) [] All other indications or diagnoses (If checked, no further questions)		
9	What is the indication or diagnosis? [] Plaque psoriasis (If checked, go to 10) [] Psoriatic arthritis (If checked, go to 16) [] All other indications or diagnoses (If checked, no further questions)		
10	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
11	Has the patient tried at least TWO traditional systemic agents for psoriasis for at least 3 months? [NOTE: Examples include methotrexate (MTX), cyclosporine, acitretin tablets (Soriatane), or psoralen plus ultraviolet A light (PUVA)] [If yes, skip to question 13.]	Yes	No

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12	Has documentation been submitted to confirm that the patient has an intolerance to at least TWO traditional systemic agents for psoriasis? ACTION REQUIRED: Submit supporting documentation. [NOTE: Examples include methotrexate, cyclosporine, acitretin (Soriatane, generics), or psoralen plus ultraviolet A light (PUVA).] [If no, no further questions.]	Yes	No
13	Has documentation been submitted to confirm that the patient has had a treatment failure with preferred TNF inhibitors, Enbrel (etanercept) and an adalimumab product (Hadlima, Yusimry, or adalimumab-adbm) for at least 3 months unless intolerant or contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
14	Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the indication? [If yes, no further questions.]	Yes	No
15	Is the requested medication being prescribed by or in consultation with a dermatologist? [No further questions.]	Yes	No
16	Has the patient tried at least TWO conventional synthetic disease-modifying antirheumatic drug (DMARD) for at least 3 months? [NOTE: Examples of conventional synthetic DMARDs include methotrexate (oral or injectable), leflunomide, hydroxychloroquine, and sulfasalazine.] [If yes, skip to question 18.]	Yes	No
17	Has documentation been submitted to confirm that the patient has an intolerance to at least TWO conventional synthetic disease-modifying antirheumatic drugs (DMARDs)? ACTION REQUIRED: Submit supporting documentation. [NOTE: Examples of conventional synthetic DMARDs include methotrexate (oral or injectable), leflunomide, hydroxychloroquine, and sulfasalazine.] [If no, no further questions.]	Yes	No
18	Has documentation been submitted to confirm that the patient has had a treatment failure with preferred TNF inhibitors, Enbrel (etanercept) and an adalimumab product (Hadlima, Yusimry, or adalimumab-adbm) for at least 3 months unless intolerant or contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
19	Has documentation been submitted to confirm that the patient has had a treatment failure with Xeljanz (tofacitinib) for at least 3 months, unless intolerant or contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
20	Does the requested dose exceed the Food and Drug Administration (FDA)	Yes	No

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	approved label dosing for the indication? [If yes, no further questions.]		
21	Is the requested medication being prescribed by or in consultation with a rheumatologist or a dermatologist?	Yes	No

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: 1-833-896-0656

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.

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