# PRIOR AUTHORIZATION REQUEST

## Tremfya

**Patient Information:**

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

**Prescriber Information:**

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

**Requested Medication**

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| 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. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

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| 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?<br>[NOTE: Biologic DMARDs include Actemra (IV 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.]<br>[If yes, no further questions.] | Yes | No |

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| 2 | Is the patient currently receiving the requested medication?<br>[If no, skip to question 9.] | Yes | No |
| 3 | Has the patient been receiving medication samples for the requested medication?<br>[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?<br>[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.]<br>[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.<br>[If yes, skip to question 9.]<br>[If no, no further questions.] | Yes | No |
| 6 | Has the patient been on established therapy for at least 3 months?<br>[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.<br>[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)

[] Ulcerative Colitis (If checked, no further questions)

[] Crohn's disease (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)

[] Ulcerative Colitis (If checked, go to 23)

[] Crohn's disease (If checked, go to 29)

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[] All other indications or diagnoses (If checked, no further questions)

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| 10 | Is the patient greater than or equal to 18 years of age?<br>[If no, no further questions.] | Yes | No |
| 11 | Has documentation been submitted to confirm that the patient has an intolerance, contraindication to, or failed treatment for at least 3 months with at least TWO conventional systemic therapies (such as cyclosporine, acitretin tablets, or methotrexate)? ACTION REQUIRED: Submit supporting documentation.<br>[If no, no further questions.] | Yes | No |
| 12 | 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, Simlandi, Yusimry, or adalimumab-adbm) for at least 3 months unless intolerant or contraindicated? ACTION REQUIRED: Submit supporting documentation.<br>[If no, no further questions.] | Yes | No |
| 13 | Has documentation been submitted to confirm that the patient has had a treatment failure with a preferred ustekinumab product (Yesintek, Pyzchiva, Steqeyma), for at least 3 months or is the patient intolerant or the medication contraindicated? ACTION REQUIRED: Submit supporting documentation.<br>[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? (Dosing: 100 mg at weeks 0, 4, and then every 8 weeks)<br>[If yes, no further questions.] | Yes | No |
| 15 | Is the requested medication being prescribed by or in consultation with a dermatologist?<br>[No further questions.] | Yes | No |
| 16 | Is the patient greater than or equal to 18 years of age?<br>[If no, no further questions.] | Yes | No |
| 17 | Has documentation been submitted to confirm that the patient has an intolerance, contraindication to, or failed treatment for at least 3 months with at least TWO conventional systemic therapies (such as leflunomide, hydroxychloroquine, sulfasalazine, or methotrexate)? ACTION REQUIRED: Submit supporting documentation.<br>[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, Simlandi, Yusimry, or adalimumab-adbm) for at least 3 months unless intolerant or contraindicated? ACTION REQUIRED: Submit supporting | Yes | No |

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| | documentation.<br>[If no, no further questions.] | | |
| 19 | Has documentation been submitted to confirm that the patient has had a treatment failure with a preferred ustekinumab product (Yesintek, Pyzchiva, Steqeyma), for at least 3 months or is the patient intolerant or the medication contraindicated? ACTION REQUIRED: Submit supporting documentation.<br>[If no, no further questions.] | Yes | No |
| 20 | 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.<br>[If no, no further questions.] | Yes | No |
| 21 | Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the indication? (Dosing: 100 mg at weeks 0, 4, and then every 8 weeks)<br>[If yes, no further questions.] | Yes | No |
| 22 | Is the requested medication being prescribed by or in consultation with a rheumatologist or a dermatologist?<br>[No further questions.] | Yes | No |
| 23 | Is the patient greater than or equal to 18 years of age?<br>[If no, no further questions.] | Yes | No |
| 24 | Has documentation been submitted to confirm that the patient has an intolerance, contraindication to, or failed treatment for at least 3 months with at least TWO conventional systemic therapies (such as azathioprine, 6-mercaptopurine, cyclosporine, tacrolimus, or a corticosteroid such as prednisone or methylprednisolone)? ACTION REQUIRED: Submit supporting documentation.<br>[If no, no further questions.] | Yes | No |
| 25 | Has documentation been submitted to confirm that the patient has had an intolerance, contraindication to, or failed treatment for at least 3 months with preferred TNF inhibitor an adalimumab product (Hadlima, Simlandi, Yusimry, or adalimumab-adbm)? ACTION REQUIRED: Submit supporting documentation.<br>[If no, no further questions.] | Yes | No |
| 26 | Has documentation been provided to confirm that the patient has had an intolerance, contraindication to, or failed treatment for at least 3 months with Xeljanz (tofacitinib), following treatment failure with adalimumab? ACTION REQUIRED: Submit supporting documentation.<br>[If no, no further questions.] | Yes | No |
| 27 | Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the indication? (Dosing: 100 mg every 8 weeks beginning at week 16 **or** 200 mg every 4 weeks beginning at week 12) | Yes | No |

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| | [If yes, no further questions.] | | |
| 28 | Is the requested medication being prescribed by or in consultation with a gastroenterologist?<br>[No further questions.] | Yes | No |
| 29 | Is the patient greater than or equal to 18 years of age?<br>[If no, no further questions.] | Yes | No |
| 30 | Is the requested medication being prescribed by or in consultation with a gastroenterologist?<br>[If no, no further questions.] | Yes | No |
| 31 | Has documentation been submitted to confirm that the patient has a diagnosis of moderate to severe Crohn's disease? ACTION REQUIRED: Submit supporting documentation.<br>[If no, no further questions.] | Yes | No |
| 32 | Has documentation been submitted to confirm that the patient has an intolerance, contraindication to, or failed treatment for at least 3 months with at least TWO conventional systemic therapies (such as azathioprine, 6-mercaptopurine, or methotrexate)? ACTION REQUIRED: Submit supporting documentation.<br>[If no, no further questions.] | Yes | No |
| 33 | Has documentation been submitted to confirm that the patient has had an intolerance, contraindication to, or failed treatment for at least 3 months with the preferred TNF inhibitor, an adalimumab product (Hadlima, Simlandi, Yusimry, or adalimumab-adbm)? ACTION REQUIRED: Submit supporting documentation.<br>[If no, no further questions.] | Yes | No |
| 34 | Has documentation been submitted to confirm that the patient has had a treatment failure with a preferred ustekinumab product (Yesintek, Pyzchiva, Steqeyma), for at least 3 months or is the patient intolerant or the medication contraindicated? ACTION REQUIRED: Submit supporting documentation.<br>[If no, no further questions.] | Yes | No |
| 35 | Does the requested dose exceed Food and Drug Administration (FDA) approved label dosing for the indication? (Dosing: Induction: 400 mg [as 2 consecutive 200 mg injections] on weeks 0, 4, and 8. Dosing: Maintenance: 100 mg every 8 weeks beginning at week 16 or 200 mg every 4 weeks beginning at week 12.) | Yes | No |

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

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## 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.

**Confidentiality:** The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

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

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