



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. 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.

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 (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.] [If yes, no further questions.]	Yes	No
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2	Is the patient currently receiving the requested medication? [If no, skip to question 9.]	Yes	No
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 yes, skip to question 9.] [If no, no further questions.]	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? <input type="checkbox"/> Plaque psoriasis (If checked, no further questions) <input type="checkbox"/> Psoriatic arthritis (If checked, no further questions) <input type="checkbox"/> Ulcerative Colitis (If checked, no further questions) <input type="checkbox"/> Crohn's disease (If checked, no further questions) <input type="checkbox"/> All other indications or diagnoses (If checked, no further questions)		
9	What is the indication or diagnosis? <input type="checkbox"/> Plaque psoriasis (If checked, go to 10) <input type="checkbox"/> Psoriatic arthritis (If checked, go to 17) <input type="checkbox"/> Ulcerative Colitis (If checked, go to 25) <input type="checkbox"/> Crohn's disease (If checked, go to 31) <input type="checkbox"/> All other indications or diagnoses (If checked, no further questions)		
10	Is the patient greater than or equal to 6 years of age? [If no, no further questions.]	Yes	No

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11	Has documentation been provided to confirm the patient weighs greater than or equal to 40 kg? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
12	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. [If no, no further questions.]	Yes	No
13	Has documentation been submitted to confirm that the patient has had a treatment failure with an adalimumab product (Hadlima, Simlandi, 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	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. [If no, no further questions.]	Yes	No
15	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.) [If yes, no further questions.]	Yes	No
16	Is the requested medication being prescribed by or in consultation with a dermatologist? [No further questions.]	Yes	No
17	Is the patient greater than or equal to 6 years of age? [If no, no further questions.]	Yes	No
18	Has documentation been provided to confirm the patient weighs greater than or equal to 40 kg? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
19	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. [If no, no further questions.]	Yes	No
20	Has documentation been submitted to confirm that the patient has had a treatment failure with an adalimumab product (Hadlima, Simlandi, 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
21	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	Yes	No

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months or is the patient intolerant or the medication contraindicated? ACTION REQUIRED: Submit supporting documentation.
[If no, no further questions.]

22	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
23	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.) [If yes, no further questions.]	Yes	No
24	Is the requested medication being prescribed by or in consultation with a rheumatologist or a dermatologist? [No further questions.]	Yes	No
25	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
26	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. [If no, no further questions.]	Yes	No
27	Has documentation been submitted to confirm that the patient has had an intolerance, contraindication to, or failed treatment for at least 3 months with an adalimumab product (Hadlima, Simlandi, Yusimry, or adalimumab-adbm)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
28	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. [If no, no further questions.]	Yes	No
29	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.) [If yes, no further questions.]	Yes	No
30	Is the requested medication being prescribed by or in consultation with a gastroenterologist? [No further questions.]	Yes	No
31	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
32	Is the requested medication being prescribed by or in consultation with a gastroenterologist?	Yes	No

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[If no, no further questions.]

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| 33 | Has documentation been submitted to confirm that the patient has a diagnosis of moderate to severe Crohn's disease? ACTION REQUIRED: Submit supporting documentation.
[If no, no further questions.] | Yes | No |
| 34 | 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.
[If no, no further questions.] | Yes | No |
| 35 | Has documentation been submitted to confirm that the patient has had an intolerance, contraindication to, or failed treatment for at least 3 months with an adalimumab product (Hadlima, Simlandi, Yusimry, or adalimumab-adbm)? ACTION REQUIRED: Submit supporting documentation.
[If no, no further questions.] | Yes | No |
| 36 | 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.
[If no, no further questions.] | Yes | No |
| 37 | 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:

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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