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	Is the request for initial therapy or for a continuation of therapy? [] Initial (If checked, go to 8) [] Continuation (If checked, go to 2)		
2	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?	Yes	No

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

Version 08.2026

PRIOR AUTHORIZATION REQUEST

	[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.]		
3	Is the patient currently receiving the requested medication? [If no, skip to question 9.]	Yes	No
4	Has the patient been receiving medication samples for the requested medication? [If yes, skip to question 9.]	Yes	No
5	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 no, 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. [No further questions.]	Yes	No
8	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
9	What is the indication or diagnosis? [] Plaque psoriasis (If checked, go to 10) [] Psoriatic arthritis (If checked, go to 17) [] Ulcerative Colitis (If checked, go to 25) [] Crohn’s disease (If checked, go to 36) [] 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

PRIOR AUTHORIZATION REQUEST

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	Is the requested medication being prescribed by or in consultation with a dermatologist? [If no, no further questions.]	Yes	No
16	Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the indication? [Note: Dosing is 100 mg at weeks 0, 4, and then every 8 weeks.] [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 months, or is the patient intolerant or the medication contraindicated? ACTION REQUIRED: Submit supporting documentation.	Yes	No

PRIOR AUTHORIZATION REQUEST

	[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	Is the requested medication being prescribed by or in consultation with a rheumatologist or a dermatologist? [If no, no further questions.]	Yes	No
24	Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the indication? [Note: Dosing is 100 mg at weeks 0, 4, and then every 8 weeks.] [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 the patient been diagnosed with moderate to severe ulcerative colitis? [If no, skip to question 30.]	Yes	No
28	Has documentation been submitted to confirm that the patient has moderate to severe symptoms? ACTION REQUIRED: Submit supporting documentation. [Note: Examples include Mayo endoscopy sub-score greater than or equal to 2, greater than 6 bowel movement per day, greater than or equal to 4 bloody stools per day, hemoglobin less than 75% normal (males less than 10 g/dL, females less than 9 g/dL).] [If yes, skip to question 33.]	Yes	No
29	Has documentation been submitted to confirm that the patient has mildly active symptoms with poor prognosis factors for disease severity? ACTION REQUIRED: Submit supporting documentation. [Note: Examples include Mayo endoscopy sub-score of 3, extensive colitis, corticosteroid dependence (unable to taper after 3 months of continuous therapy), elevated C-reactive protein (CRP) greater than or equal to 10 mg/dL, low serum albumin less than 3.4 mg/dL.] [If yes, skip to question 33.]	Yes	No
30	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
31	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

PRIOR AUTHORIZATION REQUEST

	months, or is the patient intolerant or the medication contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]		
32	Has documentation been submitted 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 yes, skip to question 34.] [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 a preferred Infliximab product? ACTION REQUIRED: Submit supporting documentation. [Note: Infusion dates and dosages required.] [If no, no further questions.]	Yes	No
34	Is the requested medication being prescribed by or in consultation with a gastroenterologist? [If no, no further questions.]	Yes	No
35	Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the indication? [Note: Dosing is 100 mg every 8 weeks beginning at week 16 **or** 200 mg every 4 weeks beginning at week 12.] [No further questions.]	Yes	No
36	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
37	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
38	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
39	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
40	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

maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

41	Is the requested medication being prescribed by or in consultation with a gastroenterologist? [If no, no further questions.]	Yes	No
42	Does the requested dose exceed Food and Drug Administration (FDA) approved label dosing for the indication? [Note: Induction dosing is 400 mg (as 2 consecutive 200 mg injections) on weeks 0, 4, and 8. Maintenance dosing is 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.

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