PARAMOUNT
Affiliate of ProMedica

Criteria: P0244
Approved: 1/2018
Verified: 8/219
Reviewed:

# Prior Authorization Criteria Form

***This form applies to Paramount Advantage Members Only***

## Tremfya Non-Preferred

Complete/review information, sign and date. Please fax signed forms to Paramount at **1-844-256-2025.** You may contact Paramount by phone at **1-419-887-2520** with questions regarding the Prior Authorization process. When conditions are met, we will authorize the coverage of Tremfya.

**Drug Name (select from list of drugs shown)**

Other, Please specify  Tremfya (Guselkumab)

**Quantity** _____ **Frequency** _____ **Strength** _____

**Route of Administration** _____ **Expected Length of Therapy** _____

**Patient Information**

Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

**Prescribing Physician**

Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

**Diagnosis:** _____ **ICD Code:** _____

**Comments:** _____

**Please circle the appropriate answer for each question.**

1. Has the patient previously received Tremfya for plaque psoriasis? Y N
   [If yes, skip to question 3.]
2. Has documentation to support continued clinical effectiveness been submitted with the renewal request? Y N
   [If yes, skip to question 10.]
   [If no, no further questions.]
3. Is Tremfya prescribed for an adult patient with moderate to severe plaque psoriasis? Y N
   [If no, no further questions.]
4. Enbrel, Humira, Siliq and Taltz are the preferred products for the treatment of plaque psoriasis. Does the patient have a documented treatment failure with or clinical reason to avoid all of the preferred products? Y N
   [If no, no further questions.]

5. Does the patient meet one of the following criteria: A) At least 5 percent of the body surface area was affected by plaque psoriasis at the time of diagnosis, or B) Crucial body areas (e.g., feet, hands, face, neck, groin, intertriginous areas) were affected by plaque psoriasis at the time of diagnosis? Y N

[If no, no further questions.]

6. Does the patient meet any of the following criteria: A) Patient has experienced an inadequate response or intolerance to either phototherapy (e.g., ultraviolet B, psoralen plus ultraviolet A [PUVA]) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin, B) Pharmacologic treatment with methotrexate, cyclosporine, or acitretin is contraindicated, or C) Patient has severe psoriasis that warrants a biologic diseasemodifying antirheumatic drug (DMARD) as first-line therapy? Y N Y N

[If no, no further questions.]

7. Does the patient have one of the following documented clinical reasons to avoid Enbrel or Humira? If Yes , attach supporting chart note(s). History of demyelinating disorder / History of congestive heart failure / History of hepatitis B virus infection / Autoantibody formation/lupus-like syndrome / Risk of lymphoma Y N

[If no, skip to question 9.]

8. Has the patient had a documented inadequate response or intolerable adverse event with all of the preferred products (Siliq or Taltz)? If Yes , attach supporting chart note(s). Y N

[If yes, skip to question 10.]

[If no, no further questions.]

9. Has the patient had a documented inadequate response or intolerable adverse event with at least one preferred agent from each therapeutic class (Enbrel or Humira, AND Siliq or Taltz)? If Yes , attach supporting chart note(s). Y N

[If no, no further questions.]

10. Is the patient 18 years of age or older? Y N

I affirm that the information given on this form is true and accurate as of this date.

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**Prescriber (Or Authorized) Signature and Date**