pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

TREMFYA (guselkumab) [non-preferred] PRIOR AUTHORIZATION FORM

Cytokine and CAM Antagonists and **Quantity Limits/Daily Dose Limits** prior authorization guidelines are accessible on the DHS Pharmacy Services website at http://www.dhs.pa.gov/provider/pharmacyservices/index.htm.

PRIOR AUTHORIZATION REQUEST INFORMATION		PRESCRIBER INFORMATION	
☐New request ☐Renewal request	# of pages: ________	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
BENEFICIARY INFORMATION		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Product requested: ☐Tremfya 100 mg/ml syringe ☐Tremfya: ______________________			
Directions:		Quantity:	Refills:
Diagnosis (*submit documentation*):		Diagnosis code (*required*):	
Specialty Pharmacy Drug Program: Which specialty pharmacy will be used? ☐Diplomat Specialty ☐Walgreen's Specialty			

INITIAL requests		
1. Check all that apply to the beneficiary and *submit documentation for each*. ☐vaccinated for hepatitis B ☐screened for hepatitis B (surface antigen & core antibody) ☐has been using Tremfya in the past 90 days ☐screened for tuberculosis ☐up-to-date with all age-appropriate immunizations		
2. ***Plaque psoriasis:*** Does at least one of the following apply to the beneficiary? ☐at least 5% of body surface area (BSA) is affected ☐critical areas of the body are involved (face, palms, soles, and/or genitals)	☐Yes ☐No	*Submit documentation.*
3. ***Plaque psoriasis:*** Does the beneficiary have a history of trial and failure, contraindication, or intolerance of a 3-month trial of phototherapy? *Check all that apply.* ☐PUVA ☐UVB light ☐other:_______________	☐Yes ☐No	*Submit documentation of all treatments tried and outcomes.*
4. ***Plaque psoriasis:*** Does the beneficiary have a history of trial and failure, contraindication, or intolerance of the following medications? *Check all that apply.* ☐acitretin ☐cyclosporine ☐methotrexate	☐Yes ☐No	*Submit documentation of all medications tried and outcomes.*
5. ***Plaque psoriasis:*** Does the beneficiary have a history of trial and failure, contraindication, or intolerance of the preferred agents? *Check all that apply.* ☐Cosentyx ☐Humira	☐Yes ☐No	*Submit documentation of all medications tried and outcomes.*
6. ***For a diagnosis other than the approved indication(s)***, submit documentation supporting the use of Tremfya for the beneficiary's diagnosis & other treatments tried.		
RENEWAL requests		
1. Since starting Tremfya, did the beneficiary experience a positive clinical response and/or improved level of functioning?	☐Yes ☐No	*Submit documentation of clinical response.*

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	**Date**:

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