SENTARA COMMUNITY PLAN
(MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Tremfya™ (guselkumab) Injection

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

ATTENTION: Tremfya IV induction (loading dose) for treatment of ulcerative colitis can only be billed under the **MEDICAL BENEFIT**. NDC: 57894-0650-01/02: J1628; 200 mg/20 mL= 200 billable units

Recommended Dosage:

Indication	Dosage
Moderate-to-Severe Plaque Psoriasis (Adults) – who are candidates for systemic therapy or phototherapy	100mg administered by subcutaneous injection at Week 0, Week 4 and every 8 weeks thereafter
Active Psoriatic Arthritis (Adults)	100mg administered by subcutaneous injection at Week 0, Week 4 then every 8 weeks
Moderate-to-Severe active ulcerative colitis (Adults)	200 mg IV induction dose at weeks 0, 4, & 8 by an HCP, recommended maintenance dosage is 100 mg SC at week 16 and every 8 weeks thereafter, or 200 mg SC at week 12 and every 4 weeks thereafter

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CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

❑ DIAGNOSIS: Moderate-to-Severe Chronic Plaque Psoriasis

- ❑ Moderate-to-severe plaque psoriasis who are candidates for systemic therapy or phototherapy
- ❑ Member is ≥ 18 years
- ❑ Diagnosis of moderate to severe plaque psoriasis for ≥ 6 months with **≥ 1** of the following:
  - ❑ Affected body surface area (BSA) of ≥ 10%
  - ❑ Psoriasis Area and Severity Index (PASI) score ≥ 10
  - ❑ Incapacitation due to plaque location (e.g., head and neck, palms, soles or genitalia)
- ❑ Member did not respond adequately (or is not a candidate) to a 3- month minimum trial of topical agents (e.g.,anthralin, coal tar preparations, corticosteroids, emollients, immunosuppressives, keratolytics, retinoic acid derivatives, and/or Vitamin D analogues)
- ❑ Member did not respond adequately (or is not a candidate) to a 3-month minimum trial of ≥ 1 systemic agent (e.g., immunosuppressives, and/or methotrexate)
- ❑ Member did not respond adequately (or is not a candidate) to a 3-month minimum trial of phototherapy (e.g., psoralens with UVA light (PUVA) or UVB with coal tar or dithranol)
- ❑ Member is not receiving guselkumab in combination with another biologic agent for psoriasis or non-biologic immunomodulator (e.g., apremilast, tofacitinib, baricitinib)
- ❑ Trial and failure of **TWO (2)** of the **PREFERRED** drugs below:

❑ Humira®	❑ Enbrel®	❑ Infliximab

❑ DIAGNOSIS: Active Psoriatic Arthritis (Adults)

- ❑ Member has a diagnosis of active psoriatic arthritis
- ❑ Member is ≥ 18 years
- ❑ Trial and failure of methotrexate **OR** contraindication to methotrexate (e.g., alcohol abuse, cirrhosis, chronic liver disease, or other contraindication)
- ❑ Trial and failure of **TWO (2)** of the **PREFERRED** drugs below:

❑ Humira®	❑ Enbrel®	❑ Infliximab

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❑ DIAGNOSIS: Moderate-to-Severe Ulcerative Colitis (UC)

- ❑ Member has a diagnosis of moderate to severe ulcerative colitis
- ❑ Member is ≥ 18 years
- ❑ Trial and failure to ONE conventional agent (i.e., 6-mercaptopurine, azathioprine, balsalazide, corticosteroids, cyclosporine, mesalamine, sulfasalazine) used in the treatment of UC after at least a 3-month duration of therapy
- ❑ Member is not receiving guselkumab in combination with another biologic agent for UC or non- biologic immunomodulator (e.g., upadacitinib)
- ❑ Member has tried and failed both:

❑ Humira®	❑ Infliximab

❑ Induction Dose (If required) – One time approval for duration of 2 months, member to receive up to three (3) IV infusion doses

Authorization Criteria: To be reviewed for one-time approval under the medical benefit

- ❑ Medication will be used as induction therapy
- ❑ Medication being provided by:
  - ❑ **Location/site of drug administration:** _____
  - ❑ **NPI or DEA # of administering location**: _____
- ❑ Member to receive FDA approved loading dose of 200mg administered by intravenous infusion over at least 1 hour at Week 0, Week 4, and Week 8

Medication being provided by Specialty Pharmacy - PropriumRx

Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.*