

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 or Crohn's disease 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
<input type="checkbox"/> Moderate-to-Severe Plaque Psoriasis – who are candidates for systemic therapy or phototherapy	<ul style="list-style-type: none">100mg administered by subcutaneous injection at Week 0, Week 4 and every 8 weeks thereafter
<input type="checkbox"/> Active Psoriatic Arthritis	<ul style="list-style-type: none">100mg administered by subcutaneous injection at Week 0, Week 4 then every 8 weeks

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Indication	Dosage
<input type="checkbox"/> Moderate-to-Severe active ulcerative colitis (Adults)	<ul style="list-style-type: none"> 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
<input type="checkbox"/> Moderate-to-Severe active Crohn's disease (Adults)	<ul style="list-style-type: none"> 200 mg IV or 400mg SC induction dose at weeks 0, 4, & 8, 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

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 6 years of age or older weighing at least 40 kg
- ☐ Diagnosis of moderate to severe plaque psoriasis for ≥ 6 months with ≥ 1 of the following:
 - ☐ Affected body surface area (BSA) of $\geq 10\%$
 - ☐ 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:

<input type="checkbox"/> Humira®	<input type="checkbox"/> Enbrel®	<input type="checkbox"/> Infliximab
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☐ **DIAGNOSIS: Active Psoriatic Arthritis (Adults)**

- ☐ Member has a diagnosis of active psoriatic arthritis
- ☐ Member is 6 years of age or older weighing at least 40 kg
- ☐ Trial and failure of **TWO (2)** of the preferred drugs below:

<input type="checkbox"/> Humira®	<input type="checkbox"/> Enbrel®	<input type="checkbox"/> 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 of age or older
- ☐ 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** of the preferred drugs below:

<input type="checkbox"/> Humira®	<input type="checkbox"/> Infliximab
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☐ **DIAGNOSIS: Moderate-to-Severe Crohn's Disease (CD)**

- ☐ Member has a diagnosis of moderate to severe Crohn's disease
- ☐ Member is 18 years of age or older
- ☐ Trial and failure to of a compliant regimen of oral corticosteroids (unless contraindicated) or intravenous corticosteroids
- ☐ Member is not receiving guselkumab in combination with another biologic agent for CD or non-biologic immunomodulator (e.g., upadacitinib)
- ☐ Member has tried and failed **BOTH** of the preferred drugs below:

<input type="checkbox"/> Humira®	<input type="checkbox"/> Infliximab
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☐ **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.****