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:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

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

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

Weight: _____ **Date:** _____

Recommended Dosage: (Prefilled syringe 100 mg/mL single-use)

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
Psoriatic Arthritis (Adults)	100mg administered by subcutaneous injection at Week 0, Week 4 then every 8 weeks

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.

Prescriber is a: ❑ **Dermatologist** ❑ **Rheumatologist**

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❑ DIAGNOSIS: Moderate-to-Severe Chronic Plaque Psoriasis

- ❑ Moderate-to-severe plaque psoriasis who are candidates for systemic therapy or phototherapy.

AND

- ❑ Member is ≥ 18 years

AND

- ❑ Diagnosis of moderate to severe plaque psoriasis for ≥ 6 months with ≥ 1 of the following:
  - ❑ Affected body surface area (BSA) of ≥ 10%; OR
  - ❑ Psoriasis Area and Severity Index (PASI) score ≥ 10; OR
  - ❑ Incapacitation due to plaque location (e.g., head and neck, palms, soles or genitalia)

AND

- ❑ 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)

AND

- ❑ 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)

AND

- ❑ 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)

AND

- ❑ Member is not receiving guselkumab in combination with another biologic agent for psoriasis or non-biologic immunomodulator (e.g., apremilast, tofacitinib, baricitinib)

AND

- ❑ Trial and failure of **TWO (2)** of the **PREFERRED** drugs below:

❑ Humira®	❑ Enbrel®	❑ Infliximab

❑ DIAGNOSIS: Psoriatic Arthritis (Adults)

- ❑ Member has a diagnosis of psoriatic arthritis

AND

- ❑ Member is ≥ 18 years

AND

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- ❑ Trial and failure of methotrexate

OR

- ❑ Medication requested will be used in conjunction with methotrexate

OR

- ❑ Patient has a contraindication to methotrexate (e.g., alcohol abuse, cirrhosis, chronic liver disease, or other contraindication)

AND

- ❑ Trial and failure of **TWO (2)** of the **PREFERRED** drugs below:

❑ Humira®	❑ Enbrel®	❑ Infliximab

Medication being provided by a 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.*