# MEDICARE FORM

# Tremfya® (guselkumab) Medication Precertification Request



(All fields must be completed and legible for precertification review.)

**For Medicare Advantage Part B:**
**FAX:** 1-844-268-7263
**PHONE:** 1-866-503-0857

**For other lines of business:**
Please use other form.

**Note: Tremfya is non-preferred. Preferred products vary based on indication. See section G below.**

**Please indicate:** ☐ Start of treatment: Start date ____/____/____
☐ Continuation of therapy: Date of last treatment ____/____/____

**Precertification Requested By:** _____ Phone: _____ Fax: _____

## A. PATIENT INFORMATION

| | | | |
|---|---|---|---|
| First Name: | Last Name: | | |
| Address: | City: | State: | ZIP: |
| Home Phone: | Work Phone: | Cell Phone: | |
| DOB: | Allergies: | E-mail: | |

Current Weight: _____ lbs or _____ kgs Height: _____ inches or _____ cms

## B. INSURANCE INFORMATION

**Aetna Member ID #**: _____
**Group #**: _____
**Insured**: _____

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
Insured: _____

**Medicare**: ☐ Yes ☐ No If yes, provide ID #: _____ **Medicaid**: ☐ Yes ☐ No If yes, provide ID #: _____

## C. PRESCRIBER INFORMATION

| | | | | | |
|---|---|---|---|---|---|
| First Name: | | Last Name: *(Check One):* ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A. | | | |
| Address: | | City: | | State: | ZIP: |
| Phone: | Fax: | St Lic #: | NPI #: | DEA #: | UPIN: |
| Provider E-mail: | | Office Contact Name: | | Phone: | |

**Specialty** *(Check one):* ☐ **Dermatologist** ☐ **Gastroenterologist** ☐ **Rheumatologist** ☐ **Other**: _____

## D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

**Place of Administration:**
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____
City: _____ State: _____ ZIP: _____
Phone: _____ Fax: _____
**TIN:** _____ PIN: _____
NPI: _____

**Dispensing Provider/Pharmacy:** *Patient Selected choice*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Mail Order
☐ Other: _____
Name: _____
Address: _____
City: _____ State: _____ ZIP: _____
Phone: _____ Fax: _____
**TIN:** _____ PIN: _____
NPI: _____

## E. PRODUCT INFORMATION

**Request is for: guselkumab (Tremfya) Dose:** _____ **Frequency:** _____

## F. DIAGNOSIS INFORMATION – Please indicate primary ICD Code and specify any other where applicable.

Primary ICD Code: _____ Secondary ICD Code: _____ Other ICD Code: _____

## G. CLINICAL INFORMATION – Required clinical information must be completed in its entirety for all precertification requests.

**For initiation requests (clinical documentation required):**

☐ Yes ☐ No Will guselkumab (Tremfya) be used concomitantly with apremilast, tofacitinib, or other biologic DMARDs (e.g., adalimumab,infliximab)?

☐ Yes ☐ No Has the patient been tested for TB with a PPD test, interferon-release assay (IGRA) or chest x-ray within 6 months of initiating a biologic therapy?
(check all that apply): ☐ PPD test ☐ interferon-gamma assay (IGRA) ☐ chest x-ray
Please enter the date and results of the TB test: Date: ____/____/____ Results: ☐ Positive ☐ Negative ☐ Unknown
***If positive,*** Does the patient have latent or active TB? ☐ Latent ☐ Active
***If latent TB,*** ☐ Yes ☐ No Will TB treatment be started before initiation of therapy with guselkumab (Tremfya)?

**Note: Tremfya is non-preferred. Avsola, Remicade, and Simponi Aria are preferred for MA plans. Enbrel, Humira, Skyrizi, and Xeljanz/Xeljanz XR are preferred for MAPD plans. Preferred products vary based on indication.**

☐ Yes ☐ No Has the patient had prior therapy with Tremfya (guselkumab) within the last 365 days?

☐ Yes ☐ No Has the patient had a trial, intolerance, or contraindication to any of the following? (select all that apply)
☐ Remicade (infliximab) ☐ Avsola (infliximab-axxq) ☐ Simponi Aria (golimumab)

☐ Yes ☐ No Has the patient had a trial, intolerance, or contraindication to any of the following? (select all that apply)
☐ Enbrel (etanercept) ☐ Humira (adalimumab) ☐ Skyrizi (Risankizumab-rzaa) ☐ Xeljanz/Xeljanz XR (tofacitinib)

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| Patient First Name | Patient Last Name | Patient Phone | Patient DOB |
|---|---|---|---|
| | | | |

**G. CLINICAL INFORMATION *(continued)*** – Required clinical information must be completed in its entirety for all precertification requests.

Please explain if there are any other medical reason(s) that the patient cannot use any of the following preferred products when indicated for the patient's diagnosis (select all that apply).

☐ Remicade (infliximab) ☐ Avsola (infliximab-axxq) ☐ Simponi Aria (golimumab)

Please explain if there are any other medical reason(s) that the patient cannot use any of the following preferred products when indicated for the patient's diagnosis (select all that apply).

☐ Enbrel (etanercept) ☐ Humira (adalimumab) ☐ Skyrizi (Risankizumab-rzaa) ☐ Xeljanz/Xeljanz XR (tofacitinib)

**Plaque Psoriasis**

What is the severity of the patient's disease? ☐ Mild ☐ Moderate ☐ Severe

☐ Yes ☐ No Is there evidence that the disease is active?

☐ Yes ☐ No Is there clinical documentation of chronic disease?

Please provide the patient's Psoriasis Area and Severity Index (PASI) score: _____

Please indicate the percentage of body surface area affected by plaque psoriasis: _____%

☐ Yes ☐ No Does the plaque psoriasis involve sensitive areas? ***If yes***, please select: ☐ hands ☐ feet ☐ face ☐ genitals

☐ Yes ☐ No Is the patient a candidate for systemic treatment with conventional DMARD(s)?

→ ☐ Yes ☐ No Was the trial with systemic conventional DMARD(s) (e.g., methotrexate, acetretin, or cyclosporine) ineffective?

Provide the name and date range: Name: _____ Date range: ____/____/____ to ____/____/____

☐ Yes ☐ No Was the trial with systemic conventional DMARD(s) not tolerated?

☐ Yes ☐ No Are systemic conventional DMARDs contraindicated?

☐ Yes ☐ No Is the patient a candidate for phototherapy?

→ ☐ Yes ☐ No Was the trial with phototherapy ineffective?

Please check all that apply: ☐ Psoralens (methoxsalen, trioxsalen) with UVA light (PUVA)
☐ UVB with coal tar or dithranol
☐ UVB (standard or narrow-band)
☐ Home UVB

Date range of phototherapy use: ____/____/____ to ____/____/____

☐ Yes ☐ No Was the trial with phototherapy not tolerated?

☐ Yes ☐ No Is phototherapy contraindicated?

**For Continuation of Therapy (clinical documentation required for all requests):**

☐ Yes ☐ No Will guselkumab (Tremfya) be used concomitantly with apremilast, tofacitinib, or other biologic DMARDs (e.g., adalimumab, infliximab)?

Please indicate the length of time on guselkumab (Tremfya): _____

☐ Yes ☐ No Is there clinical documentation supporting disease stability?

☐ Yes ☐ No Is there clinical documentation supporting disease improvement?

☐ Yes ☐ No Does the patient have any risk factors for TB?

→ ☐ Yes ☐ No Has the patient had a TB test within the past year?

(check all that apply): ☐ PPD test ☐ interferon-gamma assay (IGRA) ☐ chest x-ray

Please enter the date and results of the TB test: Date: ____/____/____

Results: ☐ Positive ☐ Negative ☐ Unknown

**H. ACKNOWLEDGEMENT**

**Request Completed By *(Signature Required):*** _____ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.