



Tremfya® (guselkumab) Medication Precertification Request

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(All fields must be completed and legible for Precertification Review.)

Aetna Precertification Notification
503 Sunport Lane, Orlando, FL 32809
Phone: 1-855-240-0535
FAX: 1-877-269-9916

For Medicare Advantage Part B:
FAX: 1-844-268-7263

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 #: _____	Does patient have other coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No
Group #: _____	If yes, provide ID#: _____ Carrier Name: _____
Insured: _____	Insured: _____
Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____	Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____

C. PRESCRIBER INFORMATION

First Name:	Last Name:	<i>(Check One):</i> <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> N.P. <input type="checkbox"/> P.A.		
Address:	City:	State:	ZIP:	
Phone:	Fax:	St Lic #:	NPI #:	DEA #:
UPIN:	Office Contact Name:		Phone:	

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

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration: <input type="checkbox"/> Self-administered <input type="checkbox"/> Physician's Office <input type="checkbox"/> Outpatient Infusion Center Phone: _____ Center Name: _____ <input type="checkbox"/> Home Infusion Center Phone: _____ Agency Name: _____ <input type="checkbox"/> Administration code(s) (CPT): _____ Address: _____	Dispensing Provider/Pharmacy: Patient Selected choice <input type="checkbox"/> Physician's Office <input type="checkbox"/> Retail Pharmacy <input type="checkbox"/> Specialty Pharmacy <input type="checkbox"/> Mail Order <input type="checkbox"/> Other: _____ Name: _____ Phone: _____ Fax: _____ Address: _____ TIN: _____ PIN: _____
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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)?

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?

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB
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G. CLINICAL INFORMATION (continued) – Required clinical information must be completed in its entirety for all precertification requests.

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.