Mountain-Pacific Quality Health
Partnering within our communities to provide solutions for better health
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Montana Healthcare Programs Prior Authorization Request Form for Use of Tremfya® (guselkumab)

Member name:	DOB:	Date:
Member ID:	Prescriber phone:	
Prescriber name and specialty if applicable:	Prescriber fax:	
Dosage requested:		

Please complete below information for applicable situation, Initiation or Continuation of therapy:

☐ **INITIATION OF THERAPY**

Please check appropriate diagnosis and complete corresponding information:

1. **Active Psoriatic Arthritis OR Moderate to Severe Plaque Psoriasis**
   a. Member is 18 years of age or older: ☐ Yes ☐ No

   b. Member has a diagnosis of:
      ☐ Psoriatic Arthritis
      ☐ Moderate to Severe Plaque Psoriasis

   c. Medication is prescribed by, or in consultation with a: ☐ Dermatologist ☐ Rheumatologist

      Action Required: If not written by a specialist, a copy of the annual specialty consult is required (please attach copy of consult).

      Name of specialist: _____ **Contact date**: _____

   d. Member has trialed, and had an inadequate response or contraindication to a Montana Healthcare Programs preferred drug with the same indication: ☐ Yes ☐ No

      Drug name: _____ **Dates of use**: _____

   e. Provider attests to the following:
      ☐ The member has been screened for teburculosis (TB) prior to initiating treatment
      ☐ The provider will monitor for active infection

   f. Provider attests that member will **not** use Tremfya® concomitantly with other biologics: ☐ Yes ☐ No

LIMITATIONS:

- **Active Psoriatic Arthritis:**
  Maximum dose limit: 100 mg subcutaneous (Sub Q) at week zero, week four and every eight weeks thereafter

- **Moderate to Severe Plaque Psoriasis:**

Maximum dose limit: 100 mg Sub Q at week zero, week four and every eight weeks thereafter

Initial authorization will be issued for four doses (weeks 0, 4, 12, and 20).

☐ **CONTINUATION OF THERAPY**

1. Member has been adherent to Tremfya®: ☐ Yes ☐ No

2. Member has documentation of a positive clinical response to Tremfya® therapy (e.g., reduction in the frequency and/or severity of symptoms and exacerbations). ☐ Yes ☐ No

3. Annual specialist consult is attached if prescriber is not a specialist: ☐ Yes ☐ No ☐ N/A - prescribert is a specialist

4. Provider attests that member will **not** use Tremfya® concomitantly with other biologics: ☐ Yes ☐ No
5.

Reauthorization will be issued for 1 year.

Please complete form, including required attachments and fax to Drug Prior Authorization Unit at 1-800-294-1350