



Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Tremfya (guselkumab) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 6 months; Continuation- 12 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Tremfya (guselkumab)** . Please complete and fax this form back to Kaiser Permanente within 24 hours [fax: [1-866-331-2104](tel:1-866-331-2104)]. If you have any questions or concerns, please call [1-866-331-2103](tel:1-866-331-2103). **Requests will not be considered unless this form is complete.**

KP-MAS Formulary can be found at: [Pharmacy](#) | [Community Provider Portal](#) | [Kaiser Permanente](#)

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Prescriber Information

Is the prescriber a Rheumatologist or Dermatologist? No Yes

If consulted with a specialist, specialist name and specialty: _____

Prescriber Name: _____ Specialty: _____ NPI: _____

Prescriber Address: _____

Prescriber Phone #: _____ Prescriber Fax #: _____

Do you have an approved provider referral number from Kaiser Permanente?

Yes – please provide your provider referral number here: _____

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone # _____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: _____

Sig: _____

Drug 2: Name/Strength/Formulation: _____

Sig: _____

5–Diagnosis/Clinical Criteria

1. Is this request for initial or continuing therapy?
 Initial therapy Continuing therapy, state start date: _____
2. Indicate the patient's diagnosis for the requested medication: _____

Clinical Criteria:

Psoriatic Arthritis

1. Does the member have a diagnosis of active psoriatic arthritis?
 No Yes
2. Does the member have documented inadequate response (of at least a 3 month trial), intolerance, or contraindication to BOTH of the following?
 - a. ONE or more tumor necrosis factor (TNF alpha) inhibitors: Inflectra or Remicade (infliximab), Enbrel^{*PA} (etanercept), adalimumab biosimilars (Amjevita preferred) or Humira^{*PA}
 - b. Cosentyx^{*PA} (secukinumab) No Yes

Plaque Psoriasis

1. Does the member have a diagnosis of moderate-to-severe plaque psoriasis?
 No Yes
2. Has the member had inadequate response or contraindication to at least a 3-month trial of phototherapy unless involvement in sensitive areas (e.g., face, body folds, etc.)?
 No Yes
3. Has the member failed at least a 3-month trial of one of the following unless clinically significant adverse effects, contraindication or clinical reason to avoid treatment (i.e. pregnancy/breastfeeding, history of alcoholism or alcoholic liver disease, chronic liver disease, immunodeficiency syndrome, pre-existing blood dyscrasia, hemodialysis, or end-stage renal disease)?
 - a. Methotrexate
 - b. Acitretin No Yes
4. Is there documentation of inadequate response (at least 3-month trial), intolerance, or contraindication to ALL of the following?
 - a. At least one TNF inhibitor [i.e. adalimumab (Amjevita preferred) or infliximab product (Inflectra preferred)]
 - b. Secukinumab (Cosentyx)^{*PA} No Yes

^{*PA}This medication is also subject to PA review

For continuation of therapy, please respond to additional questions below:

1. Has the member had a positive clinical response to medication?
 No Yes
2. Has specialist follow-up occurred in the past 12 months since last review?
 No Yes

6 – Prescriber Sign-Off

Additional Information –

- 1. Please submit chart notes/medical records for the patient that are applicable to this request.**
- 2. If member has not tried preferred agent(s) please provide rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:**

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Prescriber Signature:	Date:
------------------------------	--------------

Please Note: This document contains confidential information, including protected health information, intended for a specific individual and purpose. The information is private and legally protected by law, including HIPAA. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking of any action in reliance on the contents of this telecopied information is strictly prohibited. Please notify sender if document was not intended for receipt by your facility