



MEDICARE FORM

Tremfya® (guselkumab) Medication Precertification Request

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

Virginia (HMO D-SNP)
FAX: 1-833-280-5224
PHONE: 1-855-463-0933

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:		DOB:	
Address:			City:		State: ZIP:
Home Phone:		Work Phone:		Cell Phone:	
E-mail:					
Current Weight: ____ lbs or ____ kgs		Height: ____ inches or ____ cms		Allergies:	

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:		(Check One): <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:	
Provider E-mail:		Office Contact Name:		Phone:	

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

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:		Dispensing Provider/Pharmacy: Patient Selected choice	
<input type="checkbox"/> Self-administered <input type="checkbox"/> Physician's Office		<input type="checkbox"/> Physician's Office <input type="checkbox"/> Retail Pharmacy	
<input type="checkbox"/> Outpatient Infusion Center Phone: _____		<input type="checkbox"/> Specialty Pharmacy <input type="checkbox"/> Mail Order	
Center Name: _____		<input type="checkbox"/> Other: _____	
<input type="checkbox"/> Home Infusion Center Phone: _____		Name: _____	
Agency Name: _____		Address: _____	
<input type="checkbox"/> Administration code(s) (CPT): _____		City: _____ State: _____ ZIP: _____	
Address: _____		Phone: _____ Fax: _____	
City: _____ State: _____ ZIP: _____		TIN: _____ PIN: _____	
Phone: _____ Fax: _____		NPI: _____	
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. Inflectra, Remicade, and Simponi Aria are preferred for MA plans. Enbrel, Humira, Otezla, Rinvoq, 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 and failure, intolerance, or contraindication to any of the following? (select all that apply)

Inflectra (infliximab-dyyb) Remicade (infliximab) Simponi Aria (golimumab)

Yes No Has the patient had a trial and failure, intolerance, or contraindication to any of the following? (select all that apply)

Enbrel (etanercept) Humira (adalimumab) Otezla (apremilast) Rinvoq (upadacitinib) Skyrizi (Risankizumab-rzaa)

Xeljanz/Xeljanz XR (tofacitinib)

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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.

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).

- Inflectra (infliximab-dyyb) Remicade (infliximab) 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) Otezla (apremilast) Rinvoq (upadacitinib)
 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.