Excellus

Specialty Medication Review Program

Tremfya® (guselkumab) for
Crohn's Disease, Psoriasis, Psoriatic Arthritis, & Ulcerative Colitis
(Self-Administered) or (Healthcare Professional Administered)
Rx Benefit or Medical Benefit

Complete this form and fax to:

☐ Medical **(Office Admin)**
Fax #: 1-800-306-0188
Phone #: 1-800-499-1275

If you are not **buying and billing** this medication, indicate which specialty pharmacy will be used:

☐ Pharmacy **(Self-admin)**
Fax: 1-800-956-2397
Phone: 1-800-499-1275

☐ **Accredo Health**
Fax: 1-888-773-7386
Phone: 1-866-413-4137

☐ **Walgreens Specialty Pharmacy**
Fax: 1-866-435-2173
Phone: 1-866-435-2171

Complete ALL the following Patient/Prescriber information: (Please Print)

Patient Information	
Patient Name:	Patient Phone #: ( )
Patient ID #:	Patient Birthdate:
List Patient Allergy (If Any):	
Prescriber Information	
Prescriber Name:	Prescriber Specialty:
Prescriber Address:	
Prescriber Phone #:	Prescriber Fax #:
Prescriber NPI #:	Office Contact: Extension:
If health professional administered, select treatment location: ☐ **Prescriber office** ☐ **Home/Homecare agency:**_____ ☐ **Outpatient facility** ☐ **Other:** _____	
Servicing Prescriber NPI (if different from the ordering prescriber):	
Provide address of infusion location above for medication shipping:	

Medication/Medical and Dispensing Information			
Medication (HCPCS)	**Dose**	**Height**	**Weight (lbs.**
Tremfya (J1628)	☐ 100mg SC at weeks 0 and 4, and then every 8 weeks thereafter ☐ 200mg IV at weeks 0, 4, 8 then 100mg SC every 8 weeks thereafter ☐ 200mg IV at weeks 0, 4, 8 then 200mg SC every 4 weeks thereafter ☐ 400mg (2x200mg) SC at weeks 0, 4, 8, then 100mg SC every 8 weeks thereafter ☐ 400mg (2x200mg) SC at weeks 0, 4, 8, then then 200mg SC every 4 weeks thereafter		

1. Diagnosis/ICD-10: _____

2. Is this request for a: ☐ New Start **OR** ☐ Continuation of Therapy (recertification) Start date: _____

3. If an induction dose is being requested, please choose how it will be administered:
   - ☐ IV/SC induction dose that will be **obtained/administered by a healthcare professional**
   - ☐ SC induction dose that will be **self-administered**
   - ☐ Induction dose is not being requested

4. For all request, please choose how ongoing therapy will be administered:
   - ☐ Ongoing therapy will be **self-administered (Pharmacy Benefit)** (*Fax to the Pharmacy Dept at 1-800-956-2397)
   - ☐ Ongoing therapy will be **obtained/administered by a healthcare professional (Medical Benefit)** (*Fax to Medical Dept at 1-800-306-0188

Questions/Indications for Medical Necessity	
**** See the Inflammatory CRPA Policy (Pharmacy-73) for full Prior Authorization criteria ****	
1. Select **One** of The Following Diagnoses & must be active & moderate to severe	2. Select **One** of the following prescribers
☐ Chronic Plaque Psoriasis ☐ Crohn's Disease ☐ Psoriatic Arthritis ☐ Ulcerative Colitis ☐ Other: _____	☐ Dermatologist ☐ Rheumatologist ☐ Gastroenterologist

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Crohn's Disease

1. If patient has had tried and failed or had an intolerance to at least one of the therapies below for at least 3 months, indicate which drug(s) have been tried **(letter of medical necessity and clinical progress notes must be submitted)**:

Drug Name	Period of Use	Outcomes
☐ Methotrexate, Azathioprine, 6-mercaptopurine	Start: End:	
☐ 5-ASA products (mesalamine, sulfasalazine, etc.)	Start: End:	

Plaque Psoriasis

1. Provide % BSA affected (if less than 10%, define how this is disrupting activities of daily living: BSA % : _____
_____

2. If patient has failed first line drug therapy for a trial of at least 3 months, indicate which drug(s) he/she has not responded to:

Drug Name	Period of use	Outcomes
☐ Acitretin	Start: End:	
☐ Methotrexate	Start: End:	
☐ Cyclosporine	Start: End:	
☐ Medium/High Potency Steroid (provide name(s) of steroid(s) tried:_____	Start: End:	
☐ Anthralin, Calcipotriene, or Tazarotene	Start: End:	
☐ UVB and Coal Tar	Start: End:	
☐ PUVA and Topical Corticosteroids	Start: End:	
☐ Intralesional Corticosteroid Injections	Start: End:	
☐ Other:	Start: End:	

Ulcerative Colitis

1. If patient has had tried and failed or had an intolerance to at least one of the therapies below for at least 3 months, indicate which drug(s) have been tried **(documentation of an intolerance must be submitted)**:

Drug Name	Period of Use	Outcomes
☐ Methotrexate, Azathioprine, 6-mercaptopurine	Start: End:	
☐ 5-ASA products (mesalamine, sulfasalazine, etc.)	Start: End:	
☐ Cyclosporine	Start: End:	
☐ IV or oral steroids	Start: End:	

2. The patient has been diagnosed with pouchitis and has tried an antibiotic, corticosteroid enema, or mesalamine enema? *__Documentation required__	☐ **Yes** ☐ **No**

Provide any other comments/clinical justification:

***ATTACH CLINICAL NOTES RELATED TO THIS REQUEST. IF DOCUMENTATION IS NOT PROVIDED, IT MAY DELAY THE REQUEST.**

***Prescriber Signature:** _____ **Date:** _____

I certify the above is true and accurate to the best of my knowledge.