PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Tremfya (guselkumab)

Phone: 800-728-7947 Fax back to: 866-880-4532

The Scott & White Health Plan Pharmacy Department manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:** **Supervising Physician:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. What diagnosis is this drug being prescribed for (pick one)?

☐ Plaque Psoriasis ☐ Other

Q2. Please provide ICD code for diagnosis.

Q3. Is the patient a new start to therapy?

☐ Yes ☐ No

Q4. Is the prescriber a Dermatologist?

☐ Yes ☐ No

Q5. Does the patient have moderate to severe plaque psoriasis affecting greater than 10% of body surface area (BSA)?

☐ Yes ☐ No

Q6. Does the patient have moderate to severe plaque psoriasis affecting crucial body areas such as hands, feet, face, or genitals?

☐ Yes ☐ No

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Q7. Has the patient failed an adequate trial of at least TWO TOPICAL treatments [including but not limited to corticosteroids, Vitamin D analogues, Vitamin D analogue/corticosteroid combinations, Tazorac® (tazarotene)]?

☐ Yes ☐ No

Q8. Does the patient have failure of an adequate trial of or contraindication to phototherapy (UVB or PUVA)?

☐ Yes ☐ No

Q9. Does the patient have failure of an adequate trial to any of the following? Please select all that apply.

- ☐ methotrexate
- ☐ cyclosporine
- ☐ acitretin
- ☐ leflunomide
- ☐ sulfasalazine
- ☐ tacrolimus

Q10. Does the patient have clinically significant intolerance or contraindication to the following? Please select all that apply.

- ☐ methotrexate
- ☐ cyclosporine
- ☐ acitretin
- ☐ leflunomide
- ☐ sulfasalazine
- ☐ tacrolimus

Q11. Who is the ENTITY that will be submitting the CLAIM for the DRUG and seeking reimbursement?

- ☐ Pharmacy
- ☐ Individual prescriber
- ☐ Provider or specialty group
- ☐ Facility
- ☐ Other (please specify)

Q12. Provide name and NPI of the billing entity

Q13. Will the claim for the drug be submitted as a MEDICAL claim or PHARMACY claim (Note: If a pharmacy will be

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submitting a MEDICAL claim for drug reimbursement, answer MEDICAL)?

☐ Medical ☐ Pharmacy

Q14. Additional comments

_____ _____

Prescriber Signature Date

□ Expedited/Urgent - By checking this box and signing above, I certify that applying the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function

Lack of the necessary documentation may result in a medical necessity denial. Requesting providers may speak to a SWHP pharmacist or medical director at 1-800-728-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage has been decided.