Jefferson Health Plans

PRIOR AUTHORIZATION REQUEST FORM

Individual and Family Plans

Tremfya

Fax back to: (833) 605-4407

Phone: (215) 991-4300

Jefferson Health Plans 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 (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Exchange - PA	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval.

Please answer the following questions and sign.

Q1. Is the medication being prescribed by or in consultation with one of the following:

- For plaque psoriasis (PsO): dermatologist
- For psoriatic arthritis (PsA): rheumatologist or dermatologist
- Ulcerative colitis: gastroenterologist

☐ Yes ☐ No

Q2. Is this an initial request? If YES, go to 3. If NO, go to 16.

☐ Yes ☐ No

Q3. Does the patient have moderate to severely active ulcerative colitis? If YES, go to 20. If NO, go to 4.

☐ Yes ☐ No

Q4. Does the patient have moderate to severe plaque psoriasis (PsO)? If YES, go to 5. If NO, go to 9.

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q5. Has the patient previously received a biologic or targeted synthetic drug (e.g., Sotyktu, Otezla) indicated for the treatment of moderate to severe plaque psoriasis? If YES, go to 20. If NO, go to 6.

☐ Yes ☐ No

Q6. Are chart notes or medical records attached showing crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) are affected? If YES, go to 20. If NO, go to 7.

☐ Yes ☐ No

Q7. Are chart notes or medical records attached showing at least 10% of the body surface area (BSA) is affected? If YES, go to 20. If NO, go to 8.

☐ Yes ☐ No

Q8. Are chart notes or medical records attached showing at least 3% of body surface area (BSA) is affected and the member meets any of the following criteria with chart notes or medical records attached:

• Member has had an inadequate response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin.
• The member has a clinical reason to avoid pharmacologic treatment with methotrexate, cyclosporine, and acitretin.
• Chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy is attached to the request. If therapy is not advisable, documentation of clinical reason to avoid therapy.

If YES, go to 20.

☐ Yes ☐ No

Q9. Does the patient have moderate to severe Psoriatic arthritis (PsA)? If YES, go to 10.

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q10. Has the patient previously received a biologic or targeted synthetic drug (e.g., Rinvoq, Otezla) indicated for active psoriatic arthritis with chart notes, medical record documentation, or claims history supporting previous medications tried? If YES, go to 20. If NO, go to 11.

☐ Yes ☐ No

Q11. Does the patient have severe disease? If YES, go to 20. If NO, go to 12.

☐ Yes ☐ No

Q12. Does the patient have mild to moderate disease? If YES, go to 13.

☐ Yes ☐ No

Q13. Has the patient had an inadequate response to methotrexate, leflunomide, or another conventional synthetic drug (e.g., sulfasalazine) administered at an adequate dose and duration? Chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy is attached to the request.
If YES, go to 20. If NO, go to 14.

☐ Yes ☐ No

Q14. Is there documentation that member has an intolerance, contraindication, or has a clinical reason to avoid to methotrexate or leflunomide, or another conventional synthetic drug (e.g., sulfasalazine) Chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy is attached to the request. If therapy is not advisable, documentation of clinical reason to avoid therapy.
If YES, go to 20. If NO, go to 15.

☐ Yes ☐ No

Q15. Does the patient have enthesitis? If YES, go to 20.

☐ Yes ☐ No

Q16. For continuation of therapy for PsO, has the patient achieved or maintained positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition with one of the following:

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Patient Name:	**Prescriber Name:**

• Chart notes or medical records documenting reduction in body surface area (BSA) affected from baseline.

• Chart notes or medical records showing improvement in signs and symptoms from baseline (e.g., itching, redness, flaking, scaling, burning, cracking, pain).

If YES, go to 20.

☐ Yes ☐ No

Q17. For continuation of therapy for PsA, has the patient achieved or maintained positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition when there is improvement in any of the following from baseline (chart notes or medical records attached):

• Number of swollen joints
• Number of tender joints
• Dactylitis
• Enthesitis
• Skin and/or nail involvement
• Functional status
• C-reactive protein (CRP)

If YES, go to 20.

☐ Yes ☐ No

Q18. For continuation of therapy for UC, has the patient achieved or maintains remission? If YES, go to 20. If NO, go to 19.

☐ Yes ☐ No

Q19. Are chart notes or medical records attached documenting the patient achieved or maintained a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition when there is improvement in any of the following from baseline:

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Patient Name:	**Prescriber Name:**

• Stool frequency
• Rectal bleeding
• Urgency of defecation
• C-reactive protein (CRP)
• Fecal calprotectin (FC)
• Appearance of the mucosa on endoscopy, computed tomography enterography (CTE), magnetic resonance enterography (MRE), or intestinal ultrasound
• Improvement on a disease activity scoring tool (e.g., Ulcerative Colitis Endoscopic Index of Severity [UCEIS], Mayo score)

☐ Yes ☐ No

Q20. Has the patient been evaluated for active or latent tuberculosis (TB) infection with a tuberculosis skin test [PPD], an interferon-release assay [IGRA], or a chest x-ray) within 6 months of initiating therapy for persons who are naïve to biologic drugs or targeted synthetic drugs associated with an increased risk of TB? If YES, go to 21.

☐ Yes ☐ No

Q21. Was the PPD, IGRA, or chest x-ray positive for TB? If YES, go to 22. If NO, go to 24.

☐ Yes ☐ No

Q22. Does testing confirm there is no active disease? If YES, go to 23.

☐ Yes ☐ No

Q23. For latent TB, will the patient receive TB treatment prior to initiation of the requested drug? If YES, go to 24.

☐ Yes ☐ No

Q24. Will the requested medication be used concomitantly with any other biologic drug or targeted synthetic drug?

☐ Yes ☐ No

Q25. Additional Information:

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Patient Name:	**Prescriber Name:**

Prescriber Signature _____ Date _____

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