PARAMOUNT
Affiliate of ProMedica

CRITERIA: STD
APPROVED: 1/2018
VERIFIED: 7/2020
REVIEWED:

Prior Authorization Criteria Form

This form applies to Paramount Commercial Members Only

Tremfya

Complete/review information, sign and date. Please fax signed forms to Paramount at **1-844-256-2025.** You may contact Paramount by phone at **1-419-887-2520** with questions regarding the Prior Authorization process. When conditions are met, we will authorize the coverage of drug Tremfya.

Brand Name (select from list of drugs shown)

Tremfya (guselkumab)

Quantity _____ Frequency _____ Strength_____
Route of Administration _____ Expected Length of Therapy _____

Patient Information

Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone: _____

Prescribing Physician

Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ ICD Code: _____

Comments: _____

Please circle the appropriate answer for each question.

1	Has the patient previously received Tremfya for plaque psoriasis? [If no, skip to question 4.]	Yes	No
2	Has documentation to support continued clinical effectiveness been submitted with the renewal request? [If no, no further questions.]	Yes	No
3	Is the patient 18 years of age or older?	Yes	No

	[No further questions.]		
4	Is Tremfya prescribed for an adult patient with moderate to severe plaque psoriasis? [If no, no further questions.]	Yes	No
5	Does the patient meet one of the following criteria: A) At least 5 percent of the body surface area was affected by plaque psoriasis at the time of diagnosis, or B) Crucial body areas (e.g., feet, hands, face, neck, groin, intertriginous areas) were affected by plaque psoriasis at the time of diagnosis? [If no, no further questions.]	Yes	No
6	Does the patient have an inadequate response, intolerance or contraindication to BOTH of the following: A) a three to four month trial of phototherapy, AND B) a three to four month trial of pharmacologic treatment with methotrexate, cyclosporine, or acitretin? Action Required: If Yes , attach office notes and clinical documentation for the response given. [If no, no further questions.]	Yes	No
7	Is the patient 18 years of age or older?	Yes	No

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature and Date