BlueCross BlueShield Federal Employee Program

TREMFYA
PRIOR APPROVAL REQUEST

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

Tremfya (guselkumab)

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its **entirety** for processing

Is this request for brand or generic? ❑Brand ❑Generic

1. Will the patient be given live vaccines while on this therapy? ❑Yes ❑No
2. Does the patient have any active infections, including tuberculosis (TB) and hepatitis B virus (HBV)? ❑Yes ❑No
3. Will Tremfya be used in combination with any other biologic *DMARD or targeted synthetic DMARD? ❑Yes* ❑No
   If YES, please specify: _____
   DMARDs: Actemra, Avsola, Bimzelx, Cimzia, Cosentyx, Enbrel, Entyvio, Humira or a Humira biosimilar, Ilumya, Inflectra, Kevzara, Kineret, Olumiant, Orencia, Otezla, Remicade, Renflexis, Riabni, Rinvoq, Rituxan, Ruxience, Siliq, Simponi/Simponi Aria, Skyrizi, Sotyktu, Spevigo, Stelara, Taltz, Tremfya, Truxima, Xeljanz/Xeljanz XR, Zymfentra.
4. Has the patient been on this medication continuously for the last **6 months** excluding samples? ***Please select answer below:***

❑ **YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following questions:

a. What is the patient's diagnosis?

❑Crohn's disease (CD)
- i. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 200 mg every 4 weeks? ❑Yes ❑No

❑Plaque psoriasis (PsO)
- i. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 100 mg every 8 weeks? ❑Yes ❑No

❑Psoriatic arthritis (PsA)
- i. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 100 mg every 8 weeks? ❑Yes ❑No

❑Ulcerative colitis (UC)
- i. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 200 mg every 4 weeks? ❑Yes ❑No

❑Other ***(please specify)***: _____

b. Has the patient's condition improved or stabilized with therapy? ❑Yes ❑No

❑ **NO** – this is **INITIATION** of therapy, please answer the following questions:

a. Has the patient been tested for latent tuberculosis (TB)? ❑Yes* ❑No
   If YES, was the result of the test positive or negative for TB infection? ❑Negative ❑Positive*
   If POSITIVE, has the patient completed treatment or is the patient currently receiving treatment? ❑Yes ❑No

b. What is the patient's diagnosis?

❑ Crohn's disease (CD)
- i. Does the patient have moderately to severely active Crohn's disease (CD)? ❑Yes ❑No
- ii. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to at least ONE conventional therapy option? ❑Yes ❑No
- iii. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 200 mg every 4 weeks? ❑Yes ❑No
- iv. **Standard/Basic Option patient, <u>for claims adjudicated through the pharmacy benefit</u>:** Is this medication being requested as a change from one of the following to allow the member access to their copay benefit: Cimzia, Entyvio, Omvoh, or Zymfentra? ❑Yes* ❑No
  If YES, please select medication: ❑Cimzia ❑Entyvio ❑Omvoh ❑Zymfentra

PLEASE PROCEED TO <u>PAGE 2</u> FOR ADDITIONAL DIAGNOSES

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PAGE 2 - PHYSICIAN COMPLETES

Patient Name: _____ **DOB:** _____ **Patient ID: R** _____

❑ Plaque psoriasis (PsO)

i. Does the patient have moderate to severe plaque psoriasis (PsO)? ❑Yes ❑No

ii. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to conventional systemic therapy? ***Please select answer below:***
❑Inadequate response ❑Intolerance or contraindication ❑Has not tried conventional systemic therapy

iii. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to phototherapy? ❑Inadequate response ❑Intolerance or contraindication ❑Has not tried phototherapy

iv. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 100 mg every 8 weeks? ❑Yes ❑No

v. **Standard/Basic Option patient, <u>for claims adjudicated through the pharmacy benefit</u>:** Is this medication being requested as a change from one of the following to allow the member access to their copay benefit: Bimzelx, Cimzia, Cosentyx, Ilumya, Siliq, or Sotyktu? ❑Yes***** ❑No
****If YES***, please select the medication: ❑Bimzelx ❑Cimzia ❑Cosentyx ❑Ilumya ❑Siliq ❑Sotyktu

❑Psoriatic arthritis (PsA)

i. Does the patient have active psoriatic arthritis (PsA)? ❑Yes ❑No

ii. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to a 3-month trial of at least **ONE** conventional DMARD? ❑Yes ❑No

iii. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 100 mg every 8 weeks? ❑Yes ❑No

iv. **Standard/Basic Option patient, <u>for claims adjudicated through the pharmacy benefit</u>:** Is this medication being requested as a change from one of the following to allow the member access to their copay benefit: Bimzelx, Cimzia, Cosentyx, Orencia SC, or Simponi? ❑Yes***** ❑No
****If YES***, please select the medication: ❑Bimzelx ❑Cimzia ❑Cosentyx ❑Orencia SC ❑Simponi

❑Ulcerative colitis (UC)

i. Does the patient have moderately to severely active ulcerative colitis (UC)? ❑Yes ❑No

ii. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to at least ONE conventional therapy option? ❑Yes ❑No

iii. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 200 mg every 4 weeks? ❑Yes ❑No

iv. **Standard/Basic Option patient, <u>for claims adjudicated through the pharmacy benefit</u>:** Is this medication being requested as a change from one of the following to allow the member access to their copay benefit: Entyvio, Omvoh, Simponi, Velsipity, Xeljanz/Xeljanz XR, Zeposia, or Zymfentra? ❑Yes***** ❑No
****If YES,*** please select medication: ❑Entyvio ❑Omvoh ❑Simponi ❑Velsipity ❑Xeljanz/Xeljanz XR ❑Zeposia ❑Zymfentra

❑Other ***(please specify):*** _____