

US Family Health Plan Prior Authorization Request Form for guselkumab (**Tremfya**)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:

Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Step 1 Please complete patient and physician information (please print):

Patient Name: _____	Physician Name: _____
Address: _____	Address: _____
Sponsor ID # _____	Phone #: _____
Date of Birth: _____	Secure Fax #: _____

Step 2 Please complete the clinical assessment:

1. Humira is the Department of Defense's preferred targeted biologic agent. Has the patient tried Humira?	<input type="checkbox"/> Yes proceed to question 2	<input type="checkbox"/> No proceed to question 4
2. Has the patient had an inadequate response to Humira?	<input type="checkbox"/> Yes proceed to question 5	<input type="checkbox"/> No proceed to question 3
3. Has the patient experienced an adverse reaction to Humira that is not expected to occur with the requested agent?	<input type="checkbox"/> Yes proceed to question 5	<input type="checkbox"/> No STOP Coverage not approved
4. Does the patient have a contraindication to Humira (adalimumab)?	<input type="checkbox"/> Yes proceed to question 5	<input type="checkbox"/> No STOP Coverage not approved
5. Has the patient tried and experienced an inadequate response, had an adverse reaction, or have a contraindication to Cosentyx (secukinumab)?	<input type="checkbox"/> Yes proceed to question 6	<input type="checkbox"/> No STOP Coverage not approved
6. Has the patient tried and experienced an inadequate response, had an adverse reaction, or have a contraindication to Stelara (ustekinumab)?	<input type="checkbox"/> Yes proceed to question 7	<input type="checkbox"/> No STOP Coverage not approved

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7. Is the patient 18 years of age or older?	<input type="checkbox"/> Yes proceed to question 8	<input type="checkbox"/> No STOP Coverage not approved
8. For which indication is the requested medication being prescribed?	<input type="checkbox"/> Moderate to severe plaque psoriasis who is a candidate for phototherapy or systemic therapy- proceed to question 9 <input type="checkbox"/> Active psoriatic arthritis - proceed to question 9 <input type="checkbox"/> Other – STOP Coverage not approved	
9. Has the patient failed to respond to or lost response to other systemic therapies? (For example: methotrexate, aminosalicylates [such as, sulfasalazine, mesalamine], corticosteroids, immunosuppressants [such as, azathioprine], etc.)	<input type="checkbox"/> Yes proceed to question 10	<input type="checkbox"/> No STOP Coverage not approved
10. Does the patient have evidence of a negative TB test result in the past 12 months (or TB is adequately managed)?	<input type="checkbox"/> Yes proceed to question 11	<input type="checkbox"/> No STOP Coverage not approved
11. Will the patient be receiving other targeted immunomodulatory biologics with the requested medication, including but not limited to the following: Actemra, Cimzia, Cosentyx, Enbrel, Humira, Ilumya, Kevzara, Kineret, Olumiant, Orencia, Otezla, Remicade, Rinvoq, Rituxan, Siliq, Simponi, Skyrizi, Stelara, Taltz, or Xeljanz/Xeljanz XR?	<input type="checkbox"/> Yes STOP Coverage not approved	<input type="checkbox"/> No Sign and date below

**Step
3**

I certify the above is true to the best of my knowledge. Please sign and date:

Prescriber Signature

Date

[31 March 2021]