

USFHP 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

<https://www.usfamilyhealth.org/for-providers/pharmacy-information/>

Prior Authorization does not expire. Clinical documentation may be required.

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. The provider acknowledges that Taltz is available for treatment of plaque psoriasis without the requirement to try Humira.	<input type="checkbox"/> Acknowledged Proceed to question 2
2. Is the patient 18 years of age or older?	<input type="checkbox"/> Yes proceed to question 3 <input type="checkbox"/> No STOP Coverage not approved
3. What is the indication or diagnosis?	<input type="checkbox"/> Active psoriatic arthritis – Proceed to question 4 <input type="checkbox"/> Moderate to severe plaque psoriasis (PsO) who are candidates for phototherapy or systemic therapy- Proceed to question 4 <input type="checkbox"/> Moderate to severely active ulcerative colitis (UC) - Proceed to question 5 <input type="checkbox"/> Moderately to severely active Crohn's Disease (CD)- Proceed to question 5 <input type="checkbox"/> Other – STOP - Coverage not approved
4. Has the patient had an inadequate response, intolerance, or contraindication to non-biologic systemic therapy? [For example: methotrexate, aminosalicylates, (for example, sulfasalazine, mesalamine), corticosteroids, immunosuppressants (for example, azathioprine)].	<input type="checkbox"/> Yes proceed to question 6 <input type="checkbox"/> No STOP Coverage not approved

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<p>5. Has the patient tried IV infliximab and had an inadequate response, intolerance, or failed to respond?</p>	<p align="center"><input type="checkbox"/> Yes Proceed to question 9</p>	<p align="center"><input type="checkbox"/> No proceed to question 6</p>
<p>6. Has the patient had an inadequate response to Humira?</p>	<p align="center"><input type="checkbox"/> Yes Proceed to question 9</p>	<p align="center"><input type="checkbox"/> No Proceed to question 7</p>
<p>7. Has the patient experienced an adverse reaction to Humira that is not expected to occur with the requested agent?</p>	<p align="center"><input type="checkbox"/> Yes Proceed to question 9</p>	<p align="center"><input type="checkbox"/> No Proceed to question 8</p>
<p>8. Does the patient have a contraindication to Humira (adalimumab)?</p>	<p align="center"><input type="checkbox"/> Yes Proceed to question 9</p>	<p align="center"><input type="checkbox"/> No STOP Coverage not approved</p>
<p>9. Will the patient be receiving other targeted immunomodulatory biologics with the requested medication, including but not limited to the following: TNF inhibitors, IL-1, IL-6, IL-17, IL-23, IL-36, S1p, JAK inhibitors?</p>	<p align="center"><input type="checkbox"/> Yes STOP Coverage not approved</p>	<p align="center"><input type="checkbox"/> No Sign and date below</p>

Step 3 I certify the above is true to the best of my knowledge. Please sign and date:

_____ Prescriber Signature

_____ Date