UnitedHealthcare Community Plan

Tremfya - Arizona
PRIOR AUTHORIZATION REQUEST FORM

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826.**
This form contains multiple pages. Please complete all pages to avoid a delay in our decision.
Allow at least 24 hours for review.

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance:	Policy #:	Group #:

Is the requested medication □ New or □ Continuation of Therapy? If continuation, list start date: _____
Is this patient currently hospitalized? □ Yes □ No If recently discharged, list discharge date: _____

Section B - Physician Information

First Name:		Last Name:		M.D./D.O.
Address:		City:	State:	ZIP code:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax attention to:				

Section C - Medical Information

Medication:	**Strength:**
Directions for use:	**Quantity:**
Diagnosis (Please be specific & provide as much information as possible)**:**	**ICD-10 CODE:**

Is this member pregnant? □ Yes □ No If yes, what is this member's due date? _____

Section D – Previous Medication Trials

Medications	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs
Please refer to www.uhccommunityplan.com for a list of preferred alternatives

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Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information

All Requests:

- **Is the patient currently on Tremfya therapy? □ Yes □ No (Check which apply)**
  If yes, list start date: _____

- **Does the patient have a diagnosis of chronic moderate to severe plaque psoriasis? □ Yes □ No**

- **Does the patient have greater than or equal to 5% body surface area involvement, palmoplantar, facial, or genital involvement, or severe scalp psoriasis? □ Yes □ No**

- **Does the patient have a history of failure, contraindication, or intolerance to topical therapy with ONE of the following: □ Yes □ No**
  (If yes, complete Section D above with medication information, including dose, duration, date of trial, and reason for discontinuation)
  □ **Corticosteroids** □ **Vitamin D analogs** □ **Tazarotene** □ **Calcineurin inhibitors**
  □ **Anthralin** □ **Coal tar**

- **Does the patient have a history of failure, contraindication, or intolerance to systemic therapy of at least 3 months duration with methotrexate? □ Yes □ No** (If yes, complete Section D above with medication information, including dose, duration, date of trial, and reason for discontinuation)

- **Does the patient have a history of failure, contraindication, or intolerance to either of the following preferred biologic medications? □ Yes □ No** □ Humira (adalimumab) □ Enbrel (etanercept)
  (If yes, complete Section D above with medication information, including dose, duration, date of trial, and reason for discontinuation)

- **Will the patient receive Tremfya in combination with ANY of the following: □ Yes □ No**
  □ Biologic DMARD [e.g., Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab), Cosentyx (secukinumab), Orencia (abatacept)]
  □ Janus kinase inhibitor [e.g., Xeljanz (tofacitinib)]
  □ Phosphodiesterase 4 (PDE4) inhibitor [e.g. Otezla (apremilast)]

Requests for Continuation for Therapy:

- **Does the patient have a documented positive clinical response to Tremfya therapy? □ Yes □ No**
  If yes, list response: _____

Physician Signature: _____ **Date:** _____