[Insert Physician Letterhead]

[Insert Name of Medical Director] Re: Member Name: [Insert Member Name]

[Insert Payer Name] Member Number: [Insert Member Number]

[Insert Address] Group Number: [Insert Group Number]

[Insert City, State ZIP]

**REQUEST:** Authorization for treatment with TREMFYA® (guselkumab)

**DIAGNOSIS:** [Insert Diagnosis] [Insert ICD]

**DOSE AND FREQUENCY:** [Insert Dose & Frequency]

**REQUEST TYPE:** ☐ Standard ☐ EXPEDITED

Dear [Insert Name of Medical Director or name of individual responsible for prior authorization],

I am writing to support my request for an **authorization** for the above-mentioned patient to continue treatment with TREMFYA® as medically necessary based on this patient’s current treatment success. My request is supported by the following:

**Summary of Patient’s Diagnosis**

[Insert patient’s diagnosis, date of diagnosis, lab results and date, current condition]

**Summary of Patient’s History**

[Insert:

* Document that patient does not have active tuberculosis
* Percentage of body surface area (BSA) currently affected, IGA and/or PASI severity scores
* Description of patient’s recent symptoms/condition, including photographs of plaques/location of plaques if applicable
* Previous treatment of plaque psoriasis (including TREMFYA® if applicable) and patient’s response
* Number of swollen and/or tender joints if applicable
* Number of tender or painful areas other than joints (enthesitis); number of entire fingers or toes swollen (dactylitis) if applicable
* Patient assessment of pain, patient global assessment, physician global assessment, if applicable
* Functional status, ie, Health Assessment Questionnaire Disability Index (HAQ-DI), if applicable
* Patient co-morbidities that could serve as contraindications to certain other treatments, if applicable
* Prior therapies/procedures for psoriatic arthritis (including TREMFYA® if applicable) and responses to those treatments
* Site of medical service—include appropriate one and provide rationale: Physician-supervised administration or self‑administration, eg, compliance, needle phobia, closely monitoring patients
* Summary of your professional opinion of the patient’s likely prognosis or disease progression without treatment with TREMFYA®

Note: exercise your medical judgment and discretion when providing a diagnosis and characterization of the patient’s medical condition.]

**Rationale for Treatment**

[Insert summary statement for rationale for treatment such as: considering the patient’s history, condition, current treatment with TREMFYA®, and the full Prescribing Information supporting uses of TREMFYA®, I believe treatment with TREMFYA® at this time is medically necessary, and should be a covered and reimbursed service.]

[You may consider including documents that provide additional clinical information to support the recommendation for TREMFYA® for this patient, such as the full Prescribing Information, peer-reviewed journal articles, or clinical guidelines.]

[Given the urgent nature of this request,] please provide a timely authorization. Contact my office at [Insert Phone Number] if I can provide you with any additional information.

Sincerely,

[Insert Healthcare Provider's Name and Participating Provider Number]

Enclosures [Include full Prescribing Information and the additional support noted above]