KAISER PERMANENTE®

206-988-2000
206-988-2001
prnotification@kp.org

Kaiser Foundation Health Plan of Washington
Kaiser Foundation Health Plan of Washington Options, Inc.
CONTRACT MANAGER NAME
Provider Communications, RCR-A3W-04
PO Box 34262, Seattle WA 98124-1262

JANUARY 24, 2024

GUSELKUMAB (TREMFYA) NOT COVERED UNDER THE MEDICAL BENEFIT

Dear Provider,

Effective April 1, 2024, Guselkumab (Tremfya) will **NOT** be covered under the medical benefit. **This letter is a notification of the upcoming change in coverage for this medication under the medical benefit.** Pharmacy benefit coverage remains available for members who meet prior authorization criteria.

Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington Options, Inc. requires prior authorization for a select group of injectable drugs that may be administered under the medical benefit in a physician's office or by home infusion. These reviews are intended to ensure consistent benefit adjudication as well as appropriate utilization in accordance with the Kaiser Permanente Pharmacy & Therapeutics Committee's evidence-based criteria for coverage.

BRAND NAME	GENERIC NAME	HCPCS
Tremfya	Guselkumab	J1628

Prior Authorization Criteria for Guselkumab (Tremfya) (changes in bold):

DRUG NAME	COVERAGE CRITERIA

GUSELKUMAB	**Considered a self-administered medication** for outpatient use. Not covered under the medical benefit (hospital, clinic, or home infusion). May be covered under the pharmacy benefit. Exceptions to self-administration may be considered based on the following:**
	• **First dose for new starts to allow for self-administration training OR**
	• **Documentation of impaired manual dexterity, impaired vision, or inability to safely self-administer AND**
	• **Must meet clinical criteria below**
	Covered for adult patients (18 years or older) with moderate to severe psoriasis who have not had an adequate response to topical psoriasis treatments AND
	• at least one formulary anti-TNF agent (e.g., adalimumab [Amjevita], infliximab [Inflectra]) AND
	• secukinumab AND
	• at least two of the following*:
	  ○ 12-week trial of phototherapy
	  ○ acitretin
	  ○ methotrexate

DRUG NAME	COVERAGE CRITERIA

	*Note: cyclosporine may also count towards 1 of the required therapies but should not be required.
	
	Covered for psoriatic arthritis in patients with contraindication, intolerance, or failure to:
	
	• At least one conventional synthetic disease modifying anti-rheumatic drug (csDMARD) (methotrexate preferred), and
	• Two of the following biologics (one of which must be adalimumab or infliximab):
	  ○ adalimumab (e.g., Amjevita)
	  ○ infliximab (e.g., Inflectra)
	  ○ secukinumab
	  ○ etanercept
	
	Note: csDMARD not required for patients with axial disease or severe (rapidly progressive, erosive) disease
	
	Quantity Limits:
	• Induction: 100 mg at week 0, 4, and 8
	• Maintenance: 100 mg every 8 weeks
	
	***Self-Administered Medications Policy URL: https://wa-provider-ga.kaiserpermanente.org/static/pdf/provider/pharmacy/self-administered-drugs.pdf*

Additional Information

A complete list of office-administered injectable drugs requiring prior authorization can be found on the Kaiser Permanente provider website at https://wa-provider.kaiserpermanente.org/provider-manual/clinical-review/officeinject.

To request prior authorization review, please use the Referral Request online form located on the Kaiser Permanente provider website at https://wa-provider.kaiserpermanente.org/provider-manual/clinical-review/preservice. You can also fax your request to the Review Services department toll-free at 1-888-282-2685.

Thank you for the care you provide to our members, your patients. If you have any questions about this process, please call Review Services at 1-800-289-1363, Monday through Friday from 8 a.m. to 5 p.m.

Sincerely,

Gurpreet Rawat, MD, Chair
Pharmacy & Therapeutics Committee