



AETNA BETTER HEALTH®  
Coverage Policy/Guideline

Name:	Tremfya	Page:	1 of 7
Effective Date:	2/2/2026	Last Review Date:	12/2025
Applies to:	<input type="checkbox"/> Illinois	<input type="checkbox"/> Florida	<input type="checkbox"/> Florida Kids
	<input checked="" type="checkbox"/> New Jersey	<input type="checkbox"/> Maryland	<input type="checkbox"/> Michigan
	<input type="checkbox"/> Pennsylvania Kids	<input type="checkbox"/> Virginia	<input type="checkbox"/> Kentucky PRMD

**Intent:**

The intent of this policy/guideline is to provide information to the prescribing practitioner outlining the coverage criteria for Tremfya under the patient’s prescription drug benefit.

**Description:**

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

FDA-approved Indications<sup>1</sup>

- Treatment of adults and pediatric patients 6 years of age and older who also weigh at least 40 kilograms (kg) with moderate to severe plaque psoriasis (PsO) and who are candidates for systemic therapy or phototherapy– (Reference the Biological Response Modifiers (BRMs) in the Treatment of Plaque Psoriasis NJ Protocol)
- Treatment of adults and pediatric patients 6 years of age and older who also weigh at least 40 kg with active psoriatic arthritis (PsA)
- Treatment of moderately to severely active ulcerative colitis (UC) in adults
- Treatment of moderately to severely active Crohn’s disease (CD) in adults

All other indications are considered experimental/investigational and not medically necessary.

**Applicable Drug List:**

Non-Preferred: Tremfya

**Policy/Guideline:**

**Documentation for all indications:**

The patient is unable to take a preferred ustekinumab product and ONE additional preferred product (a preferred adalimumab product, Enbrel, Cosentyx, Rinvoq, Otezla), where indicated, for the given diagnosis due to a trial and inadequate treatment response or intolerance, or a contraindication. Documentation is required for approval.

**Documentation**

Submission of the following information is necessary to initiate the prior authorization review:



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### Psoriatic arthritis (PsA)

#### *Initial requests*

Chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy. If therapy is not advisable, documentation of clinical reason to avoid therapy.

#### *Continuation requests*

Chart notes or medical record documentation supporting positive clinical response.

### Ulcerative colitis (UC) and Crohn's disease (CD)

#### *Continuation requests*

Chart notes or medical record documentation supporting positive clinical response to therapy or remission.

### **Prescriber Specialties**

This medication must be prescribed by or in consultation with one of the following:

- Psoriatic arthritis: rheumatologist or dermatologist
- Ulcerative colitis and Crohn's disease: gastroenterologist

### **Coverage Criteria**

#### Psoriatic arthritis (PsA)<sup>1,8-10</sup>

Authorization of 12 months may be granted for members 6 years of age and older weighing at least 40 kg who have previously received a biologic or targeted synthetic drug indicated for active psoriatic arthritis.

Authorization of 12 months may be granted for members 6 years of age and older weighing at least 40 kg for treatment of active psoriatic arthritis when either of the following criteria is met:

- Member has mild to moderate disease and meets any of the following criteria:
  - Member has had an inadequate response to methotrexate, leflunomide, or another conventional synthetic drug (e.g., sulfasalazine) administered at an adequate dose and duration.
  - Member has an intolerance or contraindication to methotrexate or leflunomide (see Appendix), or another conventional synthetic drug (e.g., sulfasalazine).



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- Member has enthesitis.
- Member has severe disease.

#### Ulcerative colitis (UC)<sup>1,12-14</sup>

Authorization of 12 months may be granted for treatment of moderately to severely active ulcerative colitis.

#### Crohn's disease (CD)<sup>1,15,16</sup>

Authorization of 12 months may be granted for treatment of moderately to severely active Crohn's disease.

### **Continuation of Therapy**

#### Psoriatic arthritis (PsA)<sup>1,9,10</sup>

Authorization of 12 months may be granted for all members 6 years of age and older weighing at least 40 kg (including new members) who are using the requested medication for psoriatic arthritis and who achieve or maintain a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition when there is improvement in any of the following from baseline:

- Number of swollen joints
- Number of tender joints
- Dactylitis
- Enthesitis
- Skin and/or nail involvement
- Functional status
- C-reactive protein (CRP)

#### Ulcerative colitis (UC)<sup>1,12-14</sup>

Authorization of 12 months may be granted for all members (including new members) who are using the requested medication for moderately to severely active ulcerative colitis and who achieve or maintain remission.

Authorization of 12 months may be granted for all members (including new members) who are using the requested medication for moderately to severely active ulcerative colitis and who achieve or maintain a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition when there is improvement in any of the following from baseline:



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- Stool frequency
- Rectal bleeding
- Urgency of defecation
- C-reactive protein (CRP)
- Fecal calprotectin (FC)
- Appearance of the mucosa on endoscopy, computed tomography enterography (CTE), magnetic resonance enterography (MRE), or intestinal ultrasound
- Improvement on a disease activity scoring tool (e.g., Ulcerative Colitis Endoscopic Index of Severity [UCEIS], Mayo score)

#### Crohn's disease (CD)<sup>1,15,16</sup>

Authorization of 12 months may be granted for all members (including new members) who are using the requested medication for moderately to severely active Crohn's disease and who achieve or maintain remission.

Authorization of 12 months may be granted for all members (including new members) who are using the requested medication for moderately to severely active Crohn's disease and who achieve or maintain a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition when there is improvement in any of the following from baseline:

- Abdominal pain or tenderness
- Diarrhea
- Body weight
- Abdominal mass
- Hematocrit
- Appearance of the mucosa on endoscopy, computed tomography enterography (CTE), magnetic resonance enterography (MRE), or intestinal ultrasound
- Improvement on a disease activity scoring tool (e.g., Crohn's Disease Activity Index [CDAI] score)

#### Other<sup>1,7</sup>

For all indications: Member has had a documented negative tuberculosis (TB) test (which can include a tuberculosis skin test [TST] or an interferon-release assay [IGRA]) within 12 months of initiating therapy for persons who are naïve to biologic drugs or targeted synthetic drugs associated with an increased risk of TB.

If the screening testing for TB is positive, there must be further testing to confirm there is no active disease (e.g., chest x-ray). Do not administer the requested medication to members



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with active TB infection. If there is latent disease, TB treatment must be started before initiation of the requested medication.

For all indications: Member cannot use the requested medication concomitantly with any other biologic drug or targeted synthetic drug for the same indication.

### Dosage and Administration

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

### Appendix

Examples of Clinical Reasons to Avoid Pharmacologic Treatment with Methotrexate, Cyclosporine, Acitretin, or Leflunomide<sup>11</sup>

- Clinical diagnosis of alcohol use disorder, alcoholic liver disease, or other chronic liver disease
- Drug interaction
- Risk of treatment-related toxicity
- Pregnancy or currently planning pregnancy
- Breastfeeding
- Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension)
- Hypersensitivity
- History of intolerance or adverse event.

### Approval Duration and Quantity Restrictions:

Initial and Renewal Approval: 12 months

### Quantity Level Limit:

- Tremfya (guselkumab) 100 mg/mL prefilled syringe/One-press injector:
  - 1 syringe/pen/injector per 56 days
  - Exception limit: 2 syringes/pens/injectors per 28 days
- Tremfya (guselkumab) 200 mg/2 mL prefilled syringe/pen:
  - 1 syringe/pen per 28 days
  - Exception limit: 6 syringes/pens per 56 days
- Tremfya (guselkumab) 200 mg/2 mL prefilled pen Induction Pack for Crohn's Disease:



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- Exception limit: 3 cartons (6 pens) per 56 days
- Tremfya (guselkumab) 200 mg/20 mL single-dose vial:
  - Exception limit: 60 ml (3 vials) per 56 days

\* Coverage up to the exception limits may be provided with prior authorization

**References:**

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