Ilumya

Prior Authorization Request

Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form along with supporting clinical documentation to Priority Partners, toll-free at 1-866-212-4756 to initiate the review process.** If you have questions regarding the prior authorization please contact Priority Partners at 888-819-1043 Option 4**.**

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ❑ Same as Requesting Provider
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ Same as Referring Provider ❑ Same as Requesting Provider
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

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

Required Demographic Information:

Patient Weight: _____*kg*

Patient Height: _____*cm*

Drug Information:

Strength/Measure _____ *Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un

Directions(sig) _____ *Route of administration* _____

Dosing frequency _____

Send completed form to: Priority Partners Fax: 1-866-212-4756

Priority Partners ● 7231 Parkway Drive Suite 100 ● Hanover, MD 21076
Phone: 888-819-1043 ● Fax: 1-866-212-4756 ● www.jhhc.com

Site of Service Questions:

A. Indicate the site of service requested:
- ❑ On Campus Outpatient Hospital
- ❑ Off Campus Outpatient Hospital
- ❑ Home based setting, *skip to Criteria Questions*
- ❑ Community office, *skip to Criteria Questions*
- ❑ Ambulatory infusion site, *skip to Criteria Questions*

B. Is the patient less than 18 years of age?
- ❑ Yes, *skip to Clinical Criteria Questions*
- ❑ No

C. Has the patient experienced an adverse event with the requested product that has not responded to conventional interventions (eg acetaminophen, steroids, diphenhydramine, fluids, other pre- medications or slowing of infusion rate) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after an infusion? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.*** ❑ Yes, *skip to Clinical Criteria Questions* ❑ No

D. Is the patient medically unstable which may include respiratory, cardiovascular, or renal conditions that may limit the member's ability to tolerate a large volume or load or predispose the member to a severe adverse event that cannot be managed in an alternate setting without appropriate medical personnel and equipment?
ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

E. Does the patient have severe venous access issues that require the use of special interventions only available in the outpatient hospital setting? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

F. Does the patient have significant behavioral issues and/or physical or cognitive impairment that would impact the safety of the infusion therapy AND the patient does not have access to a caregiver? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

G. Has the patient's home been deemed not eligible or appropriate for home infusion services by a home infusion provider? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

H. Does the patient have severe venous access issues that require the use of special interventions only available in the outpatient hospital setting? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.***
❑ Yes ❑ No

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Clinical Criteria Questions:

What is the ICD-10 code? _____

1. Will the requested drug be used in combination with any other biologic (e.g., Humira) or targeted synthetic drug (e.g., Olumiant, Otezla, Xeljanz)?

❒ Yes, *Continue to #2*

❒ No, *Continue to #2*

2. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic drug (e.g., Olumiant, Xeljanz) associated with an increased risk of tuberculosis?

❒ Yes, *Continue to #9*

❒ No, *Continue to #3*

3. Has the patient had a tuberculosis (TB) test (e.g., tuberculosis skin test [PPD], interferon-release assay [IGRA], chest x-ray) within 6 months of initiating therapy?

❒ Yes, *Continue to #4*

❒ No, *Continue to #4*

4. What were the results of the tuberculosis (TB) test?

❒ Positive for TB, *Continue to #5*

❒ Negative for TB, *Continue to #9*

❒ Unknown, *Continue to #9*

5. Which of the following applies to the patient?

❒ Patient has latent TB and treatment for latent TB has been initiated, *Continue to #9*

❒ Patient has latent TB and treatment for latent TB has been completed, *Continue to #9*

❒ Patient has latent TB and treatment for latent TB has not been initiated, *Continue to #9*

❒ Patient has active TB, *Continue to #9*

9. What is the diagnosis?

❒ Plaque psoriasis, *Continue to #100*

❒ Other, *Continue to #100*

100. Has the patient been diagnosed with moderate to severe plaque psoriasis?

❒ Yes, *Continue to #101*

❒ No, *Continue to #101*

101. Is the patient an adult (18 years of age or older)?

❒ Yes, *Continue to #102*

❒ No, *Continue to #102*

102. Is the requested drug being prescribed by or in consultation with a dermatologist?

❒ Yes, *Continue to #103*

❒ No, *Continue to #103*

103. Is this request for continuation of therapy with the requested drug?

❒ Yes, *Continue to #104*

❒ No, *Continue to #110*

104. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program?

❒ Yes, *Continue to #110*

❒ No, *Continue to #105*

❒ Unknown, *Continue to #110*

105. Has the patient achieved or maintained a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition since starting treatment with the requested drug?

❒ Yes, *Continue to #106*

❒ No, *Continue to #106*

106. Has the patient experienced a reduction in body surface area (BSA) affected from baseline? ***ACTION REQUIRED****: If Yes, please attach chart notes or medical record documentation of decreased body surface area affected*

❒ Yes, *Continue to #120*

❒ No, *Continue to #107*

107. Has the patient experienced an improvement in signs and symptoms of the condition from baseline (e.g., itching, redness, flaking, scaling, burning, cracking, pain)? ***ACTION REQUIRED****: If Yes, please attach chart notes or medical record documentation of improvement in signs and symptoms*

❒ Yes, *Continue to #120*

❒ No, *Continue to #120*

110. Has the patient ever received or is currently receiving a biologic (e.g., Humira) or targeted synthetic drug (e.g., Sotyktu, Otezla) indicated for treatment of moderate to severe plaque psoriasis (excluding receiving the drug via samples or a manufacturer's patient assistance program)? ***ACTION REQUIRED****: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried*

❒ Yes, *Continue to #120*

❒ No, *Continue to #111*

111. Are crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) affected? ***ACTION REQUIRED****: If Yes, please attach chart notes or medical record documentation of affected areas*

❒ Yes, *Continue to #120*

❒ No, *Continue to #112*

112. What is the percentage of body surface area (BSA) affected (prior to starting the requested medication)? ***ACTION REQUIRED****: Please attach chart notes or medical record documentation of body surface area affected*

❒ Greater than or equal to 3% to less than 10% of BSA, *Continue to #113*

❒ Greater than or equal to 10% of BSA, *Continue to #120*

❒ Less than 3% of BSA, *No Further Questions*

113. Has the patient experienced an inadequate response, or has an intolerance to phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin? ***ACTION REQUIRED****: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy*

❒ Yes, *Continue to #120*

❒ No, *Continue to #114*

114. Does the patient have a clinical reason to avoid pharmacologic treatment with methotrexate, cyclosporine, and acitretin? ***ACTION REQUIRED****: If Yes, please attach documentation of clinical reason to avoid each therapy*

❒ Yes, *Continue to #115*

❒ No, *Continue to #115*

115. Please indicate the clinical reason to avoid pharmacologic treatment with methotrexate, cyclosporine, and acitretin

❒ Clinical diagnosis of alcohol use disorder, alcoholic liver disease, or other chronic liver disease, *Continue to #120*

❒ Drug interaction, *Continue to #120*

❒ Risk of treatment-related toxicity, *Continue to #120*

❒ Pregnancy or currently planning pregnancy, *Continue to #120*

❒ Breastfeeding, *Continue to #120*

❒ Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension), *Continue to #120*

❒ Hypersensitivity, *Continue to #120*

❒ History of intolerance or adverse event, *Continue to #120*

❒ Other, *Continue to #120*

120. Is the patient currently receiving the requested drug?

❒ Yes, *Continue to #121*

❒ No, *Continue to #130*

121. Does the prescribed dose exceed 100 mg?

❒ Yes, *Continue to #122*

❒ No, *Continue to #122*

122. Is the prescribed frequency for the maintenance dose more frequent than one dose every 12 weeks?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

130. Does the prescribed dose exceed a loading dose of 100 mg at weeks 0 and 4, and a maintenance dose of 100

❒ Yes, *Continue to #131*

❒ No, *Continue to #131*

131. Is the prescribed frequency for the maintenance dose more frequent than one dose every 12 weeks?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____

Prescriber or Authorized Signature **Date (mm/dd/yy)**

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