



PRIOR AUTHORIZATION REQUEST
Ilumya

PATIENT: Name, Address, City, State, Zip, D.O.B., Member ID
Prescriber: Name, Address, City, State, Zip, Phone, Fax, NPI

Medication Requested: Qty Requested:

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided.

SECTION A: Please answer the following questions

- 1. Will the requested medication be used in combination with a BIOLOGIC or with a targeted synthetic disease-modifying antirheumatic drug (DMARD) used for an inflammatory condition?
2. What is the indication or diagnosis?
3. Is the patient currently receiving the requested medication?
4. Has the patient tried at least one traditional systemic agent for psoriasis for at least 3 months, unless intolerant?
5. Has the patient already had a 3-month trial or previous intolerance to at least one biologic?
6. Does the patient have a contraindication to methotrexate, as determined by the prescriber?
7. Is the requested medication being prescribed by or in consultation with a dermatologist?
8. Has the patient had a response, as determined by the prescriber?

Please document the diagnoses, symptoms, and/or any other information important to this review:

If you have any questions, call: 800-753-2851



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SECTION B Physician Signature

PHYSICIAN SIGNATURE

DATE

FAX COMPLETED FORM TO: 877-251-5896

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