PRIOR AUTHORIZATION REQUEST

Ilumya

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

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. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests.

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?

[] Biologic DMARD (such as Cimzia, Cosentyx, Enbrel, Erelzi, Humira, Amjevita, Cyltezo, Kevzara, Tremfya, Actemra [IV or SC], Kineret, Rituxan, Truxima, Remicade, Inflectra, Renflexis, Siliq, Skyrizi, Simponi [SC or Aria], Stelara [IV or SC], Taltz, or Orencia [SC or IV]) (If checked, no further questions)

[] Targeted synthetic DMARD (such as Olumiant, Otezla, Rinvoq, Xeljanz, or Xeljanz XR) (If checked, no further questions)

[] Conventional synthetic DMARD (such as methotrexate, leflunomide, sulfasalazine, hydroxychloroquine) (If checked, go to 2)

If you have any questions, call: 1-888-258-8250

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	[] No, the requested medication will NOT be used in combination with another BIOLOGIC or Targeted Synthetic disease-modifying antirheumatic drug (DMARD) (If checked, go to 2)		
2	What is the diagnosis or indication? [] Plaque psoriasis (If checked, go to 3) [] Other (If checked, no further questions)		
3	Is the patient currently receiving the requested medication? [If yes, skip to question 9.]	Yes	No
4	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
5	Has the patient tried at least one traditional systemic agent for psoriasis for at least 3 months, unless intolerant? [NOTE: Examples of one traditional systemic agent include methotrexate (MTX), cyclosporine, acitretin tablets, or psoralen plus ultraviolet A light (PUVA).] [If yes, skip to question 8.]	Yes	No
6	Has the patient already had a 3-month trial or previous intolerance to at least one biologic? [NOTE: Examples include an etanercept product (Enbrel, Erelzi), Cosentyx (secukinumab SC injection), an adalimumab product (Humira), Cimzia (certolizumab pegol SC injection), an infliximab product (for example, Remicade, Inflectra, Renflexis), Siliq (brodalumab SC injection), Skyrizi (risankizumab SC injection), Stelara (ustekinumab SC injection), Taltz (ixekizumab SC injection), or Tremfya (guselkumab SC injection).] [If yes, skip to question 8.]	Yes	No
7	Does the patient have a contraindication to methotrexate, as determined by the prescriber? [If no, no further questions.]	Yes	No
8	Is the requested medication being prescribed by or in consultation with a dermatologist? [No further questions.]	Yes	No
9	Has the patient had a response, as determined by the prescriber? [NOTE: The patient may not have a full response, but there should have been a recent or past response.]	Yes	No

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

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SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

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