maryland physicians care
Medicaid with a Heart

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. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

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)

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

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	[] 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) [] 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	Is the patient currently receiving the requested medication? [If no, skip to question 7.]	Yes	No
3	Has the patient been receiving medication samples for the requested medication? [If yes, skip to question 7.]	Yes	No
4	Does the patient have a previously approved prior authorization (PA) on file with the current plan? [Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If no, skip to question 7.]	Yes	No
5	Has the patient been established on therapy for at least 3 months? [If no, skip to question 7.]	Yes	No
6	Has documentation been submitted to confirm that the patient has had a clinically significant response to therapy, as determined by the provider? ACTION REQUIRED: Submit supporting documentation [If no, no further questions.]	Yes	No
7	What is the diagnosis or indication? [] Plaque psoriasis (If checked, go to 8) [] Other (If checked, no further questions)		
8	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
9	Has the patient tried at least TWO 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.] [If no, no further questions.]	Yes	No
10	Has documentation been provided to confirm that the patient had an intolerance, contraindication to, or failed treatment for at least 3 months with preferred TNF inhibitors, Enbrel (etanercept) and an adalimumab product (Simlandi, Hadlima, Yusimry, or adalimumab- adbm)? ACTION REQUIRED: Submit supporting	Yes	No

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	documentation. [If no, no further questions.]		
11	Has documentation been submitted to confirm that the patient has had a treatment failure with a preferred Ustekinumab product (Pyzchiva, Steqeyma, or Yesintek), for at least 3 months or is the patient intolerant or the medication contraindicated? ACTION REQUIRED: Submit supporting documentation? [If no, no further questions.]	Yes	No
12	Is the requested medication being prescribed by or in consultation with a dermatologist? [If no, no further questions.]	Yes	No
13	Does the requested dose exceed FDA approved label dosing for the requested indication? [Dosing: 100 mg at weeks 0, 4, and then every 12 weeks thereafter] [No further questions.]	Yes	No

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

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.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

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