maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

Sotyktu

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	What is the indication or diagnosis? [] Plaque Psoriasis (If checked, go to 2) [] Other (If checked, no further questions)		
2	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
3	Is the requested medication prescribed by or in consultation with a dermatologist?	Yes	No

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

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	[If no, no further questions.]		
4	Will the patient be evaluated for tuberculosis and other infections prior to initiation and during treatment with the requested medication? [If no, no further questions.]	Yes	No
5	Is the patient receiving other concurrent disease modifying antirheumatic drug (DMARD) therapies such as etanercept, adalimumab, infliximab, and certolizumab? [If yes, no further questions.]	Yes	No
6	Is the patient currently receiving the requested medication? [If no, skip to question 13.]	Yes	No
7	Has the patient been receiving medication samples for the requested medication? [If yes, skip to question 13.]	Yes	No
8	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 yes, skip to question 10.]	Yes	No
9	Does the provider have a documented clinical response of the member's condition which has stabilized or improved based upon the prescriber's assessment? [If yes, skip to question 13.] [If no, no further questions.]	Yes	No
10	Has the patient been established on the requested medication for at least 90 days? [NOTE: A patient who has received less than 90 days of therapy or who is restarting therapy is reviewed under initial therapy.] [If no, skip to question 13.]	Yes	No
11	Has the patient experienced a beneficial clinical response, defined as improvement from baseline (prior to initiating the requested drug) in at least one of the following: A) Estimated body surface area, B) Erythema, C) Induration/thickness, D) Scale of areas affected by psoriasis? [If no, no further questions.]	Yes	No
12	Compared with baseline (prior to initiating the requested medication), has the patient experienced an improvement in at least one symptom, such as decreased pain, itching, and/or burning? [No further questions.]	Yes	No
13	Has the patient tried at least two traditional systemic agents for psoriasis for at least 3 months, unless intolerant or contraindicated to two agents?	Yes	No

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	[NOTE: Examples of one traditional systemic agent include methotrexate, cyclosporine, or acitretin tablets.] [If yes, skip to question 15.]		
14	Has documentation been submitted to confirm that the patient has had intolerance, contraindication to, or failed treatment for at least 3 months with preferred tumor necrosis factor (TNF) inhibitors, A) Enbrel (etanercept), B) An adalimumab product (Hadlima, Yusimry, Simlandi or adalimumab-adbm)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
15	Has documentation been submitted to confirm that the patient has had a treatment failure with a preferred Ustekinumab product (Yesintek, Pyzchiva, Steqeyma), 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
16	Does the dose of the requested medication exceed Food and Drug Administration (FDA) approved label dosing for the indication? (Dosing: 1 tablet per day)	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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