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	Is the request for an INITIAL or a CONTINUATION of therapy? [] Initial (If checked, go to 8) [] Continuation (If checked, go to 2)		
2	Will the requested medication be used in combination with a Biologic or a Targeted Synthetic Disease-Modifying Antirheumatic Drug (DMARD)? Examples of Biologics include but not limited to adalimumab SC products (Humira,	Yes	No

PRIOR AUTHORIZATION REQUEST

	biosimilars), Actemra (IV or SC), Cimzia, Cosentyx, Kevzara, Kineret, Orencia (IV or SC), an infliximab product (for example, Remicade, biosimilars), rituximab IV products (Rituxan, biosimilars), Siliq, Stelara (IV or SC), Taltz, Ilumya, Skyrizi, Tremfya, Entyvio, or Simponi (Aria or SC). Examples of Targeted Synthetic DMARD include but not limited to Cibinqo, Rinvoq, Xeljanz/XR, Otezla. [If yes, no further questions.]		
3	Is the patient currently receiving the requested medication? [If no, skip to question 8.]	Yes	No
4	Has the patient been receiving medication samples of the requested medication? [If yes, skip to question 8.]	Yes	No
5	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 8.]	Yes	No
6	Has the patient been established on therapy for AT LEAST 3 months? [If no, skip to question 8.]	Yes	No
7	Has documentation been submitted to confirm that the patient has had a clinically significant response, as determined by the provider? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
8	Will the requested medication be used in combination with a Biologic or a Targeted Synthetic Disease-Modifying Antirheumatic Drug (DMARD)? Examples of Biologics include but not limited to adalimumab SC products (Humira, biosimilars), Actemra (IV or SC), Cimzia, Cosentyx, Kevzara, Kineret, Orencia (IV or SC), an infliximab product (for example, Remicade, biosimilars), rituximab IV products (Rituxan, biosimilars), Siliq, Stelara (IV or SC), Taltz, Ilumya, Skyrizi, Tremfya, Entyvio, or Simponi (Aria or SC). Examples of Targeted Synthetic DMARD include but not limited to Cibinqo, Rinvoq, Xeljanz/XR, Otezla. [If yes, no further questions.]	Yes	No
9	What is the indication or diagnosis? [] Plaque Psoriasis (If checked, go to 10) [] Psoriatic Arthritis (If checked, go to 17) [] Other (If checked, no further questions)		
10	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No

PRIOR AUTHORIZATION REQUEST

11	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
12	Has the patient tried at least two traditional systemic agents for psoriasis for at least 3 months, unless intolerant or contraindicated to two agents? [NOTE: Examples of traditional systemic agent include methotrexate, cyclosporine, or acitretin tablets.] [If no, no further questions.]	Yes	No
13	Has documentation been submitted to confirm that the patient has had intolerance, contraindication to, or failed treatment for at least 3 months with the preferred tumor necrosis factor (TNF) inhibitor, an adalimumab product (Hadlima, Yusimry, Simlandi or adalimumab-adbm)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
14	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
15	Is the requested medication being prescribed by or in consultation with a dermatologist? [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: 6 mg tablet once per day.] [No further questions.]	Yes	No
17	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
18	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
19	Has the patient tried TWO conventional synthetic disease-modifying antirheumatic drugs (DMARDs) for at least 3 months such as methotrexate (oral or injectable), leflunomide, hydroxychloroquine and/or sulfasalazine? [If yes, skip to question 21.]	Yes	No
20	Has the patient experienced an intolerance to at least TWO conventional synthetic disease-modifying antirheumatic drugs (DMARDs) such as methotrexate (oral or injectable), leflunomide, hydroxychloroquine and/or sulfasalazine?	Yes	No

PRIOR AUTHORIZATION REQUEST

	[If no, no further questions.]		
21	Has documentation been submitted to confirm that the patient has had an intolerance, contraindication to, or failed treatment for at least 3 months with preferred tumor necrosis factor (TNF) inhibitor, an adalimumab product (Hadlima, Simlandi, Yusimry, or adalimumab- adbm)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
22	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
23	Has documentation been submitted to confirm that the patient has had a treatment failure with Xeljanz (tofacitinib) for at least 3 months, unless intolerant or contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
24	Is the requested medication being prescribed by or in consultation with a rheumatologist or a dermatologist? [If no, no further questions.]	Yes	No
25	Does the dose of the requested medication exceed Food and Drug Administration (FDA) approved label dosing for the indication? [Dosing: 6 mg tablet once 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.

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

Version 04.2026

PRIOR AUTHORIZATION REQUEST

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