PRIOR AUTHORIZATION REQUEST

ICOTYDE

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 this request for initial therapy or for 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 disease-modifying antirheumatic drug (DMARD) or targeted synthetic DMARD? [Note: Examples of biologics include, but not limited to, adalimumab SC products	Yes	No

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

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	(Humira, biosimilars), Cimzia, etanercept SC products (Enbrel, biosimilars), infliximab IV products (Remicade, biosimilars), Actemra (IV or SC), Simponi, Simponi Aria (IV or SC), Orencia (IV or SC), rituximab IV products (Rituxan, biosimilars), Kineret, Siliq, Cosentyx, Taltz, Ilumya, Skyrizi, Tremfya, or Entyvio. Examples of targeted synthetic DMARD include, but not limited to, Otezla, Olumiant, Rinvoq, or Xeljanz/XR.] [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 for 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 significant response to therapy, 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 disease-modifying antirheumatic drug (DMARD) or targeted synthetic DMARD? [Note: Examples of biologics include, but not limited to, adalimumab SC products (Humira, biosimilars), Cimzia, etanercept SC products (Enbrel, biosimilars), infliximab IV products (Remicade, biosimilars), Actemra (IV or SC), Simponi, Simponi Aria (IV or SC), Orencia (IV or SC), rituximab IV products (Rituxan, biosimilars), Kineret, Siliq, Cosentyx, Taltz, Ilumya, Skyrizi, Tremfya, or Entyvio. Examples of targeted synthetic DMARD include, but not limited to, Otezla, Olumiant, Rinvoq, or Xeljanz/XR.] [If yes, no further questions.]	Yes	No
9	What is the indication or diagnosis? [] Moderate to severe plaque psoriasis (If checked, go to 10) [] Other (If checked, no further questions)		
10	Is the patient greater than or equal to 12 years of age? [If no, no further questions.]	Yes	No

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11	Does the patient weigh greater than or equal to 40 kg? [If no, no further questions.]	Yes	No
12	Does the patient have plaque psoriasis involvement greater than or equal to 10% of the body surface area (BSA) at baseline? ACTION REQUIRED: Submit supporting documentation. [If yes, skip to question 14.]	Yes	No
13	Does the patient have plaque psoriasis affecting the following areas: hands, face, feet, eyes/eyelids, neck, scalp, skin folds, and/or genitalia? [If no, no further questions.]	Yes	No
14	Has documentation been submitted to confirm that the patient has an Investigator Global Assessment (IGA) of disease severity of at least 3 at baseline? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
15	Has the patient tried a topical calcineurin inhibitor (pimecrolimus or tacrolimus) for at least 28 consecutive days? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
16	Was inadequate efficacy demonstrated with the topical calcineurin inhibitor (pimecrolimus or tacrolimus), according to the prescriber? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
17	Has the patient tried Zoryve for at least 56 consecutive days? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
18	Was inadequate efficacy demonstrated with Zoryve, according to the prescriber? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
19	Has documentation been provided to confirm that the patient has tried at least TWO traditional systemic agents for psoriasis for at least 3 months, or has a documented intolerance or contraindication to ALL traditional systemic agents for psoriasis? ACTION REQUIRED: Submit supporting documentation. [Note: Examples of traditional systemic agents include methotrexate, cyclosporine, or acitretin.] [If no, no further questions.]	Yes	No
20	Has documentation been submitted to confirm that the patient has 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	Yes	No

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	documentation. [If no, no further questions.]		
21	Has documentation been submitted to confirm that the patient has had a treatment failure with a preferred ustekinumab product (Yesintek, Pychiva, 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
22	Is the requested medication being prescribed by, or in consultation with, a dermatologist or rheumatologist? [If no, no further questions.]	Yes	No
23	Does the dose of the requested medication exceed the Food and Drug Administration (FDA) approved label dosing for the indication? [Note: Dosing is 200mg once daily.]	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.

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