SENTARA HEALTH PLANS

MEDICAL PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-844-668-1550**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If information provided is not complete, correct, or legible, authorization can be delayed**.

For Medicare Members: Medicare Coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determination (NCD) and Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable. They can be found at: https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx. Additional indications may be covered at the discretion of the health plan.

Drug Requested: Ilumya® (tildrakizumab-asmn) **J3245 (Medical)**

(Ilumya® should ONLY be administered by a healthcare provider)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight: _____ **Date:** _____

❑ Standard Review. In checking this box, the timeframe does not jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain.

NOTE: Sentara Health considers the use of concomitant therapy with more than one biologic immunomodulator (e.g., Dupixent, Entyvio, Humira, Rinvoq, Stelara) prescribed for the same or different indications to be experimental and investigational. Safety and efficacy of these combinations has **NOT** been established and will **NOT** be permitted.

Recommended Dosage: SubQ: 100 mg at weeks 0, 4, and then every 12 weeks thereafter

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CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

❑ DIAGNOSIS: Moderate-to-Severe Plaque Psoriasis

- ❑ Member has a diagnosis of moderate-to-severe **plaque psoriasis**
- ❑ Prescribed by or in consultation with a **Dermatologist**
- ❑ Member tried and failed **at least one** of either Phototherapy or Alternative System Therapy for **at least three (3) months (check each tried below)**:

❑ **Phototherapy:**	❑ **Alternative Systemic Therapy:**
❑ **UV Light Therapy** ❑ NB UV-B ❑ PUVA	❑ **Oral Medications** ❑ acitretin ❑ methotrexate ❑ cyclosporine

- ❑ Member meets **ONE** of the following:
  - ❑ Member tried and failed, has a contraindication, or intolerance to **ONE** of the **PREFERRED** biologics below **(verified by chart notes or pharmacy paid claims)**:

❑ Cimzia® IV	❑ Renflexis®

  - ❑ Member has been established on Ilumya® for at least 90 days **AND** prescription claims history indicates **at least a 90-day supply of Ilumya was dispensed within the past 130 days (verified by chart notes or pharmacy paid claims)**

Medication being provided by (check applicable box(es) below):

❑ **Physician's office** **OR** ❑ **Specialty Pharmacy – Proprium Rx**

Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.*

***Approved by Pharmacy & Therapeutics Committee**: **6/21/2018**
REVISED/UPDATED: ~~9/26/2018; 10/10/2018; 11/24/2018; 3/30/2019; (Reformatted) 4/12/2019; 4/23/2019; 7/7/2019; 9/21/2019; 10/7/2019; 12/20/2022;~~ **8/14/2023**