SENTARA COMMUNITY PLAN
(MEDICAID)

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 1-844-305-2331**. 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.**

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:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

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

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

Weight (if applicable): _____ **Date weight obtained:** _____

☐ 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.

Recommended Dosage: SubQ 100mg (two syringes) per 28 days for the induction period; then 100 mg (one syringe) every 12 weeks after the induction period

CLINICAL CRITERIA/DIAGNOSIS: 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.

(Continued on next page)

❑ DIAGNOSIS - Moderate to Severe Chronic Plaque Psoriasis

- ❑ Moderate to severe plaque psoriasis who are candidates for systemic therapy or phototherapy
- ❑ Member is 18 years of age or older
- ❑ Diagnosis of moderate to severe plaque psoriasis for at least 6 months with at least 1 of the following:
  - ❑ Affected body surface area (BSA) of ≥ 10% **OR**
  - ❑ Psoriasis Area and Sensitivity Index (PASI) score ≥ 10; **OR**
  - ❑ Incapacitation due to plaque location (e.g., head and neck; palms; soles or genitalia)
- ❑ Trial and failure of **TWO (2)** of the **PREFERRED** biologics below:

❑ adalimumab-adbm (Boehringer Ingelheim) **OR** Hadlima® (adalimumab-bwwd)	❑ Enbrel®	❑ Pyzchiva® **OR** Starjemza™ (Requires trial and failure of a preferred TNF-alpha inhibitor)

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

❑ **Physician's office** **OR** ❑ **Specialty Pharmacy – PropriumRx**

For urgent reviews: Practitioner should call Sentara Health Pre-Authorization Department if they believe a standard review would subject the member to adverse health consequences. Sentara Health's definition of urgent is a lack of treatment that could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

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/REFORMATTED: ~~9/26/2018; 10/10/2018; 11/24/2018; 3/30/2019; 4/12/2019; 4/23/2019; 7/23/2019; 10/16/2019; 10/16/2020; 6/28/2021; 7/8/2022; 6/23/2023; 12/16/2025, 2/24/2026, 3/11/2026,~~ **7/14/2026**