SENTARA COMMUNITY PLAN
(MEDICAID)

PHARMACY 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 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Sotyktu™ (deucravacitinib)

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:** _____

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.

Initial Authorization: 12 months

- ❑ **Diagnosis: Moderate-to-Severe Plaque Psoriasis**
  Dosing: Oral: 6 mg once daily
  - ❑ Member has a diagnosis of moderate-to-severe chronic plaque psoriasis
  - ❑ Prescribed by or in consultation with a Dermatologist, Rheumatologist or other specialist in the treatment of psoriasis
  - ❑ Member is 18 years of age or older

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- ❑ Symptoms persistent for ≥ 6 months with at least 1 of the following:
  - ❑ Involvement of at least 3% of body surface area (BSA)
  - ❑ Psoriasis Area and Severity Index (PASI) score of 10 or greater
  - ❑ Incapacitation due to plaque location (i.e., head and neck, palms, soles, or genitalia)
- ❑ Member is **NOT** receiving Sotyktu™ in combination with any other biologic agent
- ❑ Trial and failure (at least 3 months) of **ONE** or more conventional therapy such as:
  - ❑ Disease-modifying anti-rheumatic drug (DMARD), such as methotrexate
  - ❑ Immunosuppressant (e.g., cyclosporine)
  - ❑ Oral retinoid (e.g., acitretin)
- ❑ Trial and failure of **TWO (2)** of the preferred drugs below

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

Reauthorization: 12 months. All criteria that apply must be checked for approval. To support each line checked, all documentation (lab results, diagnostics, and/or chart notes) must be provided or request may be denied.

- ❑ Documentation (e.g., progress note) of response to therapy compared to baseline, such as redness, thickness, scaliness, amount of surface area involvement, and/or PASI score

Medication being provided by Specialty Pharmacy - PropriumRx

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 and Therapeutics Committee**: 11/18/2022
REVISED/UPDATED/REFORMATTED: ~~6/30/2023 11/9/2023, 10/17/2025;~~ **12/15/2025**