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:** _____

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:** _____

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: 6 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)

    OR
  - ❑ Psoriasis Area and Severity Index (PASI) score of 10 or greater

    OR
  - ❑ 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 (at least 3 months) unless contraindication or intolerance to, ≥ 1 preferred cytokine or CAM antagonist indicated for the treatment of this condition
- ❑ Member tried and failed, has a contraindication, or intolerance to at least **TWO** of the **PREFERRED** biologics below (verified by chart notes or pharmacy paid claims):

❑ Humira®	❑ Enbrel®	❑ Infliximab

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.****