

Prior Authorization Request Form	Ilumya
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Sendero Fax: 512-901-9724	Phone: 855-297-9191
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URGENCY: <input type="checkbox"/> STANDARD	<input type="checkbox"/> URGENT (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health or ability to regain maximum function)
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Provider Information	Patient Information
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Referring/Prescribing Physician: <input type="checkbox"/> PCP <input type="checkbox"/> Specialist Name: Please identify SPECIALTY: DEA, NPI or TIN: Contact: Phone: () Fax: ()	Patient's Name: Birth Date: ID Number: Phone Number: Patient Height: Patient Weight:
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Indicate where the drug is being DISPENSED	Indicate where the drug is being ADMINISTERED
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<input type="checkbox"/> Ambulatory Surgery Center <input type="checkbox"/> Home Care Agency <input type="checkbox"/> Inpatient Hospital <input type="checkbox"/> Long Term Care <input type="checkbox"/> Outpatient Hospital <input type="checkbox"/> Patient's Home <input type="checkbox"/> Pharmacy <input type="checkbox"/> Physician's Office <input type="checkbox"/> Other (explain):	<input type="checkbox"/> Ambulatory Surgery Center <input type="checkbox"/> Inpatient Hospital <input type="checkbox"/> Long Term Care <input type="checkbox"/> Outpatient Hospital <input type="checkbox"/> Patient's Home <input type="checkbox"/> Pharmacy <input type="checkbox"/> Physician's Office <input type="checkbox"/> Other (explain): Anticipated Date of Service:
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Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

PATIENT CLINICAL INFORMATION

CRITERIA QUESTIONS:

1. Has the patient been diagnosed with the following?
 Psoriasis
 Other: _____
2. What is the HCPCS code? _____ What is the ICD-10 code? _____
 What is the NDC#: _____
3. Will the requested drug be used in combination with any other biologic or targeted synthetic DMARD (e.g., Olumiant, Xeljanz)? Yes No
4. Has the patient had a TB screening test (e.g., a tuberculosis skin test [PPD] or an interferon-release assay [IGRA]) within 6 months of initiating therapy? Yes No
5. What were the results of the TB screening test? Positive Negative
6. Does the patient have latent or active tuberculosis (TB)? Latent Active No/Neither
7. If the patient has latent or active tuberculosis, has treatment been initiated or completed?
 Yes - treatment initiated Yes - treatment completed No
8. Is this request for continuation of therapy? Yes No
9. For continuation of therapy requests, has the patient achieved or maintained positive clinical response as evidenced by low disease activity or improvement in signs and symptoms since starting treatment with the requested drug? Yes No
10. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program? Yes No

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This authorization is not a guarantee that services will be covered or payment will be made. All medical services rendered are subject to claims review, which includes but is not limited to determination of eligibility in accordance with the member's benefit plan, any deductibles, co-payments, reasonable and customary charges, and policy maximums. The information contained in this letter is privileged and confidential. It is intended for the individual entities indicated on the form. You are hereby notified that any dissemination, distribution, copying or other use of this information for anyone other than the recipients above is unauthorized and is strictly prohibited. If you have received this letter in error, please contact the sender immediately.

DIAGNOSIS SECTION *Please only complete sections below that are relevant to the patient's diagnosis.*

Section A: Psoriasis

11. The patient is diagnosed with **psoriasis** and treatment is prescribed by or in consultation with a dermatologist or rheumatologist Yes No
12. Has the patient previously received Otezla or any other biologic medication indicated for the treatment of moderate to severe plaque psoriasis? Yes No If Yes, please indicate the drug, duration, response, and intolerance/contraindication if applicable:

13. Has the patient had an inadequate response to 1 or more of the following topical therapies?
 Corticosteroids (e.g., betamethasone, clobetasol, desonide) (4-week trial)
 Vitamin D analogs (e.g., calcitriol, calcipotriene)
 Tazarotene
 Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)
 Anthralin
 Coal tar
14. Has the patient had an inadequate response to a minimum 3 month trial of methotrexate at a minimum dose of 15mg po weekly within the last 6 months? Yes No
15. Does the patient have a contraindication or intolerance to methotrexate? Yes No If Yes, indicate contraindication/intolerance and no further questions. _____
16. Does the patient have severe psoriasis that warrants a biologic DMARD as first-line therapy (i.e. at least 10% of the body surface area (BSA) or crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) are affected)? Yes No

* Please note, the preferred biologic class is a TNF inhibitor (specifically Humira), followed by anti-IL-17 drug (specifically Siliq). The preferred anti-IL-12/23 drug is Skyrizi. Please consider prescribing one of these drugs if clinically appropriate. If Ilumya is preferred, please provide additional clinical reasoning documentation here:

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by Sendero Health Plans.

Prescriber or Authorized Signature	DATE