PARAMOUNT
Affiliate of ProMedica

Criteria: PMT
Approved: 1/2019
Verified: 12/2019
Reviewed:

Prior Authorization Criteria Form

This form applies to Paramount Commercial Members Only

Ilumya (Paramount)

Complete/review information, sign and date. Please fax signed forms to Paramount at **1-844-256-2025**. You may contact Paramount by phone at **1-419-887-2520** with questions regarding the Prior Authorization process. When conditions are met, we will authorize the coverage of Ilumya.

Drug Name (select from list of drugs shown)

Other, Please specify Ilumya (tildrakizumab-asmn)

Quantity _____ **Frequency** _____ **Strength** _____

Route of Administration _____ **Expected Length of Therapy** _____

Patient Information

Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

Prescribing Physician

Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Has the patient previously received Ilumya for plaque psoriasis? Y N
[If no, skip to question 3.]

2. Has documentation to support continued clinical effectiveness been submitted with the renewal request? Y N
[If yes, skip to question 10.]
[If no, no further questions.]

3. Is Ilumya prescribed for an adult patient with moderate to severe plaque psoriasis? Y N
[If no, no further questions.]

4. Enbrel, Humira, Cosentyx, Otezla and Stelara are the preferred products for the treatment of plaque psoriasis. Has at least one preferred agent from each therapeutic class been tried and failed, or is contraindicated? If yes, please submit supporting documentation.
[If no, no further questions.] Y N

5. Does the patient meet one of the following criteria: A) At least 5 percent of the body surface area was affected by plaque psoriasis at the time of diagnosis, or B) Crucial body areas (e.g., feet, hands, face, neck, groin, intertriginous areas) were affected by plaque psoriasis at the time of diagnosis?
[If no, no further questions.] Y N

6. Does the patient have an inadequate response, intolerance or contraindication to BOTH of the following: A) a three to four month trial of phototherapy, B) a three to four month trial of pharmacologic treatment with methotrexate, cyclosporine, or acitretin? Action Required: If Yes , attach office notes and clinical documentation for the response given.
[If no, no further questions.] Y N

7. Does the patient have one of the following documented clinical reasons to avoid Enbrel or Humira? If Yes , attach supporting chart note(s).
- History of demyelinating disorder
- History of congestive heart failure
- History of hepatitis B virus infection
- Autoantibody formation/lupus-like syndrome
- Risk of lymphoma
[If no, skip to question 9.] Y N

8. Has the patient had a documented inadequate response or intolerable adverse event with all of the non-TNF preferred products (Cosentyx, Otezla, and Stelara)? If Yes , attach supporting chart note(s).
[If yes, skip to question 10.]
[If no, no further questions.] Y N

9. Has the patient had a documented inadequate response or intolerable adverse event with at least one preferred agent from each therapeutic class (Enbrel or Humira, Cosentyx, Otezla, and Stelara)? If Yes , attach supporting chart note(s).
[If no, no further questions.] Y N

10. Is the patient 18 years of age or older? Y N

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature and Date