



## Ilumya

### Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-855-330-1720.** If you have questions regarding the prior authorization, please contact CVS Caremark at **1-888-877-0518**. For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

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**Patient's Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**Patient's ID:** \_\_\_\_\_ **Patient's Date of Birth:** \_\_\_\_\_  
**Physician's Name:** \_\_\_\_\_  
**Specialty:** \_\_\_\_\_ **NPI#:** \_\_\_\_\_  
**Physician Office Telephone:** \_\_\_\_\_ **Physician Office Fax:** \_\_\_\_\_

**Referring Provider Info:**  Same as Requesting Provider

**Name:** \_\_\_\_\_ **NPI#:** \_\_\_\_\_  
**Fax:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Rendering Provider Info:**  Same as Referring Provider  Same as Requesting Provider

**Name:** \_\_\_\_\_ **NPI#:** \_\_\_\_\_  
**Fax:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

*Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.*

**Required Demographic Information:**

*Patient Weight:* \_\_\_\_\_ kg

*Patient Height:* \_\_\_\_\_ cm

*Please indicate the place of service for the requested drug:*

- Ambulatory Surgical       Home       Off Campus Outpatient Hospital  
 On Campus Outpatient Hospital       Office       Pharmacy

**Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720**

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**Criteria Questions:**

1. What is the prescribed dose and frequency?  
**a) Loading dose:**  
 Ilumya Quantity and Frequency: \_\_\_\_\_  
 Other: \_\_\_\_\_  
**b) Maintenance dose:**  
 Ilumya Quantity and Frequency: \_\_\_\_\_  
 Other: \_\_\_\_\_
2. What is the diagnosis?  Moderate to severe plaque psoriasis  Other \_\_\_\_\_
3. What is the ICD-10 code? \_\_\_\_\_
4. Will the requested drug be used in combination with any other biologic or targeted synthetic DMARD (e.g., Olumiant, Xeljanz)?  Yes  No
5. Has the patient received (including current utilizrs) a biologic or targeted synthetic DMARD (e.g., Rinvoq, Xeljanz)? *If Yes, skip to #7*  Yes  No
6. Has the patient had a TB test (e.g., a tuberculosis skin test [PPD], an interferon-release assay [IGRA], or a chest x-ray) within 6 months of initiating therapy? *If Yes, skip to #9*  Yes  No
7. Does the patient have risk factors for TB? (e.g., persons with close contact to people with infectious TB disease; persons who have recently immigrated from areas of the world with high rates of TB [e.g., Africa, Asia, Eastern Europe, Latin America, Russia]; children less than 5 years of age who have a positive TB test; groups with high rates of TB transmission [e.g., homeless persons, injection drug users, persons with HIV infection], or persons who work or reside with people who are at an increased risk for active TB [e.g., hospitals, long-term care facilities, correctional facilities, homeless shelter])?  Yes  No *If No, skip to #12*
8. Has the patient been tested for tuberculosis (TB) within the previous 12 months?  Yes  No
9. What were the results of the TB test?  Positive for TB  Negative for TB, *skip to #12*  Unknown
10. Does the patient have latent or active tuberculosis (TB)?  Latent  Active  Unknown
11. Has treatment for latent tuberculosis (TB) infection been initiated or completed?  
 Yes - treatment initiated  Yes - treatment completed  No
12. Is the patient currently receiving Ilumya?  Yes  No
13. Is this request for continuation of therapy?  Yes  No *If No, skip to #18*
14. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program? *If Yes or Unknown, skip to #18*  Yes  No  Unknown
15. Has the patient achieved or maintained positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition since starting treatment with the requested drug?  
 Yes  No
16. Has the patient experienced a reduction in body surface area (BSA) affected from baseline? **ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation of decreased body surface area affected and no further questions.**  Yes  No
17. Has the patient experienced an improvement in signs and symptoms from baseline (e.g., itching, redness, flaking, scaling, burning, cracking, pain)? **ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation of improvement in signs and symptoms and no further questions.**  Yes  No

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18. Has the patient previously received Otezla or any other biologic medication indicated for the treatment of moderate to severe plaque psoriasis? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried and no further questions.***  
 Yes  No
19. Are crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) affected? ***ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation of affected areas and body surface area affected and no further questions.***  Yes  No
20. What is the percentage of body surface area (BSA) affected (prior to starting the requested medication)? ***ACTION REQUIRED: Please attach chart notes or medical record documentation of affected areas and body surface area affected. \_\_\_\_\_% If greater than or equal to 10%, no further questions***
21. Has the patient experienced an inadequate response, or has an intolerance to phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine or acitretin? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy and no further questions.***  Yes  No
22. Does the patient have a clinical reason to avoid pharmacologic treatment with methotrexate, cyclosporine and acitretin? ***ACTION REQUIRED: If Yes, please attach documentation of clinical reason to avoid therapy.***  
 Yes  No *If Yes, indicate clinical reason: \_\_\_\_\_*

***I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.***

**X**  
 \_\_\_\_\_  
**Prescriber or Authorized Signature**

\_\_\_\_\_  
**Date (mm/dd/yy)**

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