**Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.**
**Siliq (brodalumab) Prior Authorization (PA)**
**Pharmacy Benefits Prior Authorization Help Desk**
**Length of Authorizations: Initial- 12 months; Continuation- 12 months**

**Instructions:**

This form is used by Kaiser Permanente and/or participating providers for coverage of **Siliq (brodalumab).** Please complete all sections, incomplete forms will delay processing. Fax this form back to Kaiser Permanente within 24 hours fax: 1-866-331-2104. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless all sections are complete.**

**KP-MAS Formulary can be found at: http://www.providers.kaiserpermanente.org/mas/formulary.html**

**1 – Patient Information**

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

**2 – Provider Information**

Provider Name: _____ Specialty: _____ Provider NPI: _____

Provider Address: _____

Provider Phone #: _____Provider Fax #: _____

**3 – Pharmacy Information**

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #_____ Pharmacy Fax #: _____

**4 – Drug Therapy Requested**

Drug 1: Name/Strength/Formulation: _____

Sig: _____

Drug 2: Name/Strength/Formulation: _____

Sig: _____

**5– Diagnosis/Clinical Criteria**

1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy, State date: _____

2. Indicate the patient's diagnosis for the requested medication:
   _____patient

3. If this is being used for <u>plaque psoriasis</u> (PSO):
   a. Does the patient have chronic moderate-to-severe plaque psoriasis? **AND**
      □ No □ Yes

   b. Is there involvement of at least 5% of body surface area (BSA) or palmoplantar, facial, genital or severe scalp psoriasis? **AND**
      □ No □ Yes

   c. History of failure, contraindication, or intolerance to one of the following topical therapies? **AND**
      - Corticosteroids (e.g., betamethasone, clobetasol, desonide)
      - Vitamin D analogs (e.g., calcitriol, calcipotriene)
      - Tazarotene
      - Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)
      - Anthralin
      - Coal tar

      □ No □ Yes

   d. History of failure, contraindication, or intolerance to **s**ystemic therapy of at least 3 months duration with methotrexate? **AND**
      □ No □ Yes

   e. Was there therapeutic failure to <u>both</u> preferred agents? (e.g. Enbrel, Humira) **AND**
      □ No □ Yes

   f. Is the patient not receiving Siliq in combination with any of the following?
      - Biologic DMARD [e.g., Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab), Cosentyx (secukinumab), Orencia (abatacept)]
      - Janus kinase inhibitor [e.g., Xeljanz (tofacitinib)]
      - Phosphodiesterase 4 (PDE4) inhibitor [e.g. Otezla (apremilast)]

      □ No □ Yes

4. If this is being used for Psoriatic Arthritis (PsA):
   a. Is the patient a candidate for systemic therapy or phototherapy and have failed to respond or have lost response to other systemic therapies (e.g., methotrexate, Enbrel, Humira, Renflexis) ?
      □ No □ Yes

For continuation of therapy, please respond to additional questions below.

1. Is there documentation of positive clinical response to Siliq therapy? **AND**
   □ No □ Yes

2. Is the patient not receiving Siliq in combination with any of the following:
   - Biologic DMARD [e.g., Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab), Cosentyx (secukinumab), Orencia (abatacept)]
   - Janus kinase inhibitor [e.g., Xeljanz (tofacitinib)]

- Phosphodiesterase 4 (PDE4) inhibitor [e.g. Otezla (apremilast)]

□ No □ Yes

**6 – Provider Sign-Off**

**Additional Information – Please submit chart notes/medical records for the patient that are applicable to this request. If no to any of the above questions, please provide any additional supporting information that should be taken into consideration:** -

_____

**I certify that the information provided is accurate. Supporting documentation is available for State audits.**

| **Provider Signature:** | **Date:** |
|---|---|
| | |