Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Sotyktu® (deucravacitinib) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 1 year; Continuation- 1 year

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Sotyktu® (deucravacitinib).** Please complete and 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 this form is complete. The KP-MAS Formulary can be found at:** Pharmacy | Community Provider Portal | Kaiser Permanente

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 #: _____

1. Is this request for initial or renewal of a prior therapy?
   ☐ Initial request ☐ Renewal request

For Initial request, complete the rest of the sections below. If therapy is approved, length of approval is 1 year.

For renewal request, complete the following question to receive a 12-month approval, and sign the form.

2. 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.

   ☐ **YES** ☐ **NO**

4 – Clinical Criteria

1. Is the member ≥ 18 years of age?

   ☐ Yes ☐ No

2. Is Sotyktu® (deucravacitinib) prescribed by, or in consultation with, a dermatologist, rheumatologist, or other specialist in the treatment of psoriasis; **AND**

   ☐ Yes ☐ No

3. Does the member have a Diagnosis of moderate to severe plaque psoriasis?; **AND**

   ☐ Yes ☐ No

4. Has the member's 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); **AND**

   ☐ Yes ☐ No

5. Has the member had a trial and failure (at least 3 months) of at least one of the following conventional therapy:

   - Disease-modifying anti-rheumatic drug (DMARD), such as methotrexate; **OR**
   - Immunosuppressant (e.g., cyclosporine); **OR**
   - Oral retinoid (e.g., acitretin); **AND**

   ☐ Yes ☐ No

6. Sotyktu® (deucravacitinib) is not being used in combination with any other biologic agent; **AND**

   ☐ Yes ☐ No

7. Has the member had a 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?

   ☐ Yes ☐ No

   - If No, please provide a rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:

     _____

     _____

5 – Provider Sign-Off

Additional Information –

1. **Please submit chart notes/medical records for the patient that are applicable to this request.**

_____

_____

_____

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

Provider Signature:	**Date:**