Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Ilumya (tildrakizumab-asmn) & Siliq (brodalumab) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 6 months; Continuation- 12 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Ilumya (tildrakizumab) & Siliq (brodalumab) .** 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.**
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 – Prescriber Information

Is the prescriber a Rheumatologist or Dermatologist? □ No □ Yes

If consulted with a specialist, specialist name and specialty: _____

Prescriber Name: _____ Specialty: _____ NPI: _____

Prescriber Address: _____

Prescriber Phone #: _____Prescriber Fax #: _____

Do you have an approved provider referral number from Kaiser Permanente?
□ Yes – please provide your provider referral number here: _____

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 start date: _____

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

Clinical Criteria:

1. Does the member have a diagnosis of moderate-to-severe plaque psoriasis (>3% body surface area unless palmar-plantar involvement is severe)?
   □ No □ Yes

2. Did the member have an inadequate response or contraindication to at least a 3-month trial of phototherapy unless involvement in sensitive areas (e.g., face, body folds, etc.)?
   □ No □ Yes

3. Did the member fail at least a 3-month trial of one of the following unless clinically significant adverse effects, contraindication or clinical reason to avoid treatment (i.e. pregnancy/breastfeeding, history of alcoholism or alcoholic liver disease, chronic liver disease, immunodeficiency syndrome, pre-existing blood dyscrasia, hemodialysis, or end-stage renal disease)?
   a. Methotrexate
   b. Acitretin
   □ No □ Yes

4. Is there documentation of inadequate response, intolerance, or contraindication to ALL of the following?
   a. At least one TNF inhibitor [i.e. adalimumab product (Amjevita preferred) or infliximab product (Inflectra preferred)]
   b. Secukinumab (Cosentyx)*PA
   c. Guselkumab (Tremfya)*PA OR risankizumab-rzaa (Skyrizi)*PA
   d. Ustekinumab (Stelara)*PA
   □ No □ Yes

*PA *This medication is also subject to PA review*

For continuation of therapy, please respond to <u>additional questions</u> below:

1. Has the member had a positive clinical response to medication?
   □ No □ Yes

2. Has specialist follow-up occurred in the past 12 months since last review?
   □ No □ Yes

6 – Prescriber Sign-Off

Additional Information –

1. **Please submit chart notes/medical records for the patient that are applicable to this request.**
2. **If member has not tried preferred agent(s) please provide rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:**

_____
_____
_____

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

Prescriber Signature:	**Date:**

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