Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Sotyktu (deucravacitinib) 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 **Sotyktu (deucravacitinib)** for **Commercial, Exchange, FEHB (Federal),** and **MD Medicaid** plans**.** 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: Pharmacy | Community Provider Portal | Kaiser Permanente

1 – Patient Information

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

2 – Prescriber Information

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. Is the prescriber a Dermatologist?
   □ No □ Yes

2. Is the patient ≥18 years of age?
   □ No □ Yes

3. Does the patient have documented moderate-to-severe plaque psoriasis (>20% Body Surface Area Affected, unless involving scalp)?
   □ No □ Yes

4. Has the patient had an inadequate response (of at least a 3-month trial), intolerance, or contraindication to phototherapy?
   □ No □ Yes

5. Has the patient had documented failure or clinically significant adverse effects to at least one of the following (of at least a 3-month trial), unless contraindicated or clinical reason to avoid treatment:
   - Methotrexate
   - Acitretin

   □ No □ Yes

6. Has the patient had inadequate response (of at least a 3-month trial), intolerance and/or contraindication to ALL of the following:
   - Adalimumab product [Amjevita (adalimumab-atto) preferred]
   - Cosentyx (secukinumab)*PA
   - Ustekinumab [Yesintek (ustekinumab-kfce) preferred]*
   - Tremfya (guselkumab)*PA
   - Skyrizi (risankizumab)*PA

   □ No □ Yes

**Brand Stelara/nonpreferred ustekinumab biosimilars are subject to PA review*
**PAThis medication is also subject to PA review*

For continuation of therapy, please respond to <u>additional questions</u> below. New members who were initiated on therapy outside of Kaiser, who have not been reviewed previously, must meet all above Clinical Criteria.

1. Is there documentation of clinically significant benefit from the medication?
   □ No □ Yes

2. Has there been specialist follow-up in the last 12 months?
   □ 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:**