Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Ilumya (tildrakizumab-asmn) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorization: 12 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Ilumya (tildrakizumab-asmn).** 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 #: _____

Please check the boxes that apply:

□ Initial Request □ Continuation of Therapy Request

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. Does the member have diagnosis of moderate to severe Plaque Psoriasis (PsO) for at least 6 months? **AND**
   □ No □ Yes
2. Was there therapeutic failure to one of the preferred agents? (e.g. Enbrel, Humira) **AND**
   □ No □ Yes
3. Is there involvement of at least 10% of body surface area (BSA)? OR
   □ No □ Yes
4. Is the Psoriasis Area and Severity Index (PASI) score 10 or greater? OR
   □ No □ Yes
5. Incapacitation due to plaque location (e.g., head and neck, palms, soles or genitalia)? AND
   □ No □ Yes
6. Has the patient not responded adequately (or is not a candidate) to a 3-month minimum trial of topical agents (e.g., anthralin, coal tar preparations, corticosteroids, emollients, immunosuppressives, keratolytics, retinoic acid derivatives, and/or Vitamin D analogues)? AND
   □ No □ Yes
7. Has the patient not responded adequately (or is not a candidate) to a 3-month minimum trial of at least 1 systemic agent (e.g. Immunosuppressives, retinoic acid derivatives, and/or methotrexate)? AND
   □ No □ Yes
8. Has the patient not responded adequately (or is not a candidate) to a 3-month minimum trial of phototherapy (e.g. Psoralens with UVA light (PUVA) OR UVB with coal tar or dithranol)?
   □ No □ Yes

6 – Provider 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.

Provider Signature:	**Date:**