



**Ilumya (tildrakizumab-asmn)  
Prior Authorization Request Form**



Caterpillar Prescription Drug Benefit  
Phone: 877-228-7909 Fax: 800-424-7640

**Instructions:** Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

**URGENT**

MEMBER INFORMATION	
LAST NAME:	FIRST NAME:
PHONE NUMBER:	DATE OF BIRTH:
STREET ADDRESS:	
CITY:	STATE: ZIP CODE:
PATIENT INSURANCE ID NUMBER:	

MALE  FEMALE HEIGHT (IN/CM): \_\_\_\_\_ WEIGHT (LB/KG): \_\_\_\_\_ ALLERGIES: \_\_\_\_\_

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: [HTTPS://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI DISCLOSURE AUTHORIZATION.PDF](https://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI_DISCLOSURE_AUTHORIZATION.PDF)

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): \_\_\_\_\_  
 AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: \_\_\_\_\_

PRESCRIBER INFORMATION	
LAST NAME:	FIRST NAME:
PRESCRIBER SPECIALTY:	EMAIL ADDRESS:
NPI NUMBER:	DEA NUMBER:
PHONE NUMBER:	FAX NUMBER:
STREET ADDRESS:	
CITY:	STATE: ZIP CODE:
REQUESTOR (if different than prescriber):	OFFICE CONTACT PERSON:

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	FREQUENCY:	LENGTH OF THERAPY/REFILLS:	QUANTITY:
<input type="checkbox"/> NEW THERAPY	<input type="checkbox"/> RENEWAL	IF RENEWAL: DATE THERAPY INITIATED:	
DURATION OF THERAPY (SPECIFIC DATES):			

Continued on next page.





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MEMBER'S LAST NAME: \_\_\_\_\_ MEMBER'S FIRST NAME: \_\_\_\_\_

<b>1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION?</b> <input type="checkbox"/> YES (if yes, complete below) <input type="checkbox"/> NO		
<b>MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE):</b>  	<b>DURATION OF THERAPY (SPECIFY DATES):</b>  	<b>RESPONSE/REASON FOR FAILURE/ALLERGY:</b>  
<b>2. LIST DIAGNOSES:</b> <input type="checkbox"/> Plaque psoriasis <input type="checkbox"/> Other Diagnosis _____ ICD-10 Code(s): _____		<b>ICD-10:</b>  
<b>3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.</b>		
<b>Clinical information:</b> Is drug being used as part of a clinical trial? <input type="checkbox"/> Yes <input type="checkbox"/> No  <b>Initial Request:</b> Will the patient be using Ilumya concurrently with a tumor necrosis factor (TNF) inhibitor? <input type="checkbox"/> Yes <input type="checkbox"/> No  Has the patient had a 3-month trial and inadequate response to the Enbrel(etanercept)? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>*Must provide documentation, including trial dates.</i>  Has the patient had a 3-month trial and inadequate response to the Humira (adalimumab)? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>*Must provide documentation, including trial dates.</i>  Is prescriber a dermatologist? <input type="checkbox"/> Yes <input type="checkbox"/> No  Does the patient have plaques covering at least 3% of their body surface area (BSA) or less than 3% of BSA with involvement of palms, soles, head and neck, or genitalia which cause disruption of normal activities? <input type="checkbox"/> Yes <input type="checkbox"/> No  Has the patient had an inadequate response to topical therapy (e.g., corticosteroids, anthralin, calcipotriene, tazarotene)? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>*Must provide documentation, including trial dates.</i>  Select if the patient has had a trial and inadequate response to the following phototherapy options: <input type="checkbox"/> Psoralens with UVA light (PUVA) <input type="checkbox"/> UVB with coal tar  Select if the patient has had a trial and inadequate response to the following systemic therapies: <input type="checkbox"/> Acitretin <input type="checkbox"/> Cyclosporine <input type="checkbox"/> Methotrexate <i>*Must provide documentation, including trial dates.</i>  Does the patient have documentation of a contraindication to all oral systemic therapies? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>*Must provide documentation.</i>		
<b>Renewal Request:</b> Is prescriber a dermatologist? <input type="checkbox"/> Yes <input type="checkbox"/> No  Is patient continuing to respond to therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>*Must provide documentation.</i>		





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**Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?**

\_\_\_\_\_

**Please note:** Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

**ATTESTATION:** I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

**Prescriber Signature or Electronic I.D. Verification:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**CONFIDENTIALITY NOTICE:** The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.

**FAX THIS FORM TO: 800-424-7640**

**MAIL REQUESTS TO:** Magellan Rx Management Prior Authorization Program; c/o Magellan Health, Inc.  
4801 E. Washington Street, Phoenix, AZ 85034  
Phone: 877-228-7909

