

**Cytokine and CAM – Interleukin-23 and Interleukin-12/23 Agents
 Clinical Prior Authorization (PA) Request Form
 CT Medical Assistance Program
To Be Completed By Prescriber**

<u>Prescriber Information</u>	<u>Patient Information</u>
Prescriber's NPI:	Patient's Medicaid ID Number:
Prescriber Name:	Patient Name:
Prescriber Subspecialty:	Patient DOB:
Phone ()	Patient Current Weight:
Fax ()	Patient Primary ICD Diagnosis Code:
<u>Prescription Information</u>	
Drug, Strength, and Dosage Form Requested:	Frequency of Dosing:
<input type="checkbox"/> New therapy <input type="checkbox"/> Continuation	Quantity Requested:

<u>Preferred Agents:</u>	<u>Non-Preferred Agents:</u>	
PYZCHIVA SUBCUTANEOUS SYRINGE*	ILUMYA SYRINGE	STELARA SYRINGE, VIAL*
PYZCHIVA SUBCUTANEOUS VIAL*	IMULDOSA SYRINGE, VIAL*	TREMFYA PEN, SYRINGE, VIAL
SELARSDI SUBCUTANEOUS SYRINGE*	OMVOH SYRINGE, VIAL	USTEKINUMAB SYRINGE, VIAL*
SELARSDI INTRAVENOUS VIAL*	OTULFI SYRINGE, VIAL*	USTEKINUMAB-AEKN SYRINGE*
STEQEYMA SUBCUTANEOUS SYRINGE*	PYZCHIVA INTRAVENOUS VIAL*	USTEKINUMAB-AAUZ SYRINGE*
STEQEYMA INTRAVENOUS VIAL*	SELARSDI SUBCUTANEOUS VIAL*	USTEKINUMAB-TTWE SYRINGE*
	SKYRIZI PEN, SYRINGE, VIAL	USTEKINUMAB-TTWE VIAL*
	STARJEMZA SYRINGE, VIAL*	WEZLANA SYRINGE, VIAL*
		YESINTEK SYRINGE, VIAL*

*Ustekinumab product

Clinical Information

(attach supporting documentation, **required**)

Note: Using samples to initiate therapy does not meet authorization requirements

1. Prescribed by or in consultation with a rheumatologist, dermatologist, gastroenterologist or any other specialist familiar with the treated disease state (or as appropriate for diagnosis)? ○ Please Specify: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Is patient using in combination with another targeted immunomodulator?	<input type="checkbox"/> Yes <input type="checkbox"/> No

<p>○ Please specify alternate agent: _____</p>	
<p>3. Does patient have active TB, or other active infection prior to initiation?</p> <p>○ Please specify infection: _____</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>4. For diagnosis of Moderate-to-Severe disease activity of the following: Crohn’s Disease (CD), Psoriatic Arthritis (PsA), Plaque Psoriasis (PsO) or Ulcerative Colitis (UC): Patient has trialed and failed ONE preferred tumor necrosis factor inhibitor (TNFi) OR preferred USTEKINUMAB biosimilar for a minimum of 30 days OR documented adverse event/adverse drug reaction or contraindication to preferred agents:</p> <ul style="list-style-type: none"> ▪ Preferred agent trialed: _____ ▪ Trial Dates: _____ ▪ Reason for Failure: _____ ▪ If Adverse Reaction, Adverse Event, or Contraindication, please specify details: _____ _____ 	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

For Initial Approval:
Medication Requested and Documented diagnosis of ONE of the following:
(attach supporting documentation, required)

<p><u>Ilumya (tildrakizumab-asmn) (18+ years of age):</u></p> <ul style="list-style-type: none"> • Patient has a documented diagnosis of Moderate-to-Severe Plaque Psoriasis (PsO) AND • A candidate for systemic therapy or phototherapy AND • Failure to achieve the desired therapeutic outcome following a trial of at least ONE preferred agent appropriate for the specified indication (as outlined above in Question 4 of the Clinical Information section) 	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p><u>OmvoH (mirikizumab-mrkz) (18+ years of age):</u></p> <ul style="list-style-type: none"> • Patient has a documented diagnosis of ONE of the following: <ul style="list-style-type: none"> ○ Crohn’s Disease (CD) ○ Ulcerative Colitis (UC) AND • Failure to achieve the desired therapeutic outcome following a trial of at least ONE preferred agent appropriate for the specified indication (as outlined above in Question 4 of the Clinical Information section) 	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

Skyrizi (risankizumab-rzaa) (18+ years of age):

Yes No

- Patient has a documented diagnosis of ONE of the following:
 - Plaque Psoriasis (PsO) and patient is a candidate for systemic therapy or phototherapy
 - Psoriatic Arthritis (PsA)
 - Crohn’s Disease (CD)
 - Ulcerative Colitis (UC) **AND**
- Failure to achieve the desired therapeutic outcome following a trial of at least ONE preferred agent appropriate for the specified indication (as outlined above in Question 4 of the Clinical Information section)

Tremfya (guselkumab):

Yes No

- Patient has a documented diagnosis of ONE of the following:
 - Plaque Psoriasis (PsO) and patient is a candidate for systemic therapy or phototherapy (6+ years of age and weighs 40 kg or more)
 - Psoriatic Arthritis (PsA) (6+ years of age and weighs 40 kg or more)
 - Crohn’s Disease (CD) (18+ years of age)
 - Ulcerative Colitis (UC) (18+ years of age) **AND**

Failure to achieve the desired therapeutic outcome following a trial of at least ONE preferred agent appropriate for the specified indication (as outlined above in Question 4 of the Clinical Information section)

Non-Preferred Ustekinumab products including:

Yes No

- IMULDOSA SYRINGE, VIAL
- OTULFI SYRINGE, VIAL
- PYZCHIVA INTRAVENOUS VIAL
- SELARSDI SUBCUTANOUS VIAL
- STARJEMZA SYRINGE, VIAL
- STELARA SYRINGE, VIAL
- USTEKINUMAB SYRINGE, VIAL
- USTEKINUMAB-AEKN SYRINGE
- USTEKINUMAB-AAUZ SYRINGE
- USTEKINUMAB-TTWE SYRINGE, VIAL
- WEZLANA SYRINGE, VIAL
- YESINTEK SYRINGE, VIAL

- Patient has a documented diagnosis of ONE of the following:
 - Plaque Psoriasis (PsO) and patient is a candidate for systemic therapy or phototherapy (6+ years of age)
 - Psoriatic Arthritis (PsA) (6+ years of age)
 - Crohn’s Disease (CD) (18+ years of age)

<ul style="list-style-type: none"> ○ Ulcerative Colitis (UC) (18+ years of age) AND ● Failure to achieve the desired therapeutic outcome following a trial of at least ONE preferred ustekinumab formulation (as outlined above in Question 4 of the Clinical Information section) 	
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Renewal Information

(attach supporting documentation, **required**)

Note: Using samples to initiate therapy does not meet renewal authorization requirements

<ul style="list-style-type: none"> ● Has the patient previously met the required criteria set forth in Initial Approval Section above? <ul style="list-style-type: none"> ○ Previous Approved Prior Authorization Number: _____ ○ Approval Dates: _____ 	<input type="checkbox"/> Yes <input type="checkbox"/> No
<ul style="list-style-type: none"> ● Patients' clinical response to treatment and ongoing safety has been documented and monitored 	<input type="checkbox"/> Yes <input type="checkbox"/> No
<ul style="list-style-type: none"> ● Prescriber attests that the patient has a continued need for therapy and is compliant with current regimen 	<input type="checkbox"/> Yes <input type="checkbox"/> No
<ul style="list-style-type: none"> ● Provider has completed the Clinical Information and Initial Approval sections above for ALL Non-Preferred USTEKINUMAB formulations <p><i>NOTE: Initial therapy requirements apply to both new starts and continued therapy requests for non-preferred ustekinumab formulations</i></p>	<input type="checkbox"/> Yes <input type="checkbox"/> No

Please Note: Pharmacies should not be contacting prescribers to provide pre-signed PA forms or submitting pre-signed forms for PA, nor should prescribing providers be requesting that pharmacies perform PA activities for them. PA requests must originate from the prescriber, and only the prescriber should sign the form at the time of PA submission.

I certify that documentation is maintained in my files and the information given is true and accurate for the medication requested, subject to penalty under section 17b-99 of the Connecticut General Statutes and sections 17-83k-1- to 17-83k-7, inclusive, of the Regulations of Connecticut State Agencies. I certify that the above-referenced member is a patient under my clinic's/practice's ongoing care. I understand that a prior authorization may not exceed one (1) year from the date of fill for non-controlled medications. Authorizations for Early Refill Requests are valid one time only.

Prescriber Signature*: _____ **Date:** _____

*** Mandatory (others may not sign for prescriber). In accordance with federal law, prescribers must be enrolled in the Connecticut Medical Assistance Program (CMAP). CMAP will not pay for prescriptions written by a non-enrolled provider.**

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