



MEDICARE FORM

Ilumya™ (tildrakizumab-asmn) Injectable Medication Precertification Request

Page 1 of 2

(All fields must be completed and legible for precertification review.)

For Medicare Advantage Part B: FAX: 1-844-268-7263 PHONE: 1-866-503-0857

For other lines of business: Please use other form.

Note: Ilumya is non-preferred. Preferred products may vary based on indication. See section G below.

Please indicate: Start of treatment: Start date / / Continuation of therapy: Date of last treatment / /

Precertification Requested By: Phone: Fax:

A. PATIENT INFORMATION

Form section A: Patient Information. Fields include First Name, Last Name, Address, City, State, ZIP, Home Phone, Work Phone, Cell Phone, DOB, Allergies, E-mail, Current Weight, Height.

B. INSURANCE INFORMATION

Form section B: Insurance Information. Fields include Aetna Member ID #, Group #, Insured, Does patient have other coverage?, Carrier Name.

C. PRESCRIBER INFORMATION

Form section C: Prescriber Information. Fields include First Name, Last Name, Address, City, State, ZIP, Phone, Fax, St Lic #, NPI #, DEA #, UPIN, Office Contact Name.

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Form section D: Dispensing Provider/Administration Information. Divided into Place of Administration and Dispensing Provider/Pharmacy.

E. PRODUCT INFORMATION

Form section E: Product Information. Fields include Request is for, Dose, Frequency, HCPCS Code.

F. DIAGNOSIS INFORMATION - Please indicate primary ICD Code and specify any other where applicable.

Form section F: Diagnosis Information. Fields include Primary ICD Code, Secondary ICD Code, Other ICD Code.

G. CLINICAL INFORMATION - Required clinical information must be completed in its entirety for all precertification requests.

Form section G: Clinical Information. Includes initiation request requirements, medical reason questions, and preferred products list.

Continued on next page



MEDICARE FORM

Ilumya™ (tildrakizumab-asmn) Injectable Medication Precertification Request

Page 2 of 2

(All fields must be completed and legible for precertification review.)

For Medicare Advantage Part B:

FAX: 1-844-268-7263

PHONE: 1-866-503-0857

For other lines of business:

Please use other form.

Note: Ilumya is non-preferred.

Preferred products may vary based on indication. See section G.

Patient First Name Patient Last Name Patient Phone Patient DOB

G. CLINICAL INFORMATION (continued) - Required clinical information must be completed in its entirety for all precertification requests.

Plaque Psoriasis:

Please indicate the severity of the patient's disease: mild moderate severe

Yes No Is there evidence that the disease is active?

Yes No Is there clinical documentation of chronic disease?

Yes No Is the patient a candidate for systemic therapy or phototherapy?

Please select: phototherapy systemic therapy phototherapy and systemic therapy

Please provide the patient's Psoriasis Area and Severity Index (PASI) score:

Please indicate the percentage of body surface area affected by plaque psoriasis: %

Yes No Does the plaque psoriasis involve sensitive areas? If yes, please select: hands feet face genitals

Yes No Was the trial with systemic conventional DMARD(s) (e.g., methotrexate, acetretin, or cyclosporine) ineffective?

Yes No Was the trial with systemic conventional DMARD(s) not tolerated?

Yes No Are systemic conventional DMARDs contraindicated?

Please select: acetretin cyclosporine methotrexate mycophenolate None of the above

Please indicate the length of the medication trial: Less than 1 month 1 month 2 months 3 months or greater

Yes No Was the trial with phototherapy ineffective?

Yes No Was the trial with phototherapy not tolerated?

Yes No Is phototherapy contraindicated?

Please check all that apply: Psoralens (methoxsalen, trioxsalen) with UVA light (PUVA)

UVB with coal tar or dithranol

UVB (standard or narrow band)

Home UVB

None of the above

Please indicate the length of trial: Less than 1 month 1 month 2 months 3 months or greater

For Continuation of Therapy (clinical documentation required for all requests):

Please indicate the length of time on Ilumya (tildrakizumab-asmn):

Yes No Is this continuation request a result of the patient receiving samples of Ilumya (tildrakizumab-asmn)?

Yes No Will Ilumya (tildrakizumab-asmn) be used concomitantly with apremilast, tofacitinib, or other biologic DMARDs (e.g., adalimumab, certolizumab)?

Yes No Is there clinical documentation supporting disease stability?

Yes No Is there clinical documentation supporting disease improvement?

Yes No Does the patient have any risk factors for TB?

Yes No Has the patient had a TB test within the past year?

(check all that apply): PPD test interferon-gamma assay (IGRA) chest x-ray

Please enter the results of the TB test: positive negative unknown

Yes No Has the patient received Ilumya (tildrakizumab-asmn) within the past 6 months?

Yes No Does the patient have a documented severe and/or potentially life-threatening adverse event that occurred during or following the previous infusion?

Yes No Could the adverse reaction be managed through pre-medication in the home or office setting?

Please indicate the severity of the disease at baseline (pretreatment with Ilumya (tildrakizumab-asmn)): mild moderate severe

H. ACKNOWLEDGEMENT

Request Completed By (Signature Required): Date: / /

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.