

**Montana Healthcare Programs Prior Authorization Request Form for Use of
Ilumya® (tildrakizumab-asmn)**

Member name:	DOB:	Date:
Member ID:	Prescriber phone:	
Prescriber name and specialty (if applicable):	Prescriber fax:	
Dosage requested:		

Please complete below information for applicable situation, Initiation or Continuation of therapy:**INITIATION OF THERAPY**

1. Member is 18 years of age or older: ☐ Yes ☐ No
2. Member has a diagnosis of moderate to severe plaque psoriasis: ☐ Yes ☐ No
3. Medication is prescribed by, or in consultation with: ☐ Dermatologist ☐ Rheumatologist

Action Required: If not written by a specialist, a copy of the annual specialty consult is required (please attach copy of consult).

Name of specialist: _____ Contact date: _____

4. Member has trialed, and had an inadequate response or contraindication to a Montana Healthcare Programs preferred drug with the same indication: ☐ Yes ☐ No

Drug name: _____ Dates of use: _____

5. Provider attests to the following:

- ☐ The member has been screened for tuberculosis (TB) prior to initiating treatment.
- ☐ The provider will monitor for active infection.

6. Provider attests that member will **not** use Ilumya® concomitantly with other biologics: ☐ Yes ☐ No

LIMITATIONS:

Maximum Dose Limits: 100mg subcutaneous (Sub Q) at week zero, week four and every 12 weeks thereafter.

Initial authorization will be issued for three doses (weeks zero, four and 16).

CONTINUATION OF THERAPY

1. Member has been adherent to Ilumya®: ☐ Yes ☐ No
2. Member has documentation of positive clinical response to Ilumya® therapy (e.g., reduction in the frequency and/or severity of symptoms and exacerbations): ☐ Yes ☐ No
3. Annual specialist consult attached if prescriber is not a specialist: ☐ Yes ☐ No ☐ N/A - prescriber is a specialist
4. Provider attests that member will **not** use Ilumya® concomitantly with other biologics: ☐ Yes ☐ No

Reauthorization will be issued for one year.

**Please complete form, including required attachments and fax to
Drug Prior Authorization Unit at 1-800-294-1350**