Mountain-Pacific Quality Health
Partnering within our communities to provide solutions for better health
P.O. Box 5119, Helena, MT 59604
Phone 406.443.6002 . Toll-Free 1.800.395.7961
Fax 406.513.1928 . Toll-Free 1.800.294.1350

Montana Healthcare Programs Prior Authorization Request Form for Use of Sotyktu® (deucravacitinib)

Member Name:	DOB:	Date:
Member ID:	Prescriber Phone:	
Prescriber Name/Specialty if applicable:	Prescriber Fax:	
Dosage Requested:		

Please complete below information for applicable situation, <u>Initiation</u> or <u>Continuation</u> 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 preferred TNF with the same indication from the Montana Healthcare Programs Preferred Drug List: ☐ Yes ☐ No

   Drug Name: _____ **Dates of Use**: _____
5. Provider attests that member **<u>will not</u>** use Sotyktu® concomitantly with other biologics: ☐ Yes ☐ No

<u>LIMITATIONS:</u>

- Maximum daily dose is limited to 1 tablet (6mg) per day

Initial authorization will be issued for 16 weeks

☐ **CONTINUATION OF THERAPY**

1. Member has been adherent to Sotyktu®**:** ☐ Yes ☐ No
2. Member has documentation of positive clinical response to Sotyktu® (e.g., reduction in body surface area involvement, reduction in severity index using a scoring tool): ☐ 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 **<u>will not</u>** use Sotyktu® concomitantly with other biologics: ☐Yes ☐ No

Reauthorization will be issued for 1 year

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