

Ilumya™ Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:
Medication Information (required)					
Medication Name:			Strength:		Dosage Form:
<input type="checkbox"/> Check if requesting brand			Directions for Use:		
<input type="checkbox"/> Check if request is for continuation of therapy					
Clinical Information (required)					
Select the diagnosis below: <input type="checkbox"/> Moderate to severe chronic plaque psoriasis <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____					
Clinical Information: Is the prescriber a dermatologist or rheumatologist? <input type="checkbox"/> Yes <input type="checkbox"/> No Select if the patient has tried and failed the following phototherapy (UV Light Therapy) for at least three (3) months: <input type="checkbox"/> NB UV-B <input type="checkbox"/> PUVA Select if the patient has tried and failed the following alternative systemic therapies (oral alternative systemic therapies) for at least three (3) months: <input type="checkbox"/> Acitretin <input type="checkbox"/> Cyclosporine <input type="checkbox"/> Methotrexate Select if the patient has tried and failed the following: <input type="checkbox"/> Cimzia <input type="checkbox"/> Cosentyx <input type="checkbox"/> Humira <input type="checkbox"/> Stelara <input type="checkbox"/> Tremfya					
Chart notes and any lab results MUST be submitted with this request **Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.** *Previous therapies will be verified through pharmacy paid claims or submitted chart notes.*					
Prescriber Signature: _____			Date: _____		

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: This request may be denied unless all required information is received.
 For urgent or expedited requests please call 1-800-711-4555.
 This form may be used for non-urgent requests and faxed to 1-800-527-0531.