Cigna®

Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

Ilumya
(tildrakizumab-asmn)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician's Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City	State	Zip
City	State	Zip	Patient Phone:		

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication requested:
☐ Ilumya 100mg/ml

Dose and Quantity: Duration of therapy: J-Code:

Frequency of administration: ICD10:

Is this a new start or continuation of therapy with the requested medication? If patient has been taking samples, please pick "new start".
☐ new start ☐ continuation of therapy

(Please note: there are different preferred products depending on your patient's plan. Please refer to the applicable Cigna health care professional resource [e.g. cignaforhcp.com] to determine benefit availability and the terms and conditions of coverage)

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy**
☐ Hospital Outpatient
☐ Retail pharmacy
☐ Other (please specify):
☐ Home Health / Home Infusion vendor
☐ Physician's office stock (billing on a medical claim form)
***Cigna's nationally preferred specialty pharmacy*

***Medication orders can be placed with Accredo via E-prescribe - Accredo (1620 Century Center Pkwy, Memphis, TN 38134-8822 | NCPDP 4436920), Fax 888.302.1028, or Verbal 866.759.1557*

Facility and/or doctor dispensing and administering medication:

Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

Where will this drug be administered?
☐ Patient's Home
☐ Hospital Outpatient
☐ Physician's Office
☐ Other (please specify):

***NOTE:** Per some Cigna plans, infusion of medication MUST occur in the least intensive, medically appropriate setting.*

Is this patient a candidate for re-direction to an alternate setting (such as alternate infusion site, physician's office, home) with assistance of a Specialty Care Options Case Manager? ☐ Yes ☐ No (provide medical necessity rationale):

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

What is the indication or diagnosis?
☐ plaque psoriasis
☐ other (please specify):

Clinical Information:

Will the requested medication be used in combination with a BIOLOGIC or with a targeted synthetic oral small molecule
☐ Biologic (an adalimumab product [Humira, biosimilar], Bimzelx, Cimzia, Cosentyx (IV or SC), an etanercept SC product [Enbrel, biosimilar], Entyvio (IV or SC), an infliximab IV product [Remicade, biosimilar],Kevzara, Kineret, Omvoh (IV or SC), Orencia (IV or SC), a rituximab IV product [Rituxan, biosimilar], Skyrizi (IV or SC), Siliq, Simponi [Aria or SC], an ustekinumab product [Stelara (IV or SC), biosimilars], Taltz, a tocilizumab product [Actemra (IV or SC), biosimilar], Tremfya (IV or SC), or Zymfentra).
☐ Targeted synthetic oral small molecule drug (such as Cibinqo, Leqselvi, Litfulo, Sotyktu, Olumiant, Otezla, Otezla XR, Rinvoq, Rinvoq LQ, Xeljanz, Xeljanz XR, Velsipity, or Zeposia.)
☐ Conventional synthetic DMARD (such as methotrexate, leflunomide, sulfasalazine, hydroxychloroquine)
☐ No, the requested medication will NOT be used in combination with another BIOLOGIC or Targeted Synthetic oral small molecule drug

If Plaque psoriasis:

Is the patient currently receiving the requested medication? ☐ Yes ☐ No

(if currently receiving the requested medication) Has the patient already received at least 3 months of therapy with the requested medication? Please Note: Answer No if the patient has received less than 3 months of therapy or if the patient is restarting therapy with the requested medication. ☐ Yes ☐ No

(if not currently receiving the requested medication OR has received less than 3 months) Has the patient tried at least one traditional systemic agent for psoriasis for at least 3 months, unless intolerant? Please Note: Examples of one traditional systemic agent include methotrexate [MTX], cyclosporine, or acitretin tablets. A 3-month trial of psoralen plus ultraviolet A light (PUVA) also counts. ☐ Yes ☐ No

(if no) Has the patient already had a 3-month trial or previous intolerance to at least one biologic (other than the requested drug), Otezla/Otezla XR (apremilast tablets/extended-release tablets), or Sotyktu (deucravacitinib tablets? Please Note: A biosimilar of the requested biologic does not count. Examples of biologics used for plaque psoriasis include Bimzelx, an etanercept product [Enbrel, biosimilars], Cosentyx, an adalimumab product [Humira, biosimilars], Cimzia, an infliximab product [for example, Remicade, biosimilars], Siliq, Skyrizi, Taltz, Tremfya or an ustekinumab product [Stelara SC or IV, biosimilar]. A patient who has already tried a biologic for psoriasis, Otezla/Otezla XR, or Sotyktu is not required to “step back” and try a traditional systemic agent for psoriasis. ☐ Yes ☐ No

(if no) According to the prescriber, does the patient have a contraindication to methotrexate? ☐ Yes ☐ No

(if not currently receiving the requested medication OR has received less than 3 months) Is the requested medication being prescribed by or in consultation with a dermatologist? ☐ Yes ☐ No

(if currently receiving the requested medication) Has the patient experienced a beneficial clinical response, defined as improvement from baseline (prior to initiating the requested medication) in at least one of the following: estimated body surface area, erythema, induration/thickness, and/or scale of areas affected by psoriasis? ☐ Yes ☐ No

(if currently receiving the requested medication) Compared with baseline (prior to initiating the requested medication), has the patient experienced an improvement in at least one symptom, such as decreased pain, itching, and/or burning? ☐ Yes ☐ No

Has the patient tried ANY of the following? Check ALL that apply. PLEASE NOTE: Medical documentation specific to your response must be attached to this case or your request may be denied. Documentation may include, but is not limited to, chart notes, laboratory results, medical test results, claims records, prescription receipts, and/or other information. All documentation must include patient-specific identifying information.
☐ an adalimumab product (Examples of adalimumab products include Humira [NDCs starting with 00074], Abrilada, adalimumab-adaz, adalimumab-adbm, adalimumab-fkjp, adalimumab-aaty, adalimumab-ryvk [NDCs starting with 82009], Simlandi, Amjevita, Cyltezo, Hadlima, Hulio, Hyrimoz, Idacio, Yuflyma, and Yusimry. A trial of multiple adalimumab products counts as ONE product.)
☐ Cosentyx subcutaneous
☐ Enbrel
☐ Icotyde
☐ Otezla /Otezla XR (A trial of either or both Otezla products [Otezla and Otezla XR] collectively counts as ONE product.)
☐ Skyrizi subcutaneous (pen or syringe)
☐ Sotyktu
☐ an ustekinumab product (Examples of ustekinumab products include Stelara/ustekinumab, Imuldosa [NDCs starting with 69448], Otufli, Pyzchiva, ustekinumab-ttwe, Selarsdi, ustekinumab-aekn, Starjemza, Steqeyma, and Yesintek. A trial of multiple ustekinumab products counts as ONE product.)
☐ Taltz
☐ Tremfya subcutaneous

Is the prescriber verifying that the patient has been receiving Ilumya for at least 90 days? ☐ Yes ☐ No

Is the prescriber verifying that the patient has been receiving Ilumya via paid claims (for example, patient has not been receiving samples or coupons or other types of waivers in order to obtain access to Ilumya)? ☐ Yes ☐ No

Additional Information:

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

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