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

If continuation of therapy:

(if continuation of therapy) Has the patient demonstrated a beneficial response to this medication? ☐ Yes ☐ No

(if no) Please provide support for continued use in your patient.

(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 ☐ Yes ☐ No

If Plaque psoriasis:

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

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

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

Has the patient already had a 3-month trial or previous intolerance to at least one biologic other than the requested drug? Please Note: A biosimilar of the requested biologic does not count. Examples include an etanercept product [Enbrel, biosimilars], Cosentyx, an adalimumab product [Humira, biosimilars], Cimzia, an infliximab product [for example, Remicade, biosimilars], Siliq, Skyrizi, Stelara SC, Taltz, or Tremfya. ☐ Yes ☐ No

Does the patient have a contraindication to methotrexate, as determined by the prescriber? ☐ Yes ☐ No

Is the requested medication being prescribed by or in consultation with a dermatologist? ☐ Yes ☐ No

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

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

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: *Please provide clinical rationale for the use of this drug for your patient (pertinent patient history, alternatives tried, any inability to use alternatives above or standard therapy, etc). Please include drug name(s), date(s) taken and for how long, and what the documented results were of taking each drug, including any intolerances or adverse reactions your patient experienced.*

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:**_____

Save Time! Submit Online at: www.covermymeds.com/main/prior-authorization-forms/cigna/ or via SureScripts in your EHR.

Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

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 Address: Cigna Pharmacy Services, PO Box 42005, Phoenix AZ 85080-2005