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:
What is your patient's current weight?
Is this a new start or continuation of therapy? If your patient has already begun treatment with drug samples of **Ilumya**, please choose "new start of therapy". ☐ new start of therapy ☐ continued therapy

If continued therapy:
Has your patient had a good response to therapy with this drug (such as improvement or remission)? ☐ Yes ☐ No
(if no) Please provide clinical support for the continued use of **Ilumya**:

Which applies to your patient?
☐ patient is established on this drug with previous approval by Cigna for 30 days only
☐ patient is established on this drug with previous approval by Cigna for 1 year
☐ patient is established on this drug with previous approval by another health plan
☐ patient is established on this drug with regular use for more than 1 year
☐ patient was previously established on this drug, and is restarting after a break in therapy
Please provide the dates your patient has received **Ilumya**:

(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**
☐ Prescriber's office stock (billing on a medical claim form)
☐ Other (please specify):
☐ Retail pharmacy
☐ Home Health / Home Infusion vendor
***Cigna's nationally preferred specialty pharmacy*

***Medication orders can be placed with Accredo via E-prescribe - Accredo (1640 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):

***NOTE:** Per some Cigna plans, infusion of medication MUST occur in the lowest cost, medically appropriate setting*

Is this infusion occurring in a facility affiliated with hospital outpatient setting? ☐ Yes ☐ No

If yes- Is this patient a candidate for re-direction to an alternate setting after 1-2 infusions (such as AIS, MDO, home) with assistance of a Specialty Care Option 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

Diagnosis related to use:

☐ chronic plaque psoriasis
☐ other (please specify):

Clinical Information:

Besides the drug being requested, other biological drugs include Actemra, Cimzia, Cosentyx, Enbrel, Entyvio, Humira, Inflectra, Kevzara, Kineret, Olumiant, Orencia, Otezla, Remicade, Renflexis, Rinvoq, Rituxan, Siliq, Simponi/Simponi Aria, Skyrizi, Stelara, Taltz, Tremfya, Tysabri, Xeljanz/Xeljanz XR. Which of the following best describes your patient's situation?

☐ The patient is NOT taking any other biological at this time, nor will they in the future. Ilumya is the only biological the patient is/will be using.
☐ The patient is currently on another biological, but this drug will be stopped and Ilumya will be started.
☐ The patient is currently on another biological, and Ilumya will be added. The patient may continue to take both drugs together.
☐ other/unknown

(if other/more than Ilumya) Please provide name of drug, dates taken and, if applicable, the clinical rationale for the combined use of Ilumya and another biologic to treat your patient's diagnosis.

If your patient has tried any of the biological drugs listed in the question above, please provide drug name(s), date(s) taken and what the documented results were for each drug tried.

Per the information given above, is there documentation that your patient has had failure, inadequate response or intolerance to any of the following?

☐ Cimzia ☐ Cosentyx ☐ Enbrel ☐ Humira ☐ Ilumya ☐ Inflectra ☐ Otezla
☐ Remicade ☐ Renflexis ☐ Rinvoq ☐ Siliq ☐ Skyrizi ☐ Stelara ☐ Taltz
☐ Tremfya ☐ Other: _____

Is there documentation that your patient has a contraindication per FDA label to OR is not a candidate for any of the following? Check all that apply. *Any drug listed as failed or not tolerated in the previous question CANNOT be used for this question.*

☐ Cimzia ☐ Cosentyx ☐ Enbrel ☐ Humira ☐ Ilumya ☐ Inflectra ☐ Otezla
☐ Remicade ☐ Renflexis ☐ Rinvoq ☐ Siliq ☐ Skyrizi ☐ Stelara ☐ Taltz
☐ Tremfya ☐ Other: _____

For any drugs that your patient has a contraindication per FDA label to OR that your patient is NOT a candidate for, what is the reason your patient can not try those drugs?

☐ Patient has at least one contraindication or warning as listed in the alternative drug's prescribing information.
☐ Patient is unable to take those drugs and requires the dosage formulation of the requested drug.
☐ Patient is not a candidate for those drugs due to a disease characteristic, individual clinical factor[s], or other attribute/condition.
☐ other

Which of the following applies to your patient's disease?

☐ affected BSA (body surface area) is greater than 5%
☐ affected BSA is less than 5% AND the following area(s) are involved: scalp, face, the palms and soles (palmoplantar disease), or genitals
☐ neither of the above

Has the patient already received a biologic for their condition? ☐ Yes ☐ No

Did your patient try Systemic therapy (for example, methotrexate, cyclosporine, Soriatane), but it either did not work well enough OR caused a significant intolerance? ☐ Yes ☐ No

(if no) Is your patient able to try the alternative, Systemic therapy (for example, methotrexate, cyclosporine, Soriatane)
(if no) What is the reason your patient can not try the alternative, Systemic therapy (for example, methotrexate, cyclosporine, Soriatane)?

☐ Patient has at least one contraindication or warning as listed in the alternative drug's prescribing information.
☐ Patient is not a candidate for the alternative due to a disease characteristic, individual clinical factor[s], or other attribute/condition.
☐ other

Please provide specifics to support this reason.

Did your patient try Phototherapy [narrow or broad band ultraviolet B (UVB), or psoralen plus ultraviolet A (PUVA)], but it either did not work well enough OR caused a significant intolerance? ☐ Yes ☐ No

(if no) Is your patient able to try the alternative,Phototherapy [narrow or broad band ultraviolet B (UVB), or psoralen plus ultraviolet A (PUVA)]? ☐ Yes ☐ No

(if no) What is the reason your patient can not try the alternative, Phototherapy [narrow or broad band ultraviolet B (UVB), or psoralen plus ultraviolet A (PUVA)]?

☐ Patient has at least one contraindication or warning as listed in the alternative drug's prescribing information.

☐ Patient is not a candidate for the alternative due to a disease characteristic, individual clinical factor[s], or other attribute/condition.

☐ other

Please provide specifics to support this reason.

Did your patient try Topical therapy (for example, coal tar, keratolytics, corticosteroids, anthralin, Dovonex, Tazorac)], but it either did not work well enough OR caused a significant intolerance? ☐ Yes ☐ No

(if no) Is your patient able to try the alternative, Topical therapy (for example, coal tar, keratolytics, corticosteroids, anthralin, Dovonex, Tazorac)]? ☐ Yes ☐ No

(if no) What is the reason your patient can not try the alternative, Topical therapy (for example, coal tar, keratolytics, corticosteroids, anthralin, Dovonex, Tazorac)]?

☐ Patient has at least one contraindication or warning as listed in the alternative drug's prescribing information.

☐ Patient is not a candidate for the alternative due to a disease characteristic, individual clinical factor[s], or other attribute/condition.

☐ other

Please provide specifics to support this reason.

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:**_____

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