aetna®

# MEDICARE FORM

# Ilumya™ (tildrakizumab-asmn) Injectable Medication Precertification Request



(All fields must be completed and legible for precertification review.)

**For Medicare Advantage Part B:**
**Phone:** 1-866-503-0857 **(TTY:** 711**)**
**FAX:** 1-844-268-7263

**For other lines of business:**
Please use other form.

**Note: Ilumya is non-preferred. Preferred products vary based on plan type. See section G below.**

**Please indicate:** ☐ Start of treatment: Start date ____/____/____
☐ Continuation of therapy: Date of last treatment ____/____/____

**Precertification Requested By:** _____ Phone: _____ Fax: _____

## A. PATIENT INFORMATION

| | | | |
|---|---|---|---|
| First Name: | Last Name: | | |
| Address: | City: | State: | ZIP: |
| Home Phone: | Work Phone: | Cell Phone: | |
| DOB: | Allergies: | E-mail: | |

Current Weight: _____ lbs or _____ kgs Height: _____ inches or _____ cms

## B. INSURANCE INFORMATION

**Aetna Member ID #:** _____
**Group #:** _____
**Insured:** _____

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
Insured: _____

## C. PRESCRIBER INFORMATION

| | | | | | |
|---|---|---|---|---|---|
| First Name: | | Last Name: *(Check One):* ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A. | | | |
| Address: | | City: | | State: | ZIP: |
| Phone: | Fax: | St Lic #: | NPI #: | DEA #: | UPIN: |
| Provider Email: | | Office Contact Name: | | Phone: | |

## D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

**Place of Administration:**
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____
City: _____ State: _____ ZIP: _____
Phone: _____ Fax: _____
**TIN:** _____ PIN: _____
NPI: _____

**Dispensing Provider/Pharmacy:**
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Other _____
Name: _____
Address: _____
City: _____ State: _____ ZIP: _____
Phone: _____ Fax: _____
**TIN:** _____ PIN: _____
NPI: _____

## E. PRODUCT INFORMATION

**Request is for: Ilumya (tildrakizumab-asmn): Dose:** _____ **Frequency:** _____ **HCPCS Code:** _____

## F. DIAGNOSIS INFORMATION – Please indicate primary ICD Code and specify any other where applicable.

Primary ICD Code: _____ Secondary ICD Code: _____ Other ICD Code: _____

## G. CLINICAL INFORMATION – Required clinical information must be completed in its entirety for all precertification requests.

**For Initiation Requests (clinical documentation required for all requests):**

**Note: Ilumya is non-preferred. Inflectra, Remicade, and unbranded infliximab are preferred for MA plans. Enbrel, Humira, Otezla, Skyrizi, Stelara and Tremfya are preferred for MAPD plans.**

☐ Yes ☐ No Has the patient had prior therapy with Ilumya (tildrakizumab-asmn) within the last 365 days?

☐ Yes ☐ No Has the patient had a trial and failure, intolerance, or contraindication to any of the following? (select all that apply):
☐ Inflectra (infliximab-dyyb) ☐ Remicade (infliximab) ☐ Unbranded infliximab

☐ Yes ☐ No Has the patient had a trial and failure, intolerance, or contraindication to any of the following? (select all that apply):
☐ Enbrel (etanercept) ☐ Humira (adalimumab) ☐ Otezla (apremilast) ☐ Skyrizi (risankizumab-rzaa) ☐ Stelara (ustekinumab)
☐ Tremfya (guselkumab)

Please explain if there are any medical reason(s) that the patient cannot use any of the following preferred products when indicated for the patient's diagnosis (select all that apply):
☐ Inflectra (infliximab-dyyb) ☐ Remicade (infliximab) ☐ Unbranded infliximab

_____

_____

Please explain if there are any other medical reason(s) that the patient cannot use any of the following preferred products when indicated for the patient's diagnosis (select all that apply):
☐ Enbrel (etanercept) ☐ Humira (adalimumab) ☐ Otezla (apremilast) ☐ Skyrizi (risankizumab-rzaa) ☐ Stelara (ustekinumab) ☐ Tremfya (guselkumab)

_____

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| Patient First Name | Patient Last Name | Patient Phone | Patient DOB |
|---|---|---|---|
| | | | |

**G. CLINICAL INFORMATION *(continued)* -** Required clinical information must be completed in its entirety for all precertification requests.

**Plaque Psoriasis:**

Please indicate the severity of the patient's disease: ☐ mild ☐ moderate ☐ severe

☐ Yes ☐ No Is there evidence that the disease is active?

☐ Yes ☐ No Is there clinical documentation of chronic disease?

☐ Yes ☐ No Is the patient a candidate for systemic therapy or phototherapy?

→ Please select: ☐ phototherapy ☐ systemic therapy ☐ phototherapy and systemic therapy

Please provide the patient's Psoriasis Area and Severity Index (PASI) score: _____

Please indicate the percentage of body surface area affected by plaque psoriasis: _____%

☐ Yes ☐ No Does the plaque psoriasis involve sensitive areas? ***If yes***, please select: ☐ hands ☐ feet ☐ face ☐ genitals

☐ Yes ☐ No Was the trial with systemic conventional DMARD(s) (e.g., methotrexate, acetretin, or cyclosporine) ineffective?

→ ☐ Yes ☐ No Was the trial with systemic conventional DMARD(s) not tolerated?

☐ Yes ☐ No Are systemic conventional DMARDs contraindicated?

→ Please select: ☐ acetretin ☐ cyclosporine ☐ methotrexate ☐ mycophenolate ☐ None of the above

Please indicate the length of the medication trial: ☐ Less than 1 month ☐ 1 month ☐ 2 months ☐ 3 months or greater

☐ Yes ☐ No Was the trial with phototherapy ineffective?

→ ☐ Yes ☐ No Was the trial with phototherapy not tolerated?

☐ Yes ☐ No Is phototherapy contraindicated?

→ Please check all that apply: ☐ Psoralens (methoxsalen, trioxsalen) with UVA light (PUVA)
☐ UVB with coal tar or dithranol
☐ UVB (standard or narrow band)
☐ Home UVB
☐ None of the above

Please indicate the length of trial: ☐ Less than 1 month ☐ 1 month ☐ 2 months ☐ 3 months or greater

**For Continuation of Therapy (clinical documentation required for all requests):**

Please indicate the length of time on Ilumya (tildrakizumab-asmn): _____

☐ Yes ☐ No Is this continuation request a result of the patient receiving samples of Ilumya (tildrakizumab-asmn)?

☐ Yes ☐ No Will Ilumya (tildrakizumab-asmn) be used concomitantly with apremilast, tofacitinib, or other biologic DMARDs (e.g., adalimumab, certolizumab)?

☐ Yes ☐ No Is there clinical documentation supporting disease stability?

☐ Yes ☐ No Is there clinical documentation supporting disease improvement?

☐ Yes ☐ No Does the patient have any risk factors for TB?

→ ☐ Yes ☐ No Has the patient had a TB test within the past year?

→ (check all that apply): ☐ PPD test ☐ interferon-gamma assay (IGRA) ☐ chest x-ray

Please enter the results of the TB test: ☐ positive ☐ negative ☐ unknown

☐ Yes ☐ No Has the patient received Ilumya (tildrakizumab-asmn) within the past 6 months?

→ ☐ Yes ☐ No Does the patient have a documented severe and/or potentially life-threatening adverse event that occurred during or following the previous infusion?

→ ☐ Yes ☐ No Could the adverse reaction be managed through pre-medication in the home or office setting?

Please indicate the severity of the disease at baseline (pretreatment with Ilumya (tildrakizumab-asmn)): ☐ mild ☐ moderate ☐ severe

**H. ACKNOWLEDGEMENT**

**Request Completed By *(Signature Required)*:** _____ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.