aetna™

MEDICARE FORM

Ilumya™ (tildrakizumab-asmn) Injectable Medication Precertification Request

(All fields must be completed and legible for Precertification Review.)

For Virginia HMO SNP:
FAX: 1-833-280-5224
PHONE: 1-855-463-0933

For other lines of business:
Please use other form.

Note: Ilumya is non-preferred. The preferred product for MA plans is Renflexis. The preferred product for MAPD plans is Humira.

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:
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: _____

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

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. The preferred product for MA plans is Renflexis. The preferred product for MAPD plans is Humira.

☐ Yes ☐ No Has the patient had prior therapy with Illumya (tildrakizumab-asmn) within the last 365 days?
☐ Yes ☐ No Has the patient had a trial, intolerance, or contraindication to Renflexis (infliximab-abda)?
☐ Yes ☐ No Has the patient had a trial, intolerance, or contraindication to Humira (adalimumab)?

Please explain if there are any medical reason(s) that the patient cannot use Renflexis (infliximab-abda): _____

Please explain if there are any medical reason(s) that the patient cannot use Humira (adalimumab): _____

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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 Illumya (tildrakizumab-asmn): _____

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

☐ Yes ☐ No Will Illumya (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 Illumya (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 Illumya (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.