# TEXAS MEDICAID
# Clinical Edit Prior Authorization
# tildrakizumab (ILUMYA)

| STEP 1: CLEARLY PRINT AND COMPLETE TO EXPEDITE PROCESSING | |
|---|---|
| Date: | Prescriber First & Last Name: |
| Patient First & Last Name: | Prescriber NPI: |
| Patient Address: | Prescriber Address: |
| Patient ID: | Prescriber Phone: |
| Patient Date of Birth: | Prescriber Fax: |

| STEP 2: MEDICATION INFORMATION | |
|---|---|
| Medication Requested (Name): | Quantity Requested: |
| Dose Requested: | Dosing Instructions: |

Patient's Primary Diagnosis: _____ ICD 10 Code: _____

Please indicate ONE (1) of the following:

☐ STAR / STAR KIDS client **(Go to Step 3 - PDL PA Criteria Applies)**

**OR** ☐ CHIP / PERINATE client **(Go to Step 4)**

**STEP 3: PDL PRIOR AUTHORIZATION CRITERIA FOR NON-PREFERRED PRODUCT**

1. Has the client failed a 30-day treatment trial with at least one (1) preferred agent in the last 180 days?

   ☐ Yes (Go to Step 4 Question 1) ☐ No (Go to #2)

2. Is there a documented allergy or contraindication to preferred agents in this class?

   ☐ Yes (Go to Step 4 Question 1) ☐ No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?

   ☐ Yes (Go to Step 4 Question 1) ☐ No (Deny)

**STEP 4: CLINICAL PRIOR AUTHORIZATION CRITERIA**

4. Is the client greater than or equal to (≥) 18 years of age?

   ☐ Yes (Go to #2) ☐ No (Deny)

5. Does the client have a diagnosis of moderate-to-severe Plaque Psoriasis (Ps) in the last 730 days?

   ☐ Yes (Go to #3) ☐ No (Deny)

6. Does the client have a serious active infection (including Hepatitis B virus and/or tuberculosis) in the last 180 days?

   ☐ Yes (Deny) ☐ No (Approve – 365 days)

**STEP 5: SIGN AND FAX TO:** NAVITUS PRIOR AUTHORIZATION AT: **855-668-8553**

**Prescriber Signature:** _____ **Date:** _____

If criteria not met, submit chart documentation with form citing complex medical circumstances.

For questions, please call Navitus Customer Care at 1-877-908-6023.