



Fax completed form to Navitus at: 855-668-8553  
For questions, please call: 877-908-6023

## TEXAS MEDICAID

### Drug Prior Authorization

### Cytokine & CAM Antagonists: tildrakizumab-asmn (ILUMYA)

#### Request Information (required)

This request is:

- Expedited\* (Urgent)**  
 **Standard (Non-Urgent)**

\*Expedited means the standard review time may seriously harm the member's life, health, or ability to regain maximum function.

#### Member Information (required)

#### Prescriber Information (required)

Member Name:			Prescriber Name:		
Member Insurance ID #:			NPI # :		Specialty:
Date of Birth:			Office Phone:		
Member Phone:			Office Fax:		
Member Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:

Please fill out the following information:

1. Medication Requested (Name):  
(Go to #2)

2. Quantity Requested:  
(Go to #3)

3. Dose Requested (Strength):  
(Go to #4)

4. Dosing Instructions:  
(Go to #5)

**Required Criteria**

5. Provide primary diagnosis including ICD-10 code(s):  
(Go to #6)

6. Please indicate the requested drug's formulary status: \*(Formulary available at [www.txvendordrug.com](http://www.txvendordrug.com))

Non-Preferred Drug (NPD or NAP)

(Go to #7)

Preferred Drug (PDL)

(Go to #10)

No Status, Drug is not in a Market Basket

(Go to #10)

N/A as this request is for a CHIP/PERINATE member

(Go to #10)

Preferred Drug List (PDL) Criteria (required for non-preferred products)

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

Yes

(Go to #10)

No

(Go to #8)

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

Yes

(Go to #10)

No

(Go to #9)

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

Yes

(Go to #10)

No (Deny)

(Go to #10)

**Clinical Criteria (required)**

10. Is the member greater than or equal to ( $\geq$ ) 18 years of age?

Yes

(Go to #11)

No (Deny)

(Go to #11)

11. Does the member have a diagnosis of moderate-to-severe plaque psoriasis (PS) in the last 730 days?

Yes

(Go to #12)

No (Deny)

(Go to #12)

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

Yes (Deny)

(Go to #13)

No (Approve - 365 days)

(Go to #13)

**Additional Information**

13. Please provide any additional information we should consider (or attach any supporting documents):  
(END)

**Submission Information (required)**

Prescriber Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**\*\* PLEASE FAX COMPLETED FORM TO: 855-668-8553 \*\***

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

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