

# 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?

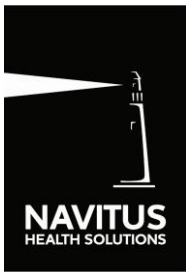
Yes (Go to Step 4 Question 1)  No (Go to #2)

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 ( $\geq$ ) 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.