



Request for Prior Authorization

FAX Completed Form To

I (800) 574-2515

DEUCRAVACITINIB (SOTYKTU)

Provider Help Desk

I (877) 776-1567

(PLEASE PRINT - ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
<b>Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.</b>		
Pharmacy NPI	Pharmacy fax	NDC

Prior authorization (PA) is required for deucravacitinib (Sotyktu). Payment will be considered when patient has an FDA approved or compendia indication for the requested drug when the following criteria are met:

1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and
2. Patient has a diagnosis of plaque psoriasis; and
  - a. Documentation of a trial and inadequate response to phototherapy, systemic retinoids, methotrexate, or cyclosporine is provided; and
  - b. Documentation of a trial and inadequate response to the preferred adalimumab agent; and
  - c. Will not be combined with any of the following systemic agents: biologic DMARD, Janus kinase inhibitor, phosphodiesterase 4 (PDE4) inhibitor, or potent immunosuppressant.

The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Non-Preferred

Sotyktu

Strength \_\_\_\_\_ Dosage Instructions \_\_\_\_\_ Quantity \_\_\_\_\_ Days Supply \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Will the Sotyktu be used in combination with any of the following systemic agents: biologic DMARD, Janus kinase inhibitor, phosphodiesterase 4 (PDE4) inhibitor, or potent immunosuppressant?

Yes  No

Document trial and inadequate response to phototherapy, systemic retinoids, methotrexate, or cyclosporine:

Drug Name & Dose: \_\_\_\_\_ Trial dates: \_\_\_\_\_

Failure reason: \_\_\_\_\_

Preferred adalimumab agent: Name/Dose: \_\_\_\_\_ Trial Dates: \_\_\_\_\_

Failure reason: \_\_\_\_\_

Medical or contraindication reason to override trial requirements: \_\_\_\_\_

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission
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IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Health and Human Services, that the member continues to be eligible for Medicaid.