SOTYKTU
PRIOR APPROVAL REQUEST

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Patient Information (required)			**Provider Information** (required)		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: R			Physician Signature:		

PHYSICIAN COMPLETES

FOR CLAIMS ADJUDICATED THROUGH THE PHARMACY BENEFIT:
For Standard and Basic Option patients Humira including preferred Humira biosimilars, Enbrel, Otezla, Skyrizi, Stelara SC, Taltz, and Tremfya are preferred products. Patients who switch to a preferred product will be eligible for 2 copays at no cost in the benefit year.

Sotyktu (deucravacitinib)

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its **entirety** for processing

Is this request for brand or generic? ❑Brand ❑Generic

How many tablets will the patient need for a 90 day supply? __________ tablet(s) per 90 days

1. **Standard/Basic Option Patient:** Would you like to participate in this program and switch the patient to one of the preferred products: Humira including preferred Humira biosimilars, Enbrel, Otezla, Skyrizi, Stelara SC, Taltz, or Tremfya? ***Answer below:***
   ❑**Yes** ***(select preferred product)***: ❑Humira/preferred biosimilar ❑Enbrel ❑Otezla ❑Skyrizi ❑Stelara SC ❑Taltz ❑Tremfya
   ❑**No**: Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to two of the medications? ***Please select answer below:***
      ❑**Yes** ***(specify medications and results)***: ____
      ____
      ❑**No**: Is there a clinical reason for not trying two of the preferred medications? ❑Yes* ❑No
         ***If YES**, please specify: ____

1. What is the patient's diagnosis?
   ❑Plaque Psoriasis (PsO) ❑Other ***(please specify)***: ____

2. Has the patient been on this medication continuously for the last **6 months** excluding samples? ***Please select answer below:***
   ❑ **NO** – this is **INITIATION** of therapy, please answer the following questions:
   a. Does the patient have moderate to severe plaque psoriasis (PsO)? ❑Yes ❑No
   b. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to conventional systemic therapy? ***Please select answer below:***
      ❑Inadequate treatment response ❑Intolerance or contraindication ❑Has not tried conventional systemic therapy
   c. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to phototherapy?
      ❑Inadequate treatment response ❑Intolerance or contraindication ❑Has not tried phototherapy
   d. Has the patient been tested for latent tuberculosis (TB)? ❑Yes* ❑No
      ***If YES**, was the result of the test positive or negative for TB infection? ❑Positive* ❑Negative
         ***If POSITIVE**, has the patient completed treatment or is the patient currently receiving treatment for latent TB? ❑Yes ❑No
   e. Does the patient have severe hepatic impairment (Child-Pugh C)? ❑Yes ❑No

   ❑ **YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following question:
   a. Has the patient's condition improved or stabilized with therapy? ❑Yes ❑No

PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL QUESTIONS

The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification. **Prescriber Certification:** I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer. Sotyktu – FEP MD Fax Form Revised 1/1/2024

SOTYKTU
PRIOR APPROVAL REQUEST

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

PAGE 2 - PHYSICIAN COMPLETES

Patient Name: ___________________________ **DOB:** ____________________ **Patient ID: R** ____________________________

3. Does the patient have active bacterial, invasive fungal, viral, or other opportunistic infections? ❑Yes ❑No
4. Will the patient be given live vaccines while on this therapy? ❑Yes ❑No
5. Will this medication be used in combination with potent immunosuppressants azathioprine or cyclosporine? ❑Yes ❑No
6. Will this medication be used in combination with any other biologic *(DMARD) or targeted synthetic DMARD? ❑Yes* ❑No

   ***If YES**, please specify the medication: ____

   DMARDs: Actemra, Avsola, Cimzia, Cosentyx, Enbrel, Entyvio, Humira or a Humira biosimilar, Ilumya, Inflectra, Kevzara, Kineret, Olumiant, Orencia, Otezla, Remicade, Renflexis, Riabni, Rinvoq, Rituxan, Ruxience, Siliq, Simponi/Simponi Aria, Skyrizi, Spevigo, Stelara, Taltz, Tremfya, Truxima, and Xeljanz/Xeljanz XR

<u>FOR CLAIMS ADJUDICATED THROUGH THE PHARMACY BENEFIT:</u>
STANDARD AND BASIC OPTION PATIENT REQUIRES THE QUESTIONS BELOW TO BE COMPLETED

1. Does the patient have a history of demyelinating disorder? ❑Yes ❑No
2. Does the patient have a history of congestive heart failure? ❑Yes ❑No
3. Does the patient have a history of Hepatitis B Virus infection? ❑Yes ❑No
4. Does the patient have autoantibody formation / lupus-like syndrome? ❑Yes ❑No

The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification. **Prescriber Certification:** I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer. Sotyktu – FEP MD Fax Form Revised 1/1/2024

SOTYKTU
PRIOR APPROVAL REQUEST

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Message:

Attached is a Prior Authorization request form.

For your convenience, there are 3 ways to complete a Prior Authorization request:

Electronically Online (ePA) Results in 2-3 **minutes** **FASTEST AND EASIEST**	Now you can get responses to drug Prior Authorization requests **securely** online. **Online** submissions may receive **instant** responses and do not require faxing or phone calls. Requests can be made 24 hours a day, 7 days a week. For more information on electronic prior authorization (ePA) and to register, go to **Caremark.com/ePA.**
Phone (4-5 **minutes** for response)	The FEP Clinical Call Center can be reached at **(877)-727-3784** between the hours of 7AM-9PM Eastern Time. A live representative will assist with the Prior Authorization, asking for the same information contained on the attached form. Please review the form and have your answers ready for faster service. The process over the phone takes on average between 4 and 5 minutes.
Fax (3-5 **days** for response)	Fax the attached form to **(877)-378-4727**. Requests sent via fax will be processed and responded to within 5 business days. The form must be filled out completely, if there is any missing information the Prior Authorization request cannot be processed. ***Please only fax the completed form once as duplicate submissions may delay processing times.***

The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification. **Prescriber Certification:** I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer. Sotyktu – FEP MD Fax Form Revised 1/1/2024