PriorityHealth

Pharmacy Prior Authorization Form

For Prior Authorization, please fax to: 877 974-4411 toll free, or 616 942-8206

This form applies to: ☒ **Commercial (Traditional)** ☒ **Commercial (Individual/Optimized)** ☐ **Medicaid**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Siliq® (brodalumab)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____

Provider Address: _____

Provider NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Product and Billing Information

☐ New Request ☐ Continuation Request

Drug product: ☐ Siliq 210 mg/1.5ml pre-filled syringe

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Dose: _____

Frequency: _____

ICD code(s): _____

SILIQ COVERAGE POLICY

- Before Siliq is covered, the patient must meet all of the General Criteria for Siliq and all of the Specific Criteria for the treatment diagnosis. If these criteria are not met, the prescriber must provide an explanation of why an exception to the criteria is necessary.
- Coverage for a diagnosis not listed below will be considered on a case by case basis. Please provide rationale for use and all pertinent patient information.
- Siliq will not be covered in combination with another biologic drug.
- Please provide rationale when requesting any dose or dosing interval not listed in the FDA label.

Criteria

General Initiation Criteria for ALL Diagnoses:

a) Patient has evidence of a negative TB test result in the past 12 months (or TB is adequately managed); AND

b) Prescriber is a specialist or has consulted with a specialist for the disease being treated.

Specific Initiation Criteria for Individual Diagnoses:

1. Plaque Psoriasis

a) Patient has tried **ALL** of the following for a period of at least 3 months:

a. One topical agent
b. One traditional, systemic agent for psoriasis (e.g., methotrexate [MTX], cyclosporine, acitretin)
c. Phototherapy
d. At least TWO of the following: Cosentyx, Humira, Otezla, or Stelara

All fields must be complete and legible for review. Your office will receive a response via fax.

New 09/2018
Last reviewed 09/2018

Note: Authorization for indications, dosing, or a route of administration not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the appropriateness of the drug, the dosing of the drug, or the route of administration to be used for the identified indication.

Priority Health Precertification Documentation

A. What condition is this drug being requested for?

- ☐ Plaque psoriasis
- ☐ Other – the patient's condition is: _____
  Rationale for use: _____

B. Has the patient had a negative TB test result in the past 12 months?

- ☐ Yes Date: _____
- ☐ No, rationale for use: _____

C. Will the patient be receiving other biologic therapy in combination with Sililq?

- ☐ No ☐ Yes, rationale for use: _____

D. Has the patient had a trial with one or more topical agents for a period of at least 3 months?

- ☐ Yes
- ☐ No – rationale for use: _____

E. Has the patient had a trial with phototherapy for a period of at least 3 months?

- ☐ Yes, UVA
- ☐ Yes, UVB
- ☐ No – rationale for use: _____

F. Has the patient tried a traditional, systemic agent for a period of at least 3 months?

- ☐ No – rationale for use: _____
- ☐ Yes – *Please mark all that apply*:
  - ☐ Methotrexate Dates of therapy: _____
  - ☐ Cyclosporine Dates of therapy: _____
  - ☐ Acitretin Dates of therapy: _____
  - ☐ Other Drug: _____ Dates of therapy: _____

G. Has the patient tried two of the following for at least 3 months?

- ☐ No – rationale for use: _____
- ☐ Yes – *Please mark all that apply*:
  - ☐ Cosentyx Dates of therapy: _____
  - ☐ Humira Dates of therapy: _____
  - ☐ Otezla Dates of therapy: _____
  - ☐ Stelara Dates of therapy: _____

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