PRIORITY PARTNERS
7231 Parkway Dr., Suite 100
Hanover, MD 21076

JOHNS HOPKINS
HEALTH PLANS

9/9/2026	<%PANumber%>

Prior Authorization

Internal Use Only

JOHNS HOPKINS HEALTH PLANS
Icotyde - Priority Partners MCO

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Johns Hopkins Health Plans at **1-410-424-4607**.
Please contact Johns Hopkins Health Plans at **1-888-819-1043** with questions regarding the Prior Authorization process.
When conditions are met, we will authorize the coverage of Icotyde - Priority Partners MCO.

Drug Name (select from list of drugs shown)
Icotyde (icotrokinra)

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information
Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

Prescribing Physician
Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Will the requested medication be used for any indications or uses that are not Food and Drug Administration (FDA)-approved or guideline-supported? Y N

NOTE: Submission of medical records is required.

	[If yes, no further questions.]
2.	Will the requested medication be used concurrently with a biologic disease-modifying antirheumatic drug (DMARD)? Y N
	[If yes, no further questions.]
3.	Does the patient have a documented diagnosis of moderate to severe plaque psoriasis? Y N
	NOTE: Submission of medical records is required.
	[If no, no further questions.]
4.	Has the plan authorized this medication in the past for this patient (i.e., previous authorization is on file under this plan)? Y N
	NOTE: The use of physician samples, or manufacturer product discounts, does not guarantee coverage under the provisions of the medical and/or pharmacy benefit. All pertinent criteria must be met in order to be eligible for benefit coverage.
	[If no, skip to question 6.]
5.	Is the patient experiencing clinical improvement from treatment as supported by one of the following condition-indicated outcomes: A) Reduction in the signs and symptoms, B) Prolonged beneficial clinical response, C) Inhibition of structural damage progression, or D) Improved physical functioning? Y N
	NOTE: Submission of medical records is required.
	[No further questions.]
6.	Does the patient have one of the following: A) body surface area (BSA) involvement of greater than 10%, or B) BSA involvement less than or equal to 10%, but involves sensitive areas (palms/soles of feet, genitalia, head, or neck)? Y N
	NOTE: Submission of medical records is required.
	[If no, no further questions.]
7.	Has the patient had a documented trial and an insufficient response or contraindication to at least one of the following: A) phototherapy, or B) systemic therapy with methotrexate or cyclosporine? Y N
	NOTE: Submission of medical records is required.
	[If no, no further questions.]
8.	Does the patient have moderate disease? Y N
	[If no, skip to question 10.]
9.	Has the patient had a documented trial and an insufficient response to topical pharmacologic therapy (corticosteroids, vitamin D analogues, or retinoids), unless their use is contraindicated? Y N
	NOTE: Submission of medical records is required.
	[If no, no further questions.]

10. Does the patient weigh at least 40 kg?	Y N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
11. Is the patient between 12 years to 17 years of age?	Y N
[If no, skip to questions 13.]	
12. Has the patient tried and had an insufficient response with both etanercept and a preferred ustekinumab product?	Y N
NOTE: Submission of medical records is required.	
[No further questions.]	
13. Is the patient 18 years of age or older?	Y N
[If no, no further questions.]	
14. Has the patient tried and had an insufficient response with TWO of the following: brodalumab, etanercept, a preferred adalimumab product, or a preferred ustekinumab product?	Y N
NOTE: Submission of medical records is required.	

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date