



9/16/2025
Prior Authorization
Internal Use Only
JOHNS HOPKINS HEALTH PLANS Sotyktu - 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 Sotyktu - Priority Partners MCO.

Drug Name (select from list of drugs shown) Sotyktu (deucravacitinib)
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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: _____
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Comments: _____

Please circle the appropriate answer for each question.	
1. Has the plan authorized this medication in the past for this patient (i.e., previous authorization is on file under this plan)?	<input type="checkbox"/> Y <input type="checkbox"/> 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 yes, skip to question 9.]	
2. Does the patient have a documented diagnosis of moderate to severe plaque psoriasis?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
3. 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)?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
4. Has the patient had a documented trial and insufficient response or contraindication to at least one of the following: A) phototherapy, or B) systemic therapy with methotrexate or cyclosporine?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
5. Does the patient have moderate disease?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If no, skip to question 7.]	
6. Has the patient had a documented trial and insufficient response to topical pharmacologic therapy (corticosteroids, vitamin D analogues, or retinoids), unless their use is contraindicated?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
7. Has the patient tried and had insufficient response to brodalumab, etanercept, adalimumab, or a preferred ustekinumab product?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
8. Is the patient 18 years of age or older?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If yes, skip to question 10.]	
[If no, no further questions.]	
9. Is the patient experiencing clinical improvement from treatment as supported by one of the following outcomes: A) reduction in the signs and symptoms, B) prolonged beneficial clinical response, C) inhibition of structural damage progression, or D) improved physical functioning?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	

10. Will the requested drug be used concurrently with a biologic disease-modifying antirheumatic drug (DMARD)?

Y N

[If yes, no further questions.]

11. Will the requested drug be used in combination with other janus kinase (JAK) inhibitors or potent immunosuppressants (such as azathioprine and cyclosporine)?

Y N

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