Prior Authorization Request Form for
brodulamab **(Siliq)**

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

USFHP Pharmacy Prior Authorization Form

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID # _____ Phone #: _____
Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

1. Humira is the Department of Defense's preferred targeted biologic agent. Has the patient tried Humira?	☐ Yes proceed to question **2**	☐ No proceed to question **4**
2. Has the patient had an inadequate response to Humira?	☐ Yes proceed to question **5**	☐ No proceed to question **3**
3. Has the patient experienced an adverse reaction to Humira that is not expected to occur with the requested agent?	☐ Yes proceed to question **5**	☐ No **STOP** **Coverage not approved**
4. Does the patient have a contraindication to Humira (adalimumab)?	☐ Yes proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Is the request for renewal of therapy?	☐ Yes proceed to question **17**	☐ No proceed to question **6**
6. Has the patient experienced intolerance, an adverse reaction or have a contraindication to Cosentyx?	☐ Yes proceed to question **7**	☐ No **STOP** **Coverage not approved**
7. Has the patient tried and failed or have a contraindication to Stelara?	☐ Yes proceed to question **8**	☐ No **STOP** **Coverage not approved**
8. Has the patient tried and failed or have a contraindication to Tremfya?	☐ Yes proceed to question **9**	☐ No **STOP** **Coverage not approved**

Continue on next page

9. Has the patient tried and failed or have a contraindication to Ilumya?	☐ Yes proceed to question **10**	☐ No **STOP** **Coverage not approved**
10. Has the patient tried and failed or have a contraindication to Taltz?	☐ Yes proceed to question **11**	☐ No **STOP** **Coverage not approved**
11. Does the patient have or has the patient had Crohn's Disease?	☐ Yes **STOP** **Coverage not approved**	☐ No proceed to question **12**
12. Is the patient 18 years of age or older?	☐ Yes proceed to question **13**	☐ No **STOP** **Coverage not approved**
13. Does this adult patient have a diagnosis of moderate to severe plaque psoriasis?	☐ Yes proceed to question **14**	☐ No **STOP** **Coverage not approved**
14. Is the patient a candidate for phototherapy or systemic therapy?	☐ Yes proceed to question **15**	☐ No **STOP** **Coverage not approved**
15. Has the patient had an inadequate response to non-biologic systemic therapy? (For example: methotrexate, aminosalicylates [e.g. sulfasalazine, mesalamine], corticosteroids, immunosuppressants [e.g. azathioprine], etc.)	☐ Yes proceed to question **16**	☐ No **STOP** **Coverage not approved**
16. Does the patient have evidence of a negative TB test result in the past 12 months (or TB is adequately managed)?	☐ Yes proceed to question **18**	☐ No **STOP** **Coverage not approved**
17. Has the patient responded to therapy?	☐ Yes proceed to question **18**	☐ No **STOP** **Coverage not approved**
18. Will the patient be receiving other targeted immunomodulatory biologics with Siliq, including but not limited to the following: Actemra, Cimzia, Cosentyx, Enbrel, Humira, Ilumya, Kevzara, Kineret, Olumiant, Orencia, Otezla, Remicade, Rituxan, Simponi, Stelara, Taltz, Tremfya or Xeljanz/Xeljanz XR?	☐ Yes **STOP** **Coverage not approved**	☐ No proceed to question **19**

19. Has the patient exhibited suicidal ideation and behavior?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**

Step 3

I certify the above is true to the best of my knowledge. Please sign and date:

Prescriber Signature _____ Date _____

[24 April 2019]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: