TRICARE Prior Authorization Request Form for
deucravacitinib (Sotyktu)

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

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

# USFHP Pharmacy Prior Authorization Form

| 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 clinical assessment:**

| | | |
|---|---|---|
| **1. Humira is the Department of Defense's preferred targeted biologic agent. Has the patient tried Humira?** | ☐ Yes<br>Proceed to question **2** | ☐ No<br>Proceed to question **4** |
| **2. Has the patient had an inadequate response to Humira?** | ☐ Yes<br>Proceed to question **5** | ☐ No<br>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<br>Proceed to question **5** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **4. Does the patient have a contraindication to Humira (adalimumab)?** | ☐ Yes<br>Proceed to question **5** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **5. Has the patient tried and experienced an inadequate response, had an adverse reaction, or have a contraindication to Cosentyx (secukinumab)?** | ☐ Yes<br>Proceed to question **6** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **6. Is the patient 18 years of age or older?** | ☐ Yes<br>Proceed to question **7** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **7. What is the diagnosis or indication?** | ☐ Moderate to severe plaque psoriasis in a patient who is a candidate for systemic therapy or phototherapy – Proceed to question **8**<br>☐ Other indication or diagnosis – **STOP: coverage not approved.** | |
| **8. Has the patient had an inadequate response to non-biologic systemic therapy (for example: methotrexate or corticosteroids)?** | ☐ Yes<br>Proceed to question **9** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **9. Will the patient be using the requested medication concomitantly with other Targeted Immunomodulatory Biologics (TIB) agents (for example, Enbrel, Remicade)?** | ☐ Yes<br>**STOP**<br>**Coverage not approved** | ☐ No<br>Proceed to question **10** |

| | | |
|---|---|---|
| **10. Is the provider aware of the FDA safety alerts and warnings and precautions?** | ☐ Yes<br>Proceed to question **11** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **11. Has the patient had evidence of a negative TB test result in the past 12 months (or TB is adequately managed)?** | ☐ Yes<br>**Sign and date below.** | ☐ No<br>**STOP**<br>**Coverage not approved** |

**Step 3**

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

Prescriber Signature _____ Date _____

[15 February 2023]

| **For Internal Use Only** | |
|---|---|
| ☐ Approved: | Duration of Approval: _____month(s) |
| ☐ Denied: | Authorized By: |
| ☐ Incomplete/Other: | PA#: |