USFHP Prior Authorization Request Form for
icotrokinra (Icotyde)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:

Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? Call 1-877-880-7007

https://www.usfamilyhealth.org/for-providers/pharmacy-information/

Prior authorization expires in ONE year. Initial TRICARE PA approval is required for renewal. Coverage will be approved indefinitely. Clinical documentation may be required.

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. Has the patient received this medication under the TRICARE benefit in the last 6 months? *Please choose "No" if the patient did not previously have a TRICARE approved PA for the requested medication.*	☐ Yes (subject to verification) Proceed to question **12**	☐ No Proceed to question **2**
2. The provider acknowledges that adalimumab is TRICARE's preferred biologic product.	☐ **Acknowledged** Proceed to question **3**	
3. Has the patient had an inadequate response to adalimumab OR the patient experienced an adverse reaction to adalimumab that is not expected to occur with icotrokinra OR the patient has a contraindication to adalimumab?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. The provider acknowledges that ustekinumab-aauz (Otulfi) is TRICARE's preferred IL-23 product.	☐ **Acknowledged** Proceed to question **5**	
5. Has the patient had an inadequate response to ustekinumab-aauz (Otulfi) OR the patient experienced an adverse reaction to ustekinumab-aauz (Otulfi) that is not expected to occur with icotrokinra OR the patient has a contraindication to ustekinumab-aauz (Otulfi)?	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**
6. The provider acknowledges that a trial of ixekizumab (Taltz) is required.	☐ **Acknowledged** Proceed to question **7**	

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7. Has the patient had an inadequate response to ixekizumab (Taltz) OR the patient experienced an adverse reaction to ixekizumab (Taltz) that is not expected to occur with icotrokinra (Icotyde) OR the patient has a contraindication to ixekizumab?	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**
8. Is the patient 12 years of age or older?	☐ Yes Proceed to question **9**	☐ No **STOP** **Coverage not approved**
9. What is the indication or diagnosis?	☐ Moderate to severe plaque psoriasis and is a candidate for phototherapy or systemic therapy - Proceed to question **10** ☐ Other diagnosis – **STOP – Coverage not approved**	
10. Has the patient had inadequate response, intolerance, or contraindication to non-biologic systemic therapy (For example: methotrexate, aminosalicylates, corticosteroids, immunosuppressants etc.)?	☐ Yes Proceed to question **11**	☐ No **STOP** **Coverage not approved**
11. Will the patient be receiving any other targeted immunomodulatory biologics concurrently, including but not limited to the following: TNF inhibitors, IL-1, IL-6, IL-17, IL-23, IL-36, JAK inhibitors?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**
12. Has the patient had a positive response to therapy?	☐ Yes Proceed to question **13** **Sign and date below**	☐ No **STOP** **Coverage not approved**
13. Will the patient be receiving any other targeted immunomodulatory biologics concurrently, including but not limited to the following: TNF inhibitors, IL-1, IL-6, IL-17, IL-23, IL-36, JAK inhibitors?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and sate below**

Step 3

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

Prescriber Signature _____ Date _____