Prescriber Criteria Form Sotyktu 2026 PA Fax 5622-A v1 010126.docx Sotyktu (deucravacitinib) Coverage Determination
This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673**. Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Sotyktu (deucravacitinib).

Drug Name: Sotyktu (deucravacitinib)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Has the patient previously received the requested medication for plaque psoriasis? [If yes, then no further questions.]	Yes	No
2	Does the patient have a diagnosis of moderate-to-severe plaque psoriasis? [If no, then no further questions.]	Yes	No
3	Does the patient meet one of the following criteria: A) crucial body areas [e.g., hands, feet, face, scalp, neck, genitals/groin, intertriginous areas] are affected at the time of diagnosis, B) patient has severe psoriasis that warrants a biologic as first-line therapy (i.e., at least 10 percent of the body surface area [BSA] is affected)? [If yes, then no further questions.]	Yes	No
4	Is at least 3 percent of body surface area (BSA) affected by plaque psoriasis at the time of diagnosis? [If no, then no further questions.]	Yes	No
5	Does the patient meet either of the following criteria: A) patient has experienced an inadequate treatment response or intolerance to either phototherapy (e.g., ultraviolet B [UVB], psoralen plus ultraviolet A [PUVA]) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin, B) pharmacologic treatment with methotrexate, cyclosporine, or acitretin is contraindicated?	Yes	No

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.
Prescriber (or Authorized) Signature: _____ Date:_____