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Specialty Pharmacy Services You Can Rely On
15 Earhart Drive, Suite 101, Amherst, NY 14221

PLAQUE PSORIASIS AUTHORIZATION AND RE-AUTHORIZATION REQUEST

TEL: (716) 929-1000 | 1-800-809-4763 FAX: (716) 532-7360

Member Name:	Today's Date:
Date of birth: Sex: Weight:	Prescriber: Hospital/Clinic:
Home Phone Number:	Phone Number: Fax Number:
Home Address/City/State/Zip:	Address/City/State/Zip:
Payor: ☐ Independent Health ☐ Anne Arundel Health System ☐ Pharmacy Benefit Dimensions ☐ Commercial ☐ Medicaid ☐ Medicare ☐ Self-funded Insurance ID: Group Number:	Allergies: ☐ Medication ships to patient home ☐ Medication ships to provider office

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: _____ ICD10 Code: _____

Will medication be self-injected? ☐ Yes ☐ No

Has patient had psoriasis greater than 1 year? ☐ Yes ☐ No

Has patient failed to respond to a 3 month trial of listed conventional agents? (Methotrexate, Tazarotene, topical corticosteroids, cyclosporine, Anthralin, tacrolimus, calcitriol, phototherapy, acitretin)

☐ Yes ☐ No Name and length of therapy: _____

Other previous treatments: _____

_____

Clinical impression: _____

TB Skin test result: _____ Date: _____

DRUG SELECTION

☐ New Authorization Request ☐ Reauthorization Request

☐ **Cosentyx** ☐ **Humira** ☐ **Otezla**:

☐ **Stelara** ☐ **Enbrel** ☐ **Siliq:** REMS certified? ☐ Yes ☐ No

☐ **Taltz** ☐ **Tremfya** ☐ **Remicade**

☐ **Cimzia** ☐ **Ilumya** ☐ **Hadlima (Adalimumab-bwwd)**

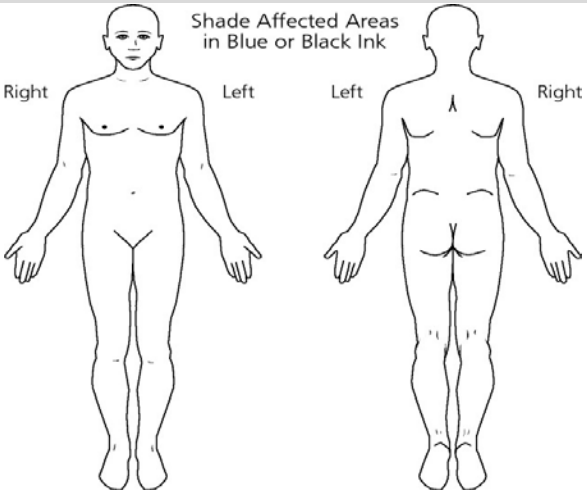
☐ **Adalimumab-adaz**

☐ **Other** _____

☐ **Initial** Dose: _____ Frequency: _____

☐ **Maintenance** Dose: _____ Frequency: _____

Submission of Disease Severity Form (completed within the last three months)



1. **Complete the body surface area diagram to the left by shading affected areas of body.**
   BSA:_____%
2. **Are hands and or feet affected and severely interfering with activities of daily living**
   ☐ Yes ☐ No
3. **<u>For reauthorization:</u> Clinical response or remission of disease maintained with continued use?** ☐ Yes ☐ No
4. **Please add any additional information below:**
   _____
   _____
   _____
   _____

***For reauthorization, patient must show improvement from baseline or maintenance of improvement, based on disease severity assessment form, which must be submitted.**