reliance|rx℠
45 Earhart Drive, Suite 110, 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 Needed:
Date of birth: Sex: Weight:	Prescriber:	Hospital/Clinic:
Home Phone Number: ( )	Phone Number: ( )	Fax Number: ( )
Home Address: City: State: Zip:	Address:	City: State: Zip:
Member's Insurance ID:	Office Phone :	Office Fax Number:
Allergies:	Office Contact:	

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

☐URGENT REQUEST

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

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

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

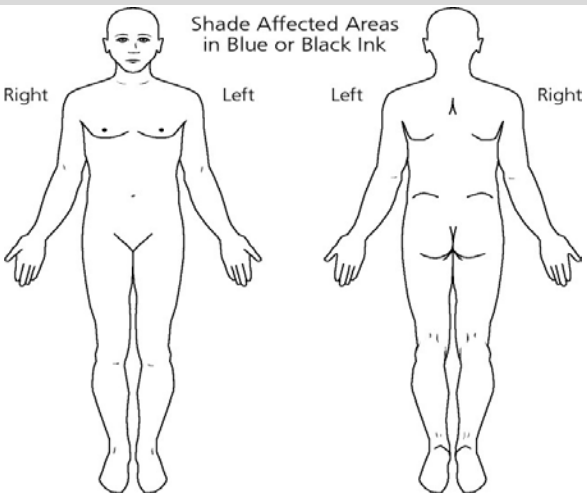
☐ **Cimzia** ☐ **Ilumya**

☐ **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.**