



45 Earhart Drive, Suite 110, Amherst, NY 14221

PSORIATIC ARTHRITIS
AUTHORIZATION/ 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
ICD10 Code:
Primary Diagnosis:
When was patient diagnosed with psoriatic arthritis?
Does patient have any of the below clinical features?
Involvement of DIP joints, asymmetric distribution of joint disease,
spondylarthrosis, sausage digits, new bone formation, cutaneous
findings, and nail manifestations of psoriatic arthritis?
Has patient had an updated TB test within the last year?
Date of test: Result:

Has the patient failed to respond to a 3 month trial of conventional
agents? (Methotrexate, sulfasalazine, leflunomide, hydroxychloroquine,
NSAIDs)
If yes, name and length of therapy
Other previous treatments:
Clinical impression:

DRUG SELECTION
New Authorization Request Reauthorization Request
URGENT REQUEST
Enbrel Cosentyx Remicade
Humira Stelara Otezla
Cimzia Orencia Simponi
Taltz Xeljanz
OTHER
Initial
Dose:
Frequency:
Maintenance
Dose:
Frequency:
Will medication be self-injected? Yes No

Reauthorization and additional comments
1. For reauthorization: Clinical response or remission of disease maintained with continued use? Yes No
2. Please add any additional information in the comments section below: