15 Earhart Drive, Suite 101, 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? ☐ Yes ☐ No

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? ☐ Yes ☐ No
Date of test: _____ Result:_____

Has the patient failed to respond to a 3 month trial of conventional agents? (Methotrexate, sulfasalazine, leflunomide, hydroxychloroquine, NSAIDs)
☐ Yes ☐ No
If yes, name and length of therapy_____
_____

Other previous treatments: _____
_____

Clinical impression: _____
_____
_____

DRUG SELECTION

☐ New Authorization Request ☐ Reauthorization 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:**
_____
_____
_____
_____