Member Name: {{MEMFIRST}} {{MEMLAST}} **DOB:** {{MEMBERDOB}} **PA Number:** {{PANUMBER}}

{{PANUMCODE}}

{{DISPLAY_PAGNAME}}
{{PACDESCRIPTION}}

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to {{COMPANY_NAME}} at {{CLIENT_PAG_FAX}}. Please contact {{COMPANY_NAME}} at {{CLIENT_PAG_PHONE}} with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of {{DRUGNAME}}.

Patient's Name: {{MEMFIRST}} {{MEMLAST}} **Date**: {{TODAY}}
Patient's ID: {{MEMBERID}} **Patient's Date of Birth:** {{MEMBERDOB}}
Physician's Name: {{PHYFIRST}} {{PHYLAST}} **Patient Phone:** <<MEMPHONE>>
Specialty: _____ **NPI#:** _____
Physician Office Telephone: {{PHYSICIANPHONE}} **Physician Office Fax:** {{PHYSICIANFAX}}
Physician Office Address: <<PHYADDRESS1>> <<PHYADDRESS2>> <<PHYCITY>>, <<PHYSTATE>> <<PHYZIP>>
Drug Name: {{DRUGNAME}}

Quantity: _____ **Frequency:** _____ **Strength:** _____
Route of Administration: _____ **Expected Length of Therapy:** _____
Diagnosis: <<DIAGNOSIS>> **ICD Code**: <<ICD9>>

1. What is the diagnosis?
   ❑ Plaque psoriasis
   ❑ Other _____
2. What is the ICD-10 code? _____
3. What is the patient's weight? Indicate in kilograms (kg). _____
4. Is the patient currently using the requested drug? ❑ Yes ❑ No
5. Will the requested drug be used in combination with any other biologic (e.g., Humira) or targeted synthetic drug (e.g., Otezla, Sotyktu) for the same indication? ❑ Yes ❑ No
6. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic drug (e.g., Olumiant, Xeljanz) associated with an increased risk of tuberculosis?
   If Yes, skip to #10 ❑ Yes ❑ No
7. Has the patient had a tuberculosis (TB) test (e.g., tuberculosis skin test [TST], interferon-release assay [IGRA]) within 6 months of initiating therapy? ❑ Yes ❑ No
8. What were the results of the tuberculosis (TB) test?
   ❑ Positive for TB ❑ Negative for TB, *skip to #10* ❑ Unknown
9. Which of the following applies to the patient?
   ❑ Patient has latent TB and treatment for latent TB has been initiated
   ❑ Patient has latent TB and treatment for latent TB has been completed
   ❑ Patient has latent TB and treatment for latent TB has not been initiated
   ❑ Patient has active TB
10. Is the requested drug being prescribed by or in consultation with a dermatologist? ❑ Yes ❑ No
11. Is this request for continuation of therapy with the requested drug? ❑ Yes ❑ No *If No, skip to #16*
12. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program? *If Yes or Unknown, skip to #16* ❑ Yes ❑ No ❑ Unknown
13. Has the patient achieved or maintained a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition since starting treatment with the requested drug?
    ❑ Yes ❑ No

14. Has the patient experienced a reduction in body surface area (BSA) affected from baseline? ***ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation of decreased body surface area affected and no further questions.*** ❑ Yes ❑ No

15. Has the patient experienced an improvement in signs and symptoms of the condition from baseline (e.g., itching, redness, flaking, scaling, burning, cracking, pain)? ***ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation of improvement in signs and symptoms.***
    ❑ Yes ❑ No *No further questions.*

16. Has the patient ever received or is currently receiving a biologic or targeted synthetic drug (e.g., Sotyktu, Otezla) indicated for treatment of moderate to severe plaque psoriasis (excluding receiving the drug via samples or a manufacturer's patient assistance program)? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried and no further questions.*** ❑ Yes ❑ No

17. Are crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) affected? ***ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation of affected areas and no further questions.*** ❑ Yes ❑ No

18. Is the percentage of body surface area (BSA) affected (prior to starting the requested medication) less than 3%?
    ❑ Yes ❑ No

19. What is the percentage of body surface area (BSA) affected (prior to starting the requested medication)? ***ACTION REQUIRED: Please attach chart notes or medical record documentation of body surface area affected.*** *Indicate percentage.*
    ❑ Greater than or equal to 3% to less than 10% of BSA._____ *Continue to #20*
    ❑ Greater than or equal to 10% of BSA._____ *No further questions.*

20. Has the patient experienced an inadequate response, or has an intolerance to phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine or acitretin? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy and no further questions.*** ❑ Yes ❑ No

21. Does the patient have a clinical reason to avoid pharmacologic treatment with methotrexate, cyclosporine, and acitretin? ***ACTION REQUIRED: If Yes, please attach documentation of clinical reason to avoid each therapy.***
    ❑ Yes ❑ No

22. Please indicate the clinical reason to avoid pharmacologic treatment with methotrexate, cyclosporine, and acitretin.
    ❑ Clinical diagnosis of alcohol use disorder, alcoholic liver disease, or other chronic liver disease
    ❑ Drug interaction
    ❑ Risk of treatment-related toxicity
    ❑ Pregnancy or currently planning pregnancy
    ❑ Breastfeeding
    ❑ Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension)
    ❑ Hypersensitivity
    ❑ History of intolerance or adverse event
    ❑ Other _____

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

_____

Prescriber (Or Authorized) Signature and Date