PA Request Criteria

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This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at . Please contact CVS/Caremark at 1-888-413-2723 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of the medication.

Patient Name: _____ **Date:** 7/2/2026
Patient ID: _____ **Patient Date Of Birth:** _____
Patient Group No: _____ **NPI#:** **Patient Phone:** _____ **Physician Name:**
Specialty:
Physician Office Telephone:
Physician Office Address: _____

Drug Name (specify drug) _____

Quantity: _____ **Frequency:** _____ **Strength:** _____

Route of Administration: _____ **Expected Length of Therapy:** _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please check the appropriate answer for each applicable question.

1. Will the requested drug be used in combination with any other biologic (e.g., Humira) or targeted synthetic drug (e.g., Olumiant, Otezla, Xeljanz) for the same indication? **Y** ☐ **N** ☐

2. What is the diagnosis?
   - Plaque psoriasis (If checked, go to 3) ☐
   - Other, please specify. (If checked, no further questions) ☐

   _____

3. Is the requested drug being prescribed by or in consultation with a dermatologist? **Y** ☐ **N** ☐

4. Has the patient been diagnosed with moderate to severe plaque psoriasis? **Y** ☐ **N** ☐

5. Is the patient 12 years of age or older? **Y** ☐ **N** ☐

6. Is this request for continuation of therapy with the requested drug? **Y** ☐ **N** ☐

7. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program?
   - Yes (If checked, go to 11) ☐
   - No (If checked, go to 8) ☐
   - Unknown (If checked, go to 11) ☐

8. 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? **Y** ☐ **N** ☐

9. 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. **Y** ☐ **N** ☐
   ACTION REQUIRED: Submit supporting documentation

10. 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. **Y** ☐ **N** ☐
    ACTION REQUIRED: Submit supporting documentation

11. Has the patient ever received or is currently receiving a biologic (e.g., Humira) or targeted synthetic drug (e.g., Sotyktu, Otezla) indicated for the 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.
ACTION REQUIRED: Submit supporting documentation — **Y** ☐ **N** ☐

12. Are high impact sites (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.
ACTION REQUIRED: Submit supporting documentation — **Y** ☐ **N** ☐

13. Is the percentage of body surface area (BSA) affected (prior to starting the requested medication) less than 3%? — **Y** ☐ **N** ☐

14. What is the percentage of body surface area (BSA) affected (prior to starting the requested medication)? Indicate percentage. ACTION REQUIRED: Please attach chart notes or medical record documentation of body surface area affected.

- Greater than or equal to 3% to less than 10% BSA (If checked, go to 15) ☐
- Greater than equal to 10% of BSA (If checked, go to 18) ☐

ACTION REQUIRED: Submit supporting documentation

15. 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.
ACTION REQUIRED: Submit supporting documentation — **Y** ☐ **N** ☐

16. 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 therapy.
ACTION REQUIRED: Submit supporting documentation — **Y** ☐ **N** ☐

17. 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 (If checked, go to 18) ☐
- Drug interaction (If checked, go to 18) ☐
- Risk of treatment-related toxicity (If checked, go to 18) ☐
- Pregnancy or currently planning pregnancy (If checked, go to 18) ☐
- Breastfeeding (If checked, go to 18) ☐
- Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension) (If checked, go to 18) ☐
- Hypersensitivity (If checked, go to 18) ☐
- History of intolerance or adverse event (If checked, go to 18) ☐
- Other, please specify. (If checked, no further questions) ☐

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18. Does the prescribed dose exceed 200 mg? — **Y** ☐ **N** ☐

19. Is the prescribed frequency more frequent than one dose once a day? — **Y** ☐ **N** ☐

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.

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Prescriber (Or Authorized) Signature and Date