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Patient Information

Patient Name:

Patient Phone: ☐☐☐ - ☐☐☐ - ☐☐☐☐

Patient ID:

Patient Group No:

Patient DOB: ☐☐ / ☐☐ / ☐☐☐☐

Prescribing Physician

Physician Name:

Physician Phone: ☐☐☐ - ☐☐☐ - ☐☐☐☐

Physician Fax: ☐☐☐ - ☐☐☐ - ☐☐☐☐

Physician Address:

City, State, Zip:

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. What is the patient's age?

   18 years of age or older (If checked, go to 2) ☐

   _____

   Less than 18 years of age (If checked, no further questions) ☐

   _____

2. What is the diagnosis?

   Plaque psoriasis (If checked, go to 3) ☐

   Plaque psoriasis with co-existent psoriatic arthritis (If checked, no further questions) ☐

   Other, please specify: (If checked, no further questions) ☐

   _____

3. Is the request for Sotyktu? **Y** ☐ **N** ☐

   [If Yes, then go to 4. If No, then go to 5.]

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

   [If Yes, then no further questions. If No, then go to 7.]

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? **Y** ☐ **N** ☐

   [If Yes, then no further questions. If No, then go to 6.]

6. What is the requested medication?

   Otezla/Otezla XR (If checked, go to 11) ☐

   Other, please specify: (If checked, go to 7) ☐

   _____

7. 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? **Y** ☐ **N** ☐

   [If Yes, then go to 12. If No, then go to 8.]

8. Has the patient had a tuberculosis (TB) test (e.g., tuberculosis skin test [TST], interferon-release assay [IGRA]) within 12 months of initiating therapy? **Y** ☐ **N** ☐

   [If Yes, then go to 9. If No, then no further questions.]

9. What were the results of the TB test?

   Positive for TB (If checked, go to 10) ☐

   Negative for TB (If checked, go to 12) ☐

   Unknown (If checked, no further questions) ☐

10. Which of the following applies to the patient?

    Patient has latent TB and treatment for latent TB has been initiated (If checked, go to 12) ☐

    Patient has latent TB and treatment for latent TB has been completed (If checked, go to 12) ☐

    Patient has latent TB and treatment for latent TB has not been initiated (If checked, no further questions) ☐

    Patient has active TB (If checked, no further questions) ☐

11. What is the severity of the disease?

    Mild plaque psoriasis (If checked, no further questions) ☐

    Moderate plaque psoriasis (If checked, go to 13) ☐

    Severe plaque psoriasis (If checked, go to 13) ☐

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

    [If Yes, then go to 13. If No, then no further questions.]

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

    [If Yes, then go to 14. If No, then no further questions.]

14. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug (if applicable)? **Y** ☐ **N** ☐

    [If Yes, then go to 15. If No, then go to 21.]

15. Is the patient currently receiving the requested drug or a biosimilar of the requested drug (if applicable) through samples or a manufacturer's patient assistance program?

    Yes (If checked, go to 21) ☐

    No (If checked, go to 16) ☐

    Unknown (If checked, go to 21) ☐

16. 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 or a biosimilar of the requested drug? **Y** ☐ **N** ☐

[If Yes, then go to 17. If No, then no further questions.]

17. What is the patient's current psoriasis involvement in body surface area (BSA) percent? Indicate in percentage. ACTION REQUIRED: Attach supporting chart note(s) or medical record documentation for current psoriasis involvement of BSA percent.

Less than or equal to 3% (If checked, no further questions) ☐

Greater than 3% (If checked, go to 18) ☐

ACTION REQUIRED: Submit supporting documentation

18. What is the patient's percent improvement in body surface area (BSA) from baseline? Indicate in percentage. ACTION REQUIRED: Attach supporting chart note(s) or medical record documentation for percent improvement of BSA from baseline.

Less than 75% BSA improvement (If checked, go to 19) ☐

Greater than or equal to 75% BSA improvement (If checked, no further questions) ☐

ACTION REQUIRED: Submit supporting documentation

19. What is the patient's percent reduction in the Psoriasis Area Severity Index (PASI) score from baseline? Indicate score reduction in percentage. ACTION REQUIRED: Attach supporting chart note(s) or medical record documentation for percent reduction of PASI score from baseline.

Greater than or equal to 75% reduction (If checked, no further questions) ☐

Greater than or equal to 50% and less than 75% reduction (If checked, go to 20) ☐

Less than 50% reduction (If checked, no further questions) ☐

ACTION REQUIRED: Submit supporting documentation

20. What is the patient's Dermatology Life Quality Index (DLQI) score? Indicate patient's DLQI score. ACTION REQUIRED: Attach supporting chart note(s) or medical record documentation for Dermatology Life Quality Index (DLQI) score.

Less than or equal to 5 (If checked, no further questions) ☐

Greater than 5 (If checked, no further questions) ☐

ACTION REQUIRED: Submit supporting documentation

21. Has the patient received or is currently receiving a biologic (e.g., Humira) or targeted synthetic drug (e.g., Sotyktu, Otezla) within the past 120 days 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. **Y** ☐ **N** ☐

ACTION REQUIRED: Submit supporting documentation

[If Yes, then no further questions. If No, then go to 22.]

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

[If Yes, then go to 25. If No, then go to 23.]

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

Greater than or equal to 3% but less than 10% (If checked, go to 24) ☐

Greater than or equal to 10% (If checked, go to 33) ☐

ACTION REQUIRED: Submit supporting documentation

24. What is the patient's Psoriasis Area Severity Index (PASI) score? Indicate patient's PASI score. ACTION REQUIRED: Attach supporting chart note(s) or medical record documentation of Psoriasis Area Severity Index (PASI) score.

Greater than or equal to 10 (If checked, go to 26) ☐

Less than 10 (If checked, go to 25) ☐

ACTION REQUIRED: Submit supporting documentation

25. Is the affected area severe at localized sites and associated with significant functional impairment and/or high levels of distress (e.g., nail disease or involvement of high-impact and difficult-to-treat sites such as face, scalp, palms, soles, flexures and genitals)? ACTION REQUIRED: If Yes, please attach supporting chart notes or medical record documentation of affected area(s) with significant functional impairment and/or high levels of distress. **Y** ☐ **N** ☐
ACTION REQUIRED: Submit supporting documentation

[If Yes, then go to 33. If No, then no further questions.]

26. Has the patient had an inadequate response at the maximum tolerated dose to a medium to super-high potency topical corticosteroid therapy for a duration of at least 4 weeks? ACTION REQUIRED: If Yes, please attach supporting chart notes, medical record documentation, or claims history of all prior and current use of treatment regimens for topical corticosteroid therapy, including dosage, duration, and response to therapy. **Y** ☐ **N** ☐
ACTION REQUIRED: Submit supporting documentation

[If Yes, then go to 33. If No, then go to 27.]

27. Has the patient had an inadequate response at the maximum tolerated dose to a topical calcineurin inhibitor therapy for a duration of at least 8 weeks? ACTION REQUIRED: If Yes, please attach supporting chart note(s), medical record documentation, or claims history of all prior and current use of treatment regimens for topical calcineurin inhibitor therapy, including dosage, duration, and response to therapy. **Y** ☐ **N** ☐
ACTION REQUIRED: Submit supporting documentation

[If Yes, then go to 33. If No, then go to 28.]

28. Has the patient had an inadequate response at the maximum tolerated dose to a topical vitamin D analog therapy for a duration of at least 12 weeks? ACTION REQUIRED: If Yes, please attach supporting chart note(s), medical record documentation, or claims history of all prior and current use of treatment regimens for topical vitamin D analog therapy, including dosage, duration, and response to therapy. **Y** ☐ **N** ☐
ACTION REQUIRED: Submit supporting documentation

[If Yes, then go to 33. If No, then go to 29.]

29. Has the patient had an inadequate response at the maximum tolerated dose to a topical retinoid therapy for a duration of at least 12 weeks? ACTION REQUIRED: If Yes, please attach supporting chart note(s), medical record documentation, or claims history of all prior and current use of treatment regimens for topical retinoid therapy, including dosage, duration, and response to therapy. **Y** ☐ **N** ☐
ACTION REQUIRED: Submit supporting documentation

[If Yes, then go to 33. If No, then go to 30.]

30. Has the patient had an inadequate response at the maximum tolerated dose to a topical aryl hydrocarbon receptor agonist therapy for a duration of at least 12 weeks? ACTION REQUIRED: If Yes, please attach supporting chart note(s), medical record documentation, or claims history of all prior and current use of treatment regimens for topical aryl hydrocarbon receptor agonist therapy, including dosage, duration, and response to therapy. **Y** ☐ **N** ☐
ACTION REQUIRED: Submit supporting documentation

[If Yes, then go to 33. If No, then go to 31.]

31. Has the patient had an inadequate response at the maximum tolerated dose to a topical phosphodiesterase 4 inhibitor therapy for a duration of at least 8 weeks? ACTION REQUIRED: If Yes, please attach supporting chart note(s), medical record documentation, or claims history of all prior and current use of treatment regimens for topical phosphodiesterase 4 inhibitor therapy, including dosage, duration, and response to therapy. **Y** ☐ **N** ☐
ACTION REQUIRED: Submit supporting documentation

[If Yes, then go to 33. If No, then go to 32.]

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

[If Yes, then go to 33. If No, then no further questions.]

33. Has the patient had a trial of phototherapy (e.g., UVB, PUVA) for a duration of at least 3 months? ACTION REQUIRED: If Yes, please attach supporting chart note(s) or medical record documentation for phototherapy, including duration and response to therapy. **Y** ☐ **N** ☐
ACTION REQUIRED: Submit supporting documentation

[If Yes, then go to 35. If No, then go to 34.]

34. Does the patient meet any of the following criteria: a) the patient has experienced an intolerable adverse event with phototherapy, b) the patient has a clinical reason to avoid phototherapy, or c) the patient does not have access to phototherapy? ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation supporting previous treatments tried (if applicable), including duration and response to therapy. If therapy is not advisable, please attach documentation of clinical reason to avoid therapy.

- ☐ Yes, intolerable adverse event to phototherapy (If checked, go to 35)
- ☐ Yes, clinical reason to avoid phototherapy (If checked, go to 35)
- ☐ Yes, does not have access to phototherapy (If checked, go to 35)
- ☐ None of the above (If checked, no further questions)

ACTION REQUIRED: Submit supporting documentation

35. Has the patient had a trial of methotrexate at a dose of at least 25 mg/week or at the maximum tolerated dose for a duration of at least 3 months? ACTION REQUIRED: If Yes, please attach supporting chart note(s), medical record documentation, or claims history of all prior and current use of treatment regimens for methotrexate, including dosage, duration, and response to therapy. **Y** ☐ **N** ☐
ACTION REQUIRED: Submit supporting documentation

[If Yes, then no further questions. If No, then go to 36.]

36. Has the patient had a trial of cyclosporine at a dose of at least 5 mg/kg/day or at the maximum tolerated dose for a duration of at least 6 weeks? ACTION REQUIRED: If Yes, please attach supporting chart note(s), medical record documentation, or claims history of all prior and current use of treatment regimens for cyclosporine, including dosage, duration, and response to therapy. **Y** ☐ **N** ☐
ACTION REQUIRED: Submit supporting documentation

[If Yes, then no further questions. If No, then go to 37.]

37. Has the patient had a trial of acitretin at a dose of at least 50 mg/day or at the maximum tolerated dose for a duration of at least 3 months? ACTION REQUIRED: If Yes, please attach supporting chart note(s), medical record documentation, or claims history of all prior and current use of treatment regimens for acitretin, including dosage, duration, and response to therapy. **Y** ☐ **N** ☐
ACTION REQUIRED: Submit supporting documentation

[If Yes, then no further questions. If No, then go to 38.]

38. Does the patient have a clinical reason to avoid systemic pharmacologic treatment with methotrexate, cyclosporine, and acitretin? ACTION REQUIRED: Please attach documentation of clinical reason to avoid therapy. **Y** ☐ **N** ☐
ACTION REQUIRED: Submit supporting documentation

[If Yes, then go to 39. If No, then no further questions.]

39. 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, no further questions)
- ☐ Drug interaction (If checked, no further questions)
- ☐ Risk of treatment-related toxicity (If checked, no further questions)
- ☐ Pregnancy or currently planning pregnancy (If checked, no further questions)
- ☐ Breastfeeding (If checked, no further questions)
- ☐ Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension) (If checked, no further questions)

Hypersensitivity (If checked, no further questions) ☐

History of intolerance or adverse event (If checked, no further questions) ☐

Other, please specify. (If checked, no further questions) ☐

_____

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

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