AmeriHealth Caritas North Carolina

# Pharmacy Request for Prior Approval – Plaque Psoriasis (Adult)

**(Avsola, Cimzia, Cosentyx, Enbrel, Humira, Ilumya, Inflectra, Otezla, Remicade, Renflexis, Siliq, Skyrizi, Stelara, Taltz, and Tremfya)**

**Beneficiary Information**

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: _____

**Prescriber Information**

6. Prescriber Name: _____ NPI #: _____
Mailing address: _____ City: _____ State: _____ ZIP: _____
7. Requester Contact Information: _____
Name: _____ Phone #: _____ Fax #: _____

**Drug Information**

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy: __up to 30 days __60 days __90 days __120 days __180 days __365 days __Other: _____

**Clinical Information**

1. Is the beneficiary 18 years old or older? Yes___ No___
2. Does the beneficiary have a diagnosis of moderate to severe chronic Plaque Psoriasis? Yes___ No___
3. Is the beneficiary on any other injectable immunomodulator? Yes___ No___
4. Has the beneficiary been screened for latent tuberculosis infection? Yes___ No___
5. Has the beneficiary been tested with Hep-B SAG and Core Ab? Yes___ No___
6. Has the beneficiary failed to respond to, or has been unable to tolerate phototherapy and **ONE** of the following medications (methotrexate, cyclosporine, or soritane) for plaque psoriasis or has contraindications to these treatments? Yes___ No___
7. Does the beneficiary have a body surface area (BSA) involvement of at least 3%? Yes___ No___
8. Does the beneficiary have involvement of the palms, soles, head and neck, or genitalia, causing disruption in normal daily activities and/or employment? Yes___ No___
9. Has the beneficiary tried and failed Cosentyx, Enbrel, or Humira? Yes___ No___

9a. If no, please provide the clinical reason why the beneficiary has not tried Cosentyx, Enbrel, or Humira: _____
_____

**For coverage of Siliq (please answer questions 1-11)**

10. Is the beneficiary registered in the Siliq Risk Evaluation and Mitigation Program (REMS Program)? Yes___ No___
11. Is the prescribing provider registered in the Siliq Risk Evaluation and Mitigation Program (REMS Program)? Yes___ No___

Signature of Prescriber: _____ Date: _____

***Prescriber signature mandatory**

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

**Fax this form to: 1-877-234-4274, or call Pharmacy Prior Authorization: 1-866-885-1406**