

**PRIOR AUTHORIZATION REQUEST FORM**

EOC ID:

**Medicare Part D Cosentyx  
(secukinumab)**

**Phone: 800-728-7947 Fax back to: 866-880-4532**

Scott & White Prescription Services manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

<b>Patient Name:</b>	<b>Prescriber Name:</b>
Member/Subscriber Number:	<b>Supervising Physician:</b>
Date of Birth:	Fax: Phone:
Group Number:	Office Contact:
Address:	NPI: State Lic ID:
City, State ZIP:	Address:
Primary Phone:	City, State ZIP:
	Specialty/facility name (if applicable):

Drug Name and Strength:

Directions / SIG:

**Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.**

Q1. What diagnosis is this drug being prescribed for (pick one)? <input type="checkbox"/> Plaque Psoriasis <input type="checkbox"/> Psoriatic Arthritis <input type="checkbox"/> Ankylosing Spondylitis <input type="checkbox"/> Other
Q2. Please provide ICD code for diagnosis.
Q3. Is the prescriber a Rheumatologist? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q4. Is the prescriber a Dermatologist? <input type="checkbox"/> Yes <input type="checkbox"/> No

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<b>Patient Name:</b>	<b>Prescriber Name:</b>
	<b>Supervising Physician:</b>

Q5. If request is for plaque psoriasis, does the patient have moderate to severe plaque psoriasis affecting greater than 5% of the body surface area or affecting crucial body areas such as hands, feet, face, or genitals?

Yes  No

Q6. If request is for plaque psoriasis, has the patient failed or does the patient have a contraindication to at least TWO of the following: potent topical corticosteroids, calcipotriene, tazarotene, phototherapy, acitretin, methotrexate, or cyclosporine.

Yes (Please Specify)  No

Q7. Additional comments

\_\_\_\_\_  
Prescriber Signature

\_\_\_\_\_  
Date

Expedited/Urgent - By checking this box and signing above, I certify that applying the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function

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