



## PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Siliq (brodalumab)

Phone: 800-728-7947

Fax back to: 866-880-4532

The Scott & White Health Plan Pharmacy Department 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>                  |               |
|                           | <b>Supervising Physician:</b>            |               |
| Member/Subscriber Number: | Fax:                                     | Phone:        |
| Date of Birth:            | Office Contact:                          |               |
| Group Number:             | NPI:                                     | State Lic ID: |
| Address:                  | Address:                                 |               |
| City, State ZIP:          | City, State ZIP:                         |               |
| Primary Phone:            | 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)?<br><input type="checkbox"/> Plaque Psoriasis <input type="checkbox"/> Other                                                                                                                                                           |
| Q2. Please provide ICD code for diagnosis.                                                                                                                                                                                                                                                             |
| Q3. Please indicate location of administration.<br><input type="checkbox"/> Home<br><input type="checkbox"/> Long Term Care (LTC) facility<br><input type="checkbox"/> Physician office (drug from office stock)<br><input type="checkbox"/> Physician office (drug from pharmacy with a prescription) |
| Q4. Is the prescriber a Dermatologist?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                     |
| Q5. Does the patient have moderate to severe plaque psoriasis affecting greater than 10% of body surface area (BSA)?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                       |
| Q6. Does the patient have moderate to severe plaque psoriasis affecting crucial body areas such as hands, feet, face,                                                                                                                                                                                  |



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|                                                                                                                                                                                                                                                                                                                                              |                                                          |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|
| <b>Patient Name:</b>                                                                                                                                                                                                                                                                                                                         | <b>Prescriber Name:</b><br><b>Supervising Physician:</b> |
| or genitals?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                     |                                                          |
| Q7. Has the patient failed at least TWO TOPICAL treatments [including but not limited to corticosteroids, Vitamin D analogues, Vitamin D analogue/corticosteroid combinations, Tazorac® (tazarotene)]?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                                           |                                                          |
| Q8. Has the patient failed or does the patient have a contraindication to phototherapy (UVB or PUVA)?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                            |                                                          |
| Q9. Has the patient failed or does the patient have a contraindication to methotrexate, cyclosporine, acitretin, leflunomide, sulfasalazine, OR tacrolimus?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                      |                                                          |
| Q10. Please select all of the following agents that the patient has failed, has an intolerance or contraindication to:<br><input type="checkbox"/> Humira<br><input type="checkbox"/> Enbrel<br><input type="checkbox"/> Cosentyx<br><input type="checkbox"/> Remicade<br><input type="checkbox"/> Stelara<br><input type="checkbox"/> Other |                                                          |
| Q11. 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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|----------------------|----------------------------------------------------------|

Lack of the necessary documentation may result in a medical necessity denial. Requesting providers may speak to the SWHP medical director at 1-888-316-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage has been decided.

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