PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Psoriasis

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.**

Patient Name:	**Prescriber Name:** **Supervising Physician:**	
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 drug is being requested?

- ☐ Enbrel 25 MG VIAL (GCN 52651)
- ☐ Enbrel 25 MG/0.5 ML SYRINGE (GCN 98398)
- ☐ Enbrel 50 MG/ML SYRINGE (GCN 23574)
- ☐ Enbrel 50 MG/ML MINI CARTRIDGE (GCN 43924)
- ☐ Enbrel 50 MG/ML SURECLICK PEN (GCN 97724)
- ☐ Humira 40 MG/0.8 ML PEN (GCN 97005)
- ☐ Humira 40 MG/0.8 ML SYRINGE (GCN 18924)
- ☐ Humira PEN CROHN-UC-HS 40 MG (GCN 97005)
- ☐ Humira PEN PSORIA-UVEITIS 40MG (GCN 97005)
- ☐ Humira 40 MG/0.4 ML PEN Citrate free/Low volume (GCN 43506)
- ☐ Humira 40 MG/0.4 ML SYRINGE Citrate free/Low volume (GCN 43505)
- ☐ Humira PEN CROHN-UC-HS 80 MG Citrate free/Low volume (GCN 44014)
- ☐ Humira PEN PSOR-UVEI 80MG-40MG Citrate free/Low volume (GCN 44954)
- ☐ Other (Please specify)

Q2. What are the quantity and days supply requested?

Q3. Is the patient a new start to therapy?

☐ Yes ☐ No

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Q4. What diagnosis is this drug being prescribed for (pick one)?

☐ Plaque psoriasis ☐ Other

Q5. Please provide ICD code(s) for diagnosis.

Q6. Is the prescriber a Dermatologist?

☐ Yes ☐ No

Q7. Does the patient have moderate to severe plaque psoriasis affecting greater than 5% of body surface area (BSA)?

☐ Yes ☐ No

Q8. Does the patient have moderate to severe plaque psoriasis affecting crucial body areas such as hands, feet, face, or genitals?

☐ Yes ☐ No

Q9. 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)]?

☐ Yes ☐ No

Q10. Has the patient failed, or does the patient have a contraindication to phototherapy (UVB or PUVA)?

☐ Yes ☐ No

Q11. Does the patient have failure of an adequate trial to the following DMARDs? Please select all that apply.

- ☐ methotrexate
- ☐ cyclosporine
- ☐ acitretin
- ☐ leflunomide
- ☐ sulfasalazine
- ☐ tacrolimus

Q12. Does the patient have clinically significant intolerance or contraindication to the following DMARDs? Please select all that apply.

- ☐ methotrexate

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- ☐ cyclosporine
- ☐ acitretin
- ☐ leflunomide
- ☐ sulfasalazine
- ☐ tacrolimus

Q13. Who is the ENTITY that will be submitting the CLAIM for the DRUG and seeking reimbursement?

- ☐ Pharmacy
- ☐ Individual prescriber
- ☐ Provider or specialty group
- ☐ Facility
- ☐ Other (please specify)

Q14. Provide name and NPI of the billing entity

Q15. Will the claim for the drug be submitted as a MEDICAL claim or PHARMACY claim (Note: If a pharmacy will be submitting a MEDICAL claim for drug reimbursement, answer MEDICAL)?

☐ Medical ☐ Pharmacy

Q16. 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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	Prescriber Name:
Patient Name:	**Supervising Physician:**

Lack of the necessary documentation may result in a medical necessity denial. Requesting providers may speak to a SWHP pharmacist or medical director at 1-800-728-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage has been decided.