carolina complete health

Immunomodulators Temporary PA Request Form

Plaque Psoriasis (Adult)
(Enbrel, Humira, Cosentyx, Cimzia, Ilumya, Inflectra, Otezla, Remicade, Renflexis, Stelara, Taltz, and Tremfya)

Beneficiary Information

1. Beneficiary Last Name:_____ 2. First Name:_____
3. Beneficiary ID #:_____4. Beneficiary Date of Birth:_____ 5. Recipient Gender:_____

Prescriber Information

6. Prescribing Provider NPI#:_____

7. Requester Contact Information - Name:_____ Phone #: _____Ext:_____

Drug Information

8. Med requested: _____9a.Strength_____9b. Quantity per 30 days___9c. Length of Therapy____

10. Is the beneficiary 18 years old or older? **YES**___ **NO**____

11. Does the beneficiary have a diagnosis of moderate to severe Plaque Psoriasis? **YES**___ **NO**____

12. Is the beneficiary on any other injectable immunomodulator? **YES**___ **NO**___

13. Has the beneficiary been screened for latent tuberculosis infection? **YES**___ **NO**___

14. Has the beneficiary been tested with Hep B SAG and Core Ab? **YES**___ **NO**____
Date of lab and result_____

15. Has the beneficiary experienced a therapeutic failure/inadequate response with methotrexate?

YES___ **NO**____

16. Does the beneficiary have a body surface area (BSA) involvement of at least 3%? **YES**___ **NO**____
Please list the beneficiary's BSA (body surface area) of involvement. _____**%**

17. 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**____

18. Has the beneficiary failed to respond to or is unable to tolerate phototherapy and **ONE** of the following meds- Soriatane (acitretin), methotrexate, cyclosporin? **YES**___ **NO**____
List medications failed or reason beneficiary cannot use other treatments_____
_____

19. If requesting a non-preferred, list preferred tried or reason beneficiary cannot use one preferred.
_____
_____
_____

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: (877) 386-4695 Pharmacy PA Call Center: (833) 585-4309