carolina complete health

## Immunomodulators Temporary PA Request Form

# Plaque Psoriasis (Pediatric) (Enbrel Taltz and Stelara)

**Beneficiary Information**

1. Beneficiary Last Name:_____2. First Name:_____

3. Beneficiary ID #:_____4. Beneficiary Date of Birth:_____5. Beneficiary 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 member's age 6 or older? **YES**_____**NO**_____

11. Does the member have a diagnosis of Plaque Psoriasis? **YES**_____**NO**_____

12. Is the member a candidate for systemic therapy or phototherapy? **YES**_____**NO**_____

13. Is the member on any other injectable immunomodulator? **YES**_____**NO**_____

14. Has the member been screened for latent tuberculosis infection? **YES**_____**NO**____

15. Has the member been tested with Hep B SAG and Core Ab? **YES**_____**NO**_____
Date of lab and result_____

16. Has the member experienced a therapeutic failure/inadequate response with methotrexate?

**YES**____**NO**_____

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

18. Does the member have involvement of the palms, soles, head and neck, or genitalia, causing disruption in normal daily activities and/or employment? **YES**_____**NO**_____

19. If requesting a non-preferred, list preferred tried or reason member 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: (833) 404-2393 Pharmacy PA Call Center: (833) 585-4309

https://www.covermymeds.com/main/prior-authorization-forms/