carolina complete health

Pharmacy Prior Approval Request for
Immunomodulators: Siliq

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. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy (in days): ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days ☐ 365 Days ☐ Other _____

Clinical Information

Request for Plaque Psoriasis (Adult)

1. Does the beneficiary have a documented definitive diagnosis of moderate-to-severe Chronic Plaque Psoriasis? ☐ **Yes** ☐ **No**
2. Is the beneficiary 18 years of age or older? ☐ **Yes** ☐ **No**
3. Is the beneficiary not on another injectable biologic immunomodulator? ☐ **Yes** ☐ **No**
4. Has the beneficiary been considered and screened for the presence of latent tuberculosis infection? ☐ **Yes** ☐ **No**
5. Has the beneficiary been tested with Hep B SAG and Core Ab? ☐ **Yes** ☐ **No**
6. Does the beneficiary have a body surface area (BSA) involvement of at least 3%? ☐ **Yes** ☐ **No**
7. 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**
8. Has the beneficiary failed to respond to, or has been unable to tolerate phototherapy and **ONE** of the following medications or beneficiary has contraindications to these treatments: Soriatane (acitretin), Methotrexate, and/or Cyclosporine? ☐ **Yes** ☐ **No**
9. Has the beneficiary had a trial and failure of Cosentyx, Enbrel or Humira or a clinical reason beneficiary cannot try Cosentyx, Enbrel or Humira? ☐ **Yes** ☐ **No**
10. Are the beneficiaries, Providers, and Pharmacies utilizing Siliq registered appropriately in the Siliq Risk Evaluation and Mitigation Strategy Program (REMS program)? ☐ **Yes** ☐ **No**

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/