

Request for Prior Authorization BIOLOGICALS FOR PLAQUE PSORIASIS

FAX Completed Form To 1 (877) 733-3195 Provider Help Desk 1 (844) 236-1464

(PLEASE PRINT - ACCURACY IS IMPORTANT)

Patient address Provider NPI	IA Medicaid Me	mber ID #	Patient name			DOB	
Prescriber address Pharmacy name Address Pharmacy NPI Pharmacy NPC Pha	Patient address	<u> </u>					
Pharmacy name Address Phone Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned. Pharmacy NPI Pharmacy fax NDC Pharmacy NPI Pharmacy fax NDC Pharmacy NPI Pharmacy fax NDC Prior authorization (PA) is required for biologicals used for plaque psoriasis. Request must adhere to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations. Payment for non-preferred biologicals for plaque psoriasis will be considered only for cases in which there is documentation of previous trials and therapy failures with two preferred biological agents. Payment will be considered under the following conditions: 1. Patient has a diagnosis of moderate to severe plaque psoriasis; and 2. Patient has documentation of an inadequate response to phototherapy, systemic retinoids, methotrexate, or cyclosporine. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated. Preferred Adalimumab-aacf Simlandi Bimzelx Simlandi Bimzelx Cosentyx Siliq Adalimumab-adbm Skyrizi Auto-Injector Siliq Cosentyx Siliq Anjevita 40mg/0.4mL Skyrizi Perfilled Syringe Siliq Siliq Anjevita 80mg/0.8mL Talz (step through one preferred TNF) Stelara Dissimilar: Pyzchiva Pyzchiva Dosage Instructions Quantity Days Supply Diagnosis: Treatment failure with a preferred oral therapy: Trial Drug Name: Trial end date: Trial end date:	Provider NPI		Prescriber name			Phone	
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Medical or contraindication reason to override trial require	rements:
Other medical conditions to consider:	
Possible drug interactions/conflicting drug therapies:	
Attach lab results and other documentation as necessary. Prescriber signature (Must match prescriber listed above.)	Date of submission

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Health and Human Services, that the member continues to be eligible for Medicaid.

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