



Request for Prior Authorization Select Topical Psoriasis Agents

FAX Completed Form To

I (833) 733 - 3195

Provider Help Desk

I (844) 236 - 1464

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #		Patient name		DOB	
Patient address					
Provider NPI		Prescriber name		Phone	
Prescriber address				Fax	
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	

Prior authorization (PA) is required for select topical psoriasis agents. Payment for a non-preferred agent will be considered for an FDA approved or compendia indicated diagnosis for the requested drug when the following criteria are met:

- Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and
- Patient has a diagnosis of plaque psoriasis with involvement estimated to affect $\leq 20\%$ of the body surface area; and
- Patient has documentation of an adequate trial and therapy failure of combination therapy with a preferred medium to high potency topical corticosteroid and a preferred topical vitamin D analog for a minimum of 4 consecutive weeks.

The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

Non-Preferred

- Vtama Zoryve

Strength

Usage Instructions

Quantity

Day's Supply

Diagnosis: _____

Preferred Medium to High Potency Topical Corticosteroid Trial:

Drug name & dose: _____ Trial dates: _____

Failure reason: _____

Preferred Topical Vitamin D Analog Trial:

Drug name & dose: _____ Trial dates: _____

Failure reason: _____

Is affected area estimated to affect $\leq 20\%$ body surface area? Yes No

Medical or contraindication reason to override trial requirements: _____

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission
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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.