PRIOR AUTHORIZATION REQUEST
Consentyx

PATIENT: Name______________________
Address: ______________________
City, State, Zip____________________
D.O.B. _____________________
Member ID:________________________

Prescriber: Name______________________
Address ______________________
City, State, Zip_____________________
Phone _____________________
Fax _____________________
NPI _____________________

Medication Requested:____________ Qty Requested: ____________

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please answer the following questions

1. Is this a request for INITIAL or CONTINUATION of therapy with the requested medication?
   - INITIAL **please answer questions 2 - 15**
   - CONTINUATION **please answer question 16**

2. Yes No Is the patient up to date with all their recommended vaccinations?
3. Yes No Has the patient been screened for latent tuberculosis (TB)?
4. Yes No Does the disease have a significant impact on the patient's physical, psychological, or social wellbeing?

5. What is the indication/diagnosis?
   - Plaque psoriasis **please answer questions 6 - 11**
   - Psoriatic arthritis **please answer questions 11 - 15**
   - All other indications/diagnosis (Please specify):____

6. Yes No Is the requested medication being prescribed by dermatologist?
7. Yes No Are the patient's symptoms controlled with topical therapy?
8. Yes No Has the patient failed a 3-month compliant trial with methotrexate (MTX) or cyclosporine OR has a true contraindication to both?
9. Yes No Does the patient have severe and extensive plaque psoriasis (for example, more than 10% of body surface area affected or a PASI score of MORE THAN 10)?
10. Yes No Has phototherapy been ineffective, cannot be used, or has resulted in rapid relapse (rapid relapse is defined as GREATER THAN 50% of baseline disease severity within 3 months)?
11. Yes No Has the patient failed a compliant 3-month trial of AT LEAST ONE formulary anti-TNF agents: Enbrel or Humira?

If you have any questions, call: 800-753-2851

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12. ☐ Yes ☐ No Is the requested medication being prescribed by rheumatologist?

13. ☐ Yes ☐ No Has the patient failed a 3-month compliant trial with methotrexate or cyclosporine?
14. ☐ Yes ☐ No Does the patient have a true contraindication to both methotrexate AND cyclosporine?
15. ☐ Yes ☐ No Does the patient have a contraindication to BOTH Enbrel AND Humira?
16. ☐ Yes ☐ No Is there documentation that confirms that the patient has shown improvement?

Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B Physician Signature

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PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 877-251-5896

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior

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