# PRIOR AUTHORIZATION REQUEST

## Siliq

**Patient Information:**

| | |
|---|---|
| Name: | |
| Member ID: | |
| Address: | |
| City, State, Zip: | |
| Date of Birth: | |

**Prescriber Information:**

| | |
|---|---|
| Name: | |
| NPI: | |
| Phone Number: | |
| Fax Number | |
| Address: | |
| City, State, Zip: | |

**Requested Medication**

| | |
|---|---|
| Rx Name: | |
| Rx Strength | |
| Rx Quantity: | |
| Rx Frequency: | |
| Rx Route of Administration: | |
| Diagnosis and ICD Code: | |

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 note that supporting clinical documentation is required for **ALL** PA requests.

| | | | |
|---|---|---|---|
| 1 | Will the requested medication be used in combination with other biologic or targeted synthetic disease-modifying antirheumatic drugs?<br>[Note: Examples of biologics include but not limited to Actemra (IV or SC), Cimzia, Cosentyx, an etanercept SC product (for example, Enbrel, biosimilars), Ilumya, Skyrizi, Kevzara, Kineret, Orencia (IV or SC), an infliximab IV products (for example, Remicade, biosimilars), a rituximab IV products (for example, Rituxan, biosimilars), Stelara (IV or SC), Taltz, Tremfya, Entyvio, or Simponi (Aria or SC). Examples of targeted synthetic DMARD include but not limited to Olumiant, Cibinqo, Otezla, Rinvoq, or Xeljanz/XR.]<br>[If yes, no further questions.] | Yes | No |
| 2 | What is the diagnosis or indication? | | |

**If you have any questions, call:**
**1-888-258-8250**

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| | | | |
|---|---|---|---|
| | [] Plaque psoriasis (If checked, go to 3)<br><br>[] Crohn's disease (If checked, no further questions)<br><br>[] Rheumatoid arthritis (If checked, no further questions)<br><br>[] Other (If checked, no further questions) | | |
| 3 | Is the patient currently receiving the requested medication?<br>[If no, skip to question 11.] | Yes | No |
| 4 | Has the patient been receiving medication samples for the requested medication?<br>[If yes, skip to question 11.] | Yes | No |
| 5 | Has the patient been established on therapy with the requested medication for at least 3 months?<br>[Note: A patient who has received less than 3 months of therapy or who is restarting therapy with the requested medication should be considered under Initial Therapy.]<br>[If no, skip to question 11.] | Yes | No |
| 6 | Does the patient have a previously approved prior authorization (PA) on file with the current plan?<br>[Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.]<br>[If no, skip to question 9.] | Yes | No |
| 7 | Has the patient experienced a beneficial clinical response, defined as improvement from baseline (prior to initiating Siliq) in at least one of the following: A) estimated body surface area, B) erythema, C) induration/thickness, and/or D) scale of areas affected by psoriasis?<br>[If no, no further questions.] | Yes | No |
| 8 | Compared with baseline (prior to receiving Siliq), has the patient experienced an improvement in at least one symptom, such as decreased pain, itching, and/or burning?<br>[No further questions.] | Yes | No |
| 9 | Has documentation been provided to confirm that there is a clinical response to therapy, defined as improvement from baseline (prior to initiating Siliq) in at least one of the following: A) estimated body surface area, B) erythema, C) induration/thickness, and/or D) scale of areas affected by psoriasis? ACTION REQUIRED: Submit supporting documentation.<br>[If no, no further questions.] | Yes | No |
| 10 | Compared with baseline (prior to receiving Siliq), has the patient experienced an improvement in at least one symptom, such as decreased pain, itching, and/or | Yes | No |

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| | | | |
|---|---|---|---|
| | burning?<br>[If no, no further questions.] | | |
| 11 | Is the patient greater than or equal to 18 years of age?<br>[If no, no further questions.] | Yes | No |
| 12 | Has the patient tried at least TWO traditional systemic agents for psoriasis for at least 3 months?<br>[Note: Examples of traditional systemic agents include methotrexate, cyclosporine, acitretin, or psoralen plus ultraviolet A light (PUVA).]<br>[If yes, skip to question 14.] | Yes | No |
| 13 | Has documentation been provided to confirm that the patient has an intolerance to at least TWO traditional systemic agents for psoriasis? ACTION REQUIRED: Submit supporting documentation.<br>[Note: Examples of traditional systemic agents include methotrexate, cyclosporine, acitretin, or psoralen plus ultraviolet A light (PUVA).]<br>[If no, no further questions.] | Yes | No |
| 14 | Has documentation been provided to confirm that the patient has an intolerance, contraindication to, or failed treatment for at least 3 months (each) with preferred TNF inhibitors (etanercept and adalimumab)? ACTION REQUIRED: Submit supporting documentation.<br>[If no, no further questions.] | Yes | No |
| 15 | Does the patient have minimum affected body surface area (BSA) GREATER THAN OR EQUAL TO 10 percent OR did the patient have a minimum affected body surface area (BSA) GREATER THAN OR EQUAL TO 10 percent prior to the start of therapy?<br>[If yes, skip to question 18.] | Yes | No |
| 16 | Does the patient have facial or scalp involvement OR did the patient have facial or scalp involvement prior to the start of therapy?<br>[If yes, skip to question 18.] | Yes | No |
| 17 | Does the patient have palmoplantar or genital involvement OR did the patient have palmoplantar involvement prior to the start of therapy?<br>[If no, no further questions.] | Yes | No |
| 18 | Does the provider attest that the patient does not have a diagnosis of Crohn's disease?<br>[If no, no further question.] | Yes | No |
| 19 | Is the requested medication prescribed by or in consultation with a dermatologist?<br>[If no, no further questions.] | Yes | No |
| 20 | Does the dose of the requested medication exceed Food and Drug Administration (FDA) approved label dosing for the indication? | Yes | No |

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

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

## FAX COMPLETED FORM TO: 1-833-896-0656

**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 authorization as per Plan policy and procedures.

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**If you have any questions, call: 1-888-258-8250**