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. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1	Will the requested medication be used in combination with other biologic or targeted synthetic disease-modifying antirheumatic drugs? [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.]	Yes	No

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	[If yes, no further questions.]		
2	Is the patient currently receiving the requested medication? [If no, skip to question 7.]	Yes	No
3	Has the patient been receiving medication samples for the requested medication? [If yes, skip to question 7.]	Yes	No
4	Does the patient have a previously approved prior authorization (PA) on file with the current plan? [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.] [If no, skip to question 7.]	Yes	No
5	Has the patient been established on therapy for at least 3 months? [If no, skip to question 7.]	Yes	No
6	Has documentation been submitted to confirm that the patient has had a clinically significant response to therapy, as determined by the provider? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
7	What is the diagnosis or indication? [] Plaque psoriasis (If checked, go to 8) [] Crohn's disease (If checked, no further questions) [] Rheumatoid arthritis (If checked, no further questions) [] Other (If checked, no further questions)		
8	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
9	Has the patient tried at least TWO traditional systemic agents for psoriasis for at least 3 months? [Note: Examples of traditional systemic agents include methotrexate, cyclosporine, or acitretin.] [If yes, skip to question 11.]	Yes	No
10	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. [Note: Examples of traditional systemic agents include methotrexate, cyclosporine, or acitretin.] [If no, no further questions.]	Yes	No

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11	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. [If no, no further questions.]	Yes	No
12	Has documentation been submitted to confirm that the patient has had a treatment failure with a preferred ustekinumab product (Pyzchiva, Steqeyma, or Yesintek), for at least 3 months or is the patient intolerant or the medication contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
13	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? [If yes, skip to question 16.]	Yes	No
14	Does the patient have facial or scalp involvement OR did the patient have facial or scalp involvement prior to the start of therapy? [If yes, skip to question 16.]	Yes	No
15	Does the patient have palmoplantar or genital involvement OR did the patient have palmoplantar involvement prior to the start of therapy? [If no, no further questions.]	Yes	No
16	Does the provider attest that the patient does not have a diagnosis of Crohn's disease? [If no, no further question.]	Yes	No
17	Does the provider attest that the patient does not have a history of suicidal ideation? [If no, no further questions]	Yes	No
18	Is the requested medication prescribed by or in consultation with a dermatologist? [If no, no further questions.]	Yes	No
19	Does the dose of the requested medication exceed Food and Drug Administration (FDA) approved label dosing for the indication? (Dosing: 210 mg at weeks 0, 1, and 2, followed by 210 mg once every 2 weeks)	Yes	No

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

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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.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

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

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