



Plaque Psoriasis - (Otezla, Cosentyx, Taltz)

Beneficiary Information

1. Beneficiary Last Name: 2. First Name: 3. Beneficiary ID #: 4. Beneficiary Date of Birth: 5. Recipient Gender:

Prescriber Information

6. Prescribing Provider NPI#: 7. Requester Contact Information Name: Phone #: Ext:

Drug Information

8. Med requested: 9a.Strength 9b. Quantity per 30 days 9c. Duration 10. Is the beneficiary 18 years old or older? YES NO 11. Does the beneficiary have a diagnosis of Plaque Psoriasis? YES NO 12. Is the beneficiary on any other injectable immunomodulator? YES NO 13. Has the beneficiary been screened for latent tuberculosis infection? YES NO 14. Has the beneficiary been tested with Hep B SAG and Core Ab? YES NO Date of lab and result:

15. Has the beneficiary experienced a therapeutic failure/inadequate response with methotrexate? YES NO

16. What is the beneficiary's BSA (body surface area) of involvement? %

17. Does the beneficiary have involvement of the palms, soles, head and neck, or genitalia, causing disruption in normal daily activities and/or employment? YES NO

18. Has the beneficiary failed to respond to or is unable to tolerate phototherapy and ONE of the following meds- Soriatane (acitretin), methotrexate, cyclosporin? YES NO List medications failed or reason beneficiary cannot use other treatments:

19. Does the beneficiary have a documented inadequate response or inability to take both Enbrel and Humira?

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

YES \_\_\_ NO \_\_\_ Explain \_\_\_\_\_

\_\_\_\_\_

Signature of Prescriber: \_\_\_\_\_ Date: \_\_\_\_\_

**(Prescriber signature mandatory)**

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

**Fax this form to: (800) 678-3189      Pharmacy PA Call Center: (866) 799-5318**