



Psoriatic Arthritis - (Enbrel, Humira, and Simponi)

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. Does the beneficiary have a diagnosis of Psoriatic Arthritis? **YES** ___ **NO** ___
11. Is the beneficiary on any other injectable immunomodulator? **YES** ___ **NO** ___
12. Has the beneficiary been screened for latent tuberculosis infection? **YES** ___ **NO** ___
13. Has the beneficiary been tested with Hep B SAG and Core Ab? **YES** ___ **NO** ___
Date of lab and result _____

14. Has the beneficiary experienced a therapeutic failure/inadequate response with methotrexate? **YES** ___ **NO** ___
15. Is the beneficiary unable to take methotrexate due to contraindications or intolerabilities? **YES** ___ **NO** ___
Explain _____
16. Does the beneficiary have clinical evidence of severe or rapidly progressing disease? **YES** ___ **NO** ___
17. If requesting a non-preferred, list preferred tried or reason beneficiary cannot use the preferred.

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