



Plaque Psoriasis - (Enbrel, Humira, Stelara)

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 Plaque Psoriasis? **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. What is the beneficiary's BSA (body surface area) of involvement? _____ %

16. 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** ___

17. Has the beneficiary failed systemic therapy (methotrexate, cyclosporine, Soriatane) for plaque psoriasis or beneficiary has contraindications to these treatments? **YES** ___ **NO** ___

List medications failed or reason beneficiary cannot use systemic treatment:

18. 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