NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

WellCare
Beyond Healthcare. A Better You.

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?

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**