NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

WellCare
Beyond Healthcare. A Better You.

Psoriatic Arthritis - (Otezla)

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 Psoriatic Arthritis? **YES**___ **NO**____

12. Has the beneficiary experienced a therapeutic failure/inadequate response with methotrexate? **YES**___ **NO**____

Explain_____

_____

13. Is the beneficiary unable to take methotrexate due to contraindications or intolerabilities? **YES**___ **NO**____

Explain_____

_____

14. Does the beneficiary have an 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**