HEALTHY U MEDICAID

PRIOR AUTHORIZATION REQUEST FORM

PSORIASIS

Avsola®, Cimzia®, Cosentyx®, Enbrel®, Hadlima™, Humira®, Ilumya™, Inflectra®, infliximab, Otezla®, Remicade®, Renflexis®, Siliq™, Skyrizi™, Sotyku™, Stelara®, Taltz®, Tremfya®

For authorization, please answer each question and fax this form PLUS chart notes back to the Healthy U Prior Authorization Department.

- For **Medical Pharmacy** please fax requests to: 801-213-1547
- For **Retail Pharmacy** please fax requests to: 385-425-4052

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for Pharmacy Customer Service for assistance at 385-425-5094

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		HCPCS Code:

Member must try formulary preferred drugs before a request for a non-formulary drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Preferred/Non-Formulary:

1. **1st Line Preferred Agents:**
   A. Hadlima™ (adalimumab-bwwd)
   B. Infliximab products: Avsola® (infliximab-axxq), Inflectra® (infliximab-dyyb), infliximab, Remicade (infliximab), Renflexis® (infliximab-abda)
2. **2nd line preferred agents with single step; after trial and failure of BOTH Hadlima and a preferred infliximab agent:**
   A. Cimzia® (certolizumab), Humira® (adalimumab), Otezla® (apremilast), Taltz® (ixekizumab)
3. **Non-Formulary Agents with a triple step; after trial and failure of BOTH Hadlima and a preferred infliximab agent and 2 second line agents:**
   A. Cosentyx® (secukinumab), Enbrel® (etanercept), Ilumya® (tildrakizumab), Siliq™ (brodalumab), Stelara® (ustekinumab), Skyrizi® (risankizumab-rzaa), Sotyktu™ (deucravacitinib), Tremfya® (guselkumab)

Product being requested: _____

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
1. Is the request made by a dermatologist or made in consultation with a dermatologist?	☐	☐	
2. Does the member have moderate to severe psoriasis disease based on the Psoriasis Area and Severity Index (PASI) and/or Body Surface Area Percentage (BSA%) **OR** high impact disease (plaques on palms/soles, scalp psoriasis, nail psoriasis)? **Note:** Otezla does not require documentation of severity	☐	☐	**Please provide documentation**

3. Has the member had an adequate trial and failure of, or contraindication to, phototherapy or photochemotherapy?	☐	☐	**Please provide documentation**
4. Has the member had an adequate trial and failure of at least one, or contraindication to all three, of the following: methotrexate, cyclosporine A, and acitretin?	☐	☐	**Please provide documentation**
5. Has the provider performed tuberculosis (TB) screening prior to therapy initiation? (Note: NOT required if the request is for Otezla)	☐	☐	**Please provide documentation**
6. If the request is for a Tumor Necrosis Factor Inhibitor, has the provider performed hepatitis B screening prior to therapy initiation?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Has the member's therapy been re-evaluated within the past 6 months?	☐	☐	
3. Has the therapy shown to be tolerable and effective with an improvement in condition?	☐	☐	**Please provide documentation**
4. Does the member show a continued medical need for the therapy?	☐	☐	**Please provide documentation**
5. Has the provider performed continued tuberculosis monitoring during therapy?	☐	☐	**Please provide documentation**
6. Has the provider performed continued Hepatitis B monitoring in HBV carriers?	☐	☐	**Please provide documentation**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician Signature:			

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy: PHARM-HU-061
Origination Date: 01/01/2022
Reviewed/Revised Date: 09/13/2023
Next Review Date: 09/13/2024
Current Effective Date: 10/01/2023