



Request for Prior Authorization
BIOLOGICALS FOR PLAQUE PSORIASIS

(PLEASE PRINT - ACCURACY IS IMPORTANT)

Form with fields for IA Medicaid Member ID #, Patient name, DOB, Patient address, Provider NPI, Prescriber name, Phone, Prescriber address, Fax, Pharmacy name, Address, Phone, Pharmacy NPI, Pharmacy fax, NDC.

Prior authorization is required for biologicals used for plaque psoriasis. Request must adhere to all FDA approved labeling. Payment for non-preferred biologicals for plaque psoriasis will be considered only for cases in which there is documentation of previous trials and therapy failures with two preferred biological agents.

In addition to the above:

Requests for TNF Inhibitors: 1) Patient has not been treated for solid malignancies, nonmelanoma skin cancer, or lymphoproliferative malignancy within the last 5 years of starting or resuming treatment with a biological agent; and 2) Patient does not have a diagnosis of congestive heart failure (CHF) that is New York Heart Association (NYHA) class III or IV and with an ejection fraction of 50% or less.

Requests for Interleukins: Medication will not be given concurrently with live vaccines.

The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Preferred

- Enbrel, Humira, Taltz (after step through one preferred TNF)

Non-Preferred

- Cimzia, Siliq, Stelara, Cosentyx, Skyrizi, Tremfya

Strength Dosage Instructions Quantity Days Supply

Screening for Hepatitis B: Date: Active Disease: Yes No

Screening for Hepatitis C: Date: Active Disease: Yes No

Screening for Latent TB infection: Date: Results:

Treatment failure with a preferred oral therapy: Trial Drug Name:

Trial start date: Trial end date:

Failure reason:

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**Non-Pharmacological Treatments Tried:** \_\_\_\_\_

Trial start date: \_\_\_\_\_ Trial end date: \_\_\_\_\_

Failure reason: \_\_\_\_\_

**Requests for TNF Inhibitors:**

**Has patient received treatment for solid malignancies, nonmelanoma skin cancer, or lymphoproliferative malignancy within last 5 years of starting or resuming treatment with a biologic agent?**  Yes  No

**Does patient have a diagnosis of NYHA class III or IV CHF diagnosis with ejection fraction of 50% or less?**  Yes  No

**Requests for Interleukins:**

**Will medication be given concurrently with live vaccines?**  Yes  No

Reason for use of Non-Preferred drug requiring prior approval: \_\_\_\_\_

Other medical conditions to consider: \_\_\_\_\_

Possible drug interactions/conflicting drug therapies: \_\_\_\_\_

***Attach lab results and other documentation as necessary.***

Prescriber signature (Must match prescriber listed above.)	Date of submission
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***IMPORTANT NOTE:*** In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.