IOWA Health and Human Services

Request for Prior Authorization
BIOLOGICALS FOR
PLAQUE PSORIASIS

FAX Completed Form To
1 (800) 574-2515
Provider Help Desk
1 (877) 776-1567

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI	Pharmacy fax	NDC

Prior authorization (PA) is required for biologicals used for plaque psoriasis. Request must adhere to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations. 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. Payment will be considered under the following conditions:
1. Patient has a diagnosis of moderate to severe plaque psoriasis; and
2. Patient has documentation of an inadequate response to phototherapy, systemic retinoids, methotrexate, or cyclosporine.
The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Preferred
- ☐ Adalimumab-aacf
- ☐ Adalimumab-adbm
- ☐ Adalimumab-fkjp
- ☐ Amjevita 40mg/0.4mL
- ☐ Amjevita 80mg/0.8mL
- ☐ Enbrel
- ☐ Humira
- ☐ Pyzchiva
- ☐ Simlandi
- ☐ Skyrizi Auto-Injector
- ☐ Skyrizi Cartridge
- ☐ Skyrizi Prefilled Syringe
- ☐ Taltz (step through one preferred TNF)
- ☐ Tremfya
- ☐ Yusimry

Non-Preferred
- ☐ Bimzelx
- ☐ Cimzia
- ☐ Cosentyx
- ☐ Siliq
- ☐ Stelara
- ☐ Other Humira Biosimilar: _____
- ☐ Other Stelara Biosimilar: _____

Strength	**Dosage Instructions**	**Quantity**	**Days Supply**
_____	_____	_____	_____

Diagnosis: _____

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

Trial start date: _____ Trial end date: _____

Failure reason: _____

Non-Pharmacological Treatments Tried: _____

Trial start date: _____ Trial end date: _____

Failure reason: _____

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Medical or contraindication reason to override trial requirements: _____

_____

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

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 Health and Human Services, that the member continues to be eligible for Medicaid.*