PRIOR AUTHORIZATION REQUEST FORM
Select Psoriasis Drugs
REQUEST FOR INITIAL THERAPY

DATE OF REQUEST: _____

MEMBER INFORMATION

NAME _____

ID# _____

BIRTHDATE _____

☑ PLEASE NOTE**:** By signing this form, you are attesting to the accuracy of the information provided, and that medical record documentation is available if requested.

PRESCRIBING PHYSICIAN INFORMATION

NAME _____

NPI# _____

ADDRESS _____

_____

PHONE# _____FAX#_____

CONTACT NAME _____

PROVIDER SIGNATURE _____

Drug Requested : ☐Enbrel ☐Humira ☐Remicade ☐Stelara

Dose/frequency/duration of therapy: _____

Diagnosis_____ **ICD-9 code** _____

Please check one □ **Initial Therapy Request** □ **Continuation of Therapy Request**

If *not* obtained at a pharmacy for self administration:

□ Obtain at MVP's specialty pharmacy (Caremark) for office administration (may be required)

□ (Circle One) Office/Hospital/Infusion Center: Other_____

□ Facility Name _____

□ Facility NPI _____ □ Facility Address _____

Request for Initial Therapy:

Current or history of other forms of psoriasis other than chronic plaque psoriasis	❑ YES	❑ NO
BSA involvement (current)	%	
BSA involvement of hands, soles, scalp or genitalia (current)	%	
BSA involvement (average over past 6 months)	%	
PASI or PGA score (current)		
History of arthritis, psoriatic arthritis, or other arthropathy	❑ YES	❑ NO
Member is > 18 years of age	❑ YES	❑ NO
Member has a history of malignancy, or chronic or recurrent infections	❑ YES	❑ NO

LIST OR PROVIDE CHART NOTES IDENTIFYING CURRENT AND PAST THERAPIES (e.g. UV therapy, methotrexate), DOSE, DURATION OF USE, AND RESPONSE. PROVIDE CONTRAINDICATIONS FOR USE OF OTHER THERAPIES.

THERAPY/DOSE	START DATE	STOP DATE	RESPONSE/COMMENTS

☑ **PLEASE NOTE:** ALL CHART NOTES/LAB REPORTS IN REFERENCE TO THIS REQUEST MUST BE RECEIVED BEFORE A REVIEW CAN BEGIN. *REQUESTS SUBMITTED WITHOUT THIS DOCUMENTATION MAY BE DENIED.*

*Refer to the MVP Formulary at **www.mvphealthcare.com** for those drugs that require prior authorization or are subject to quantity limits or step therapy.*

FAX THIS REQUEST TO:

Commercial **1-800-376-6373**
(HMO, EPO/PPO, Exchange, Medicaid, Child Health Plus, ASO)

Medicare Part D **1-800-401-0915**
(Preferred Gold, Gold PPO, GoldValue, BasiCare, USA Care, MVP RxCare)

Effective January 2015

PRIOR AUTHORIZATION REQUEST FORM
Select Psoriasis Drugs
REQUEST FOR CONTINUATION OF THERAPY

DATE OF REQUEST: _____

MEMBER INFORMATION

NAME _____

ID# _____

BIRTHDATE _____

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PRESCRIBING PHYSICIAN INFORMATION

NAME _____

NPI# _____

ADDRESS _____

_____

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CONTACT NAME _____

PROVIDER SIGNATURE _____

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Dose/frequency/duration of therapy: _____

Diagnosis_____ **ICD-9 code** _____

Please check one □ **Initial Therapy Request** □ **Continuation of Therapy Request**

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□ (Circle One) Office/Hospital/Infusion Center: Other_____

□ Facility Name _____

□ Facility NPI _____ □ Facility Address _____

Request for Continuation of Therapy:

BSA involvement (current)	%	
BSA involvement (average over past 6 months)	%	
Change in BSA involvement since initiation of therapy	%	
PASI or PGA score (current)		
History or current symptoms of arthritis, psoriatic arthritis or other arthropathy	❑ YES	❑ NO

LIST OR PROVIDE CHART NOTES IDENTIFYING CURRENT AND PAST THERAPIES (e.g. UV therapy, methotrexate), DOSE, DURATION OF USE, AND RESPONSE. PROVIDE CONTRAINDICATIONS FOR USE OF OTHER THERAPIES.

THERAPY/DOSE	START DATE	STOP DATE	RESPONSE/COMMENTS

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