

PRIOR AUTHORIZATION REQUEST FORM **Select Psoriasis Drugs** REQUEST FOR INITIAL THERAPY

DATE OF REQUEST:	PRESCRIBING PHYSICIAN INFORMATION NAME			
MEMBER INFORMATION				
MEMBER INFORMATION	NPI#			
NAME				
ID#				
BIRTHDATE	PHONE#FAX#			
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.				
record documentation is available in requested.	PROVIDER SIGNATURE			
Drug Requested : □Enbrel □Humira □Remid				
Dose/frequency/duration of therapy:	ICD 0 ands			
Diagnosis Initial Therapy Request	ICD-9 code	on of Therapy	Poguest	
If <i>not</i> obtained at a pharmacy for self administration:	□ Continuati	on of Therapy	Request	
 Obtained at a pharmacy for sen administration. Obtain at MVP's specialty pharmacy (Caremark) for of 	fice administration (may	y bo roquirod)		
□ (Circle One) Office/Hospital/Infusion Center: Other				
Collide One) Office/Hospital/Infusion Center. Other Facility Name				-
□ Facility Name □ Facility NPI □ Facility /	Addross			
	Addi 655			-
Request for Initial Therapy:				
Current or history of other forms of psoriasis other than chronic plaque psoriasis				
BSA involvement (current) %				
BSA involvement (current) BSA involvement of hands, soles, scalp or genitalia (current)	% %			
DOA involvement (nonne na	%			
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				
Member has a history of malignancy, or chronic or recurrent	iniections	☐ YES	☐ NO	
LIST OR PROVIDE CHART NOTES IDENTIFYING CURRENT DURATION OF USE, AND RESPONSE. PROVIDE CONTRA				OSE,
THERAPY/DOSE START DATE STOP DA		SPONSE/COMM		
No. 5405 NOTE	I			_
PLEASE NOTE: ALL CHART NOTES/LAB REPOR				ED
BEFORE A REVIEW CAN BEGIN. <u>REQUESTS SUBMITTED</u>	WITHOUT THIS DOCUM	<u>IENTATION MAY</u>	<u>Y BE DENIED.</u>	
Refer to the MVP Formulary at www.mvphealthcare.com for those drugs	that require prior authorization	or are subject to au	antity limits or sten then	rany
Tolor to the liver 1 officially at www.mvpneathicare.com for those drugs	macregane prior aumonzation	or are subject to que	army mimo or step then	upy.
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

	PRESCRIBING PHYSICIAN INFORMATION			
DATE OF REQUEST:	- NEGONIZINO I III OIOMINI IIII OINIMITION			
	NAME			
MEMBER INFORMATION	NDI#			
NAME	NPI#			
	ADDRESS			
ID#				
BIRTHDATE				
PLEASE NOTE: By signing this form, you are attesting	PHONE#FAX#			
to the accuracy of the information provided, and that medical	CONTACT NAME			
record documentation is available if requested.	CONTACT WANTE			
	PROVIDER SIGNATURE			
Drug Requested : □ Enbrel □ Humira □ Rer	nicade			
Dose/frequency/duration of therapy: Diagnosis	mode Dotolara			
Diagnosis	ICD-9 code			
Please check one Initial Therapy Request	□ Continuation of Therapy Request			
If <i>not</i> obtained at a pharmacy for self administration:				
□ Obtain at MVP's specialty pharmacy (Caremark) for				
□ (Circle One) Office/Hospital/Infusion Center: Other_				
- Facility Name				
□ Facility Name □ 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				
LIST OF PROVIDE CHART NOTES IDENTIFYING CLIPPE	NT AND PAST THERAPIES (e.g. UV therapy, methotrexate), DOSE,			
DURATION OF USE, AND RESPONSE. PROVIDE CONTR				
THERAPY/DOSE START DATE STOP	DATE RESPONSE/COMMENTS			
✓ PLEASE NOTE : ALL CHART NOTES/LAB REPO	RTS IN REFERENCE TO THIS REQUEST MUST BE RECEIVED			
BEFORE A REVIEW CAN BEGIN. REQUESTS SUBMITTE	<u>D WITHOUT THIS DOCUMENTATION MAY BE DENIED.</u>			
Refer to the MVP Formulary at www mynhealthcare com for those drive	is that require prior authorization or are subject to quantity limits or step therapy.			
. 13. 15 13. 15 11. 17 Torriday at 11. 11. 11. 11. 11. 11. 11. 11. 11. 11	s and regains prior additionation or are subject to quartity minto or stop therapy.			

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