NC Medicaid and NC Health Choice
Pharmacy Prior Approval Request for
Immunomodulators: Plaque Psoriasis - Adult

(Enbrel, Humira, Cosentyx, Avsola, Cimzia, Ilumya, Inflectra, Otezla, Remicade, Renflexis, Siliq, Skyrizi, Stelara, Taltz, and Tremfya)

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: ____

Prescriber Information

6. Prescribing Provider NPI #: _____
7. Requester Contact Information - Name: _____ Phone #: _____ Ext. _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy (in days): ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days ☐ 365 Days ☐ Other _____

Clinical Information

1. Is the beneficiary age 18 or older? ☐ **Yes** ☐ **No**
2. Does the beneficiary have a diagnosis of moderate to severe chronic Plaque Psoriasis? ☐ **Yes** ☐ **No**
3. Is the beneficiary on any other injectable immunomodulator? ☐ **Yes** ☐ **No**
4. Has the beneficiary been screened for latent tuberculosis infection? ☐ **Yes** ☐ **No**
5. Has the beneficiary been tested with Hep B SAG and Core Ab? ☐ **Yes** ☐ **No**
6. Has the beneficiary failed to respond to, or has been unable to tolerate phototherapy and One of the following medications (methotrexate, cyclosporine, or soritane) for plaque psoriasis or has contraindications to these treatments? ☐ **Yes** ☐ **No**
7. Does the beneficiary have a body surface area (BSA) involvement of at least 3%? ☐ **Yes** ☐ **No**
8. Does the beneficiary have involvement of the palms, soles, head and neck, or genitalia; causing disruption in normal daily activities and/or employment? ☐ **Yes** ☐ **No**
9. Has the beneficiary tried and failed Cosentyx, Enbrel, or Humira? ☐ **Yes** ☐ **No**
   9b. If no, please provide the clinical reason why the beneficiary has not tried Cosentyx, Enbrel, or Humira: _____
   _____

For coverage of Siliq (please answer questions 1-11)

10. Is the beneficiary registered in the Siliq Risk Evaluation and Mitigation Program (REMS Program)? ☐ **Yes** ☐ **No**
11. Is the prescribing provider registered in the Siliq Risk Evaluation and Mitigation Program (REMS Program)? ☐ **Yes** ☐ **No**

Signature of Prescriber: _____ Date: _____

(Prescriber Signature Mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to CSRA at (855) 710-1969 Pharmacy PA Call Center: (866) 246-8505