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

(Enbrel, Stelara, and Taltz)

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 6 or older? ☐ **Yes** ☐ **No**
2. Does the beneficiary have a diagnosis of moderate to severe Plaque Psoriasis and is a candidate for systemic therapy or phototherapy? ☐ **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 experienced a therapeutic failure or inadequate response with, or has a contraindication or intolerance to methotrexate? ☐ **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 Enbrel? ☐ **Yes** ☐ **No**
   9a. If no, please provide the clinical reason why the beneficiary has not tried Enbrel: _____
   _____

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