

## 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 info	ormation above. It must be legil	ble, correct, and c	-	rm will be returned.
Pharmacy NPI	Pharmacy fax	Pharmacy fax NDC		
precautions, drug interactions psoriasis will be considered or with two preferred biological a 1. Patient has a diagnosis of m 2. Patient has documentation ocyclosporine.  The required trials may be ove be medically contraindicated.	nly for cases in which there gents. Payment will be constoderate to severe plaque psof an inadequate response to	is documentatio sidered under the soriasis; and o phototherapy,	n of previouse following of systemic re	trials and therapy failures conditions:
Preferred Adalimumab-aacf Adalimumab-adbm Adalimumab-fkjp Amjevita 40mg/0.4mL Amjevita 80mg/0.8mL Enbrel Humira	Simlandi Skyrizi Auto-Injector Skyrizi Cartridge Skyrizi Prefilled Syring Taltz (step through on Tremfya Yusimry	•	<i>,</i> —	elx ia ntyx
Strength	Dosage Instructions	Quantity	Days Sup	oply -
Diagnosis:				
Treatment failure with a pre-	ferred oral therapy: Trial D	Orug Name:		
Trial start date:	Trial end date:			
Failure reason:				
Non-Pharmacological Treat	ments Tried:			
Trial start date:				
Failure reason:				

470-4524 (Rev. 1/25) Page 1 of 2

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Medical or contraindication reason to override trial require	rements:
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.

470-4524 (Rev. 1/25) Page 2 of 2