

Today's date _____

Date medication needed _____



Prior Authorization Form Psoriasis Agents – Medical Benefit

ONLY COMPLETED REQUESTS WILL BE REVIEWED

Stelara[®]

Check one: New start Continued treatment

Patient information (please print)

Patient name _____

Address _____

City, state, ZIP _____

Patient telephone # _____

Patient ID # _____

Date of birth _____ Height _____ Weight _____

Physician information (please print)

Prescribing physician _____

Office address _____

City, state, ZIP _____

Office contact _____

Office telephone # _____

Fax # _____ NPI _____

Upon approval, delivery is available by completing the section below.

N/A – No delivery requested (authorization only – physician will use office supply)

Delivery requested (indicate where medication should be delivered: Physician's office Patient's home)

****A copy of the prescription must accompany the medication request for delivery.****

1. Physician specialty (required; specify all):

Dermatology Other _____

2. Diagnosis for drug requested (must include ICD-9):

696.1 Chronic plaque psoriasis Other (specify diagnosis and ICD-9) _____

3. Patient medical information:

a. Is chronic plaque psoriasis moderate-to-severe? Yes No

b. Is minimum body surface area involvement 5 percent or less if psoriasis affects sensitive body areas? Yes No

c. Has the patient been evaluated (i.e., tuberculin test)? Yes No

d. Does the patient have a current infection? Yes No

4. Patient history (please list any previous or current therapies related to the diagnosis):

Drug name	Dates	Duration
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please add any other supporting medical information that may be useful in the decision-making process:

5. Prescription information:

Quantity _____ Refill x _____ month(s)

Instructions (include dose) _____ every _____ day(s)/ week(s)/ month(s)

Physician's signature _____

Fax completed form to 215-761-9165. Your office will receive a response by fax within two business days.