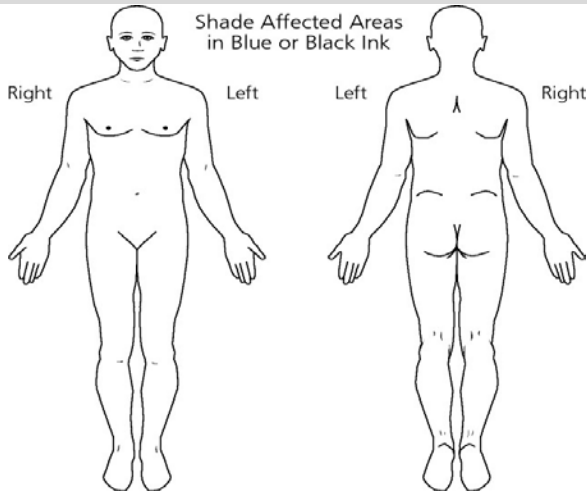


Member Name:		Today's Date:	
Date of birth:	Sex:	Weight:	Prescriber:
Home Phone Number:		Hospital/Clinic:	
Home Address/City/State/Zip:		Phone Number:	
Payor: <input type="checkbox"/> Independent Health <input type="checkbox"/> Anne Arundel Health System <input type="checkbox"/> Pharmacy Benefit Dimensions Insurance ID: _____		<input type="checkbox"/> Commercial <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Self-funded Group Number: _____	
Notes:		Fax Number:	
Allergies:		Address/City/State/Zip:	

STATEMENT OF MEDICAL NECESSITY	DRUG SELECTION
Primary Diagnosis: _____ ICD10 Code: _____ Will medication be self-injected? <input type="checkbox"/> Yes <input type="checkbox"/> No Has patient had psoriasis greater than 1 year? <input type="checkbox"/> Yes <input type="checkbox"/> No Has patient failed to respond to a 3 month trial of listed conventional agents? (Methotrexate, Tazarotene, topical corticosteroids, cyclosporine, Anthralin, tacrolimus, calcitriol, phototherapy, acitretin) <input type="checkbox"/> Yes <input type="checkbox"/> No Name and length of therapy: _____	<input type="checkbox"/> New Authorization Request <input type="checkbox"/> Reauthorization Request <input type="checkbox"/> Cosentyx <input type="checkbox"/> Humira <input type="checkbox"/> Otezla: <input type="checkbox"/> Stelara <input type="checkbox"/> Enbrel <input type="checkbox"/> Siliq: REMS certified? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Taltz <input type="checkbox"/> Tremfya <input type="checkbox"/> Remicade <input type="checkbox"/> Cimzia <input type="checkbox"/> Ilumya <input type="checkbox"/> Hadlima (Adalimumab-bwwd) <input type="checkbox"/> Adalimumab-adaz <input type="checkbox"/> Other _____ <input type="checkbox"/> Initial Dose: _____ Frequency: _____ <input type="checkbox"/> Maintenance Dose: _____ Frequency: _____
Other previous treatments: _____ _____ Clinical impression: _____ TB Skin test result: _____ Date: _____	

Submission of Disease Severity Form (completed within the last three months)



- Complete the body surface area diagram to the left by shading affected areas of body.**
BSA: _____ %
- Are hands and or feet affected and severely interfering with activities of daily living**
 Yes No
- For reauthorization: Clinical response or remission of disease maintained with continued use?** Yes No
- Please add any additional information below:**

*For reauthorization, patient must show improvement from baseline or maintenance of improvement, based on disease severity assessment form, which must be submitted.