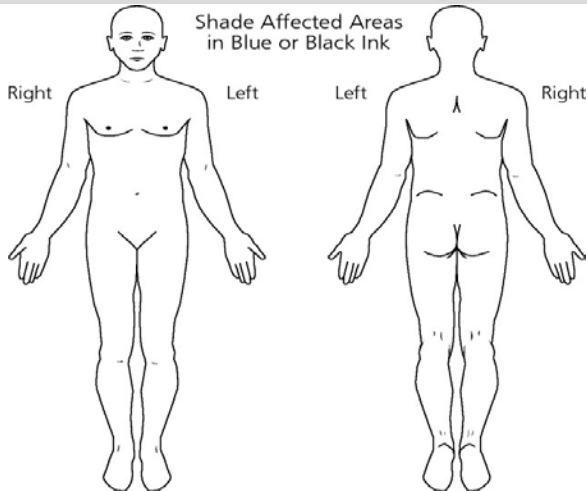


Member Name:			Today's Date:			Date Needed:					
Date of birth:		Sex:	Weight:		Prescriber:			Hospital/Clinic:			
Home Phone Number: () () ()				Phone Number: () () ()			Fax Number: () () ()				
Home Address:			City:	State:	Zip:		Address:		City:	State:	Zip:
Member's Insurance ID:						Office Phone :			Office Fax Number:		
Allergies:						Office Contact:					

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"/> 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.