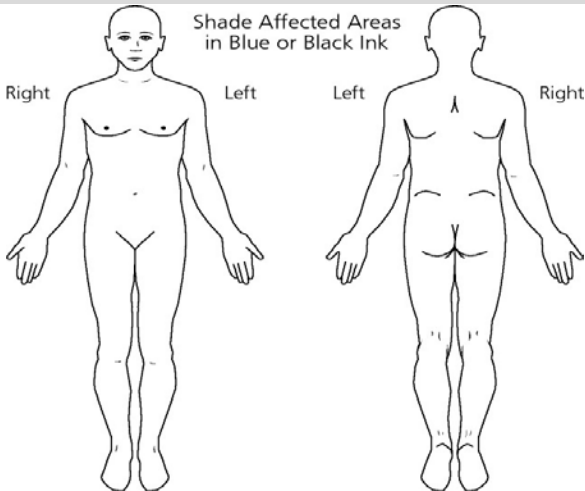


Member Name:		Today's Date:	
Date of birth:	Sex:	Weight:	Prescriber:
Home Phone Number:		Hospital/Clinic:	
Home Address/City/State/Zip:		Phone Number:	
Payor: <input type="checkbox"/> Independent Health <input type="checkbox"/> Anne Arundel Health System <input type="checkbox"/> Pharmacy Benefit Dimensions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

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.