15 Earhart Drive, Suite 101, Amherst, NY 14221

PSORIATIC ARTHRITIS AUTHORIZATION AND RE-AUTHORIZATION REQUEST

TEL: (716) 929-1000 | 1-800-809-4763 FAX: (716) 532-7360

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:
Payor: ☐ Independent Health ☐ Anne Arundel Health System ☐ Pharmacy Benefit Dimensions ☐ Commercial ☐ Medicare ☐ Medicaid ☐ Self-funded Insurance ID: Group Number:		Prescriber specialty:	
		Allergies:	

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: _____ICD10 Code: _____

Has patient tried and failed to tolerate or respond to a 3 month trial of a below listed conventional agent? (Methotrexate, leflunomide, sulfasalazine, hydroxychloroquine, NSAIDS)

☐ Yes ☐ No Name and length of therapy_____

_____

Please list all other previous therapies:

_____

_____

_____

Has the patient been screened for latent TB infection or interferon-gamma release assays? (TB Testing is not required for Otezla)

☐ Yes ☐ No

Attach baseline tuberculosis test result.

If the test is positive, then submit evidence that:

- Patient must be evaluated for latent tuberculosis before initiating BDAID therapy (latent tuberculosis should be treated before starting) AND
- Submission of yearly screening for latent TB such as annual TB skin testing results or chest x-ray, is required for patients who live, travel, or work in situations where TB exposure is likely while on treatment OR for those who have previously tested positive.

Does patient have any of the below clinical features? ☐ Yes ☐ No

Involvement of DIP joints, asymmetric distribution of joint disease, spondylarthrosis, sausage digits, new bone formation on radiographs, cutaneous findings, and characteristic nail manifestations of psoriatic arthritis

DRUG SELECTION

☐ New Authorization Request ☐ Reauthorization Request

☐ **CIMZIA**	☐ **COSENTYX**	☐ **ENBREL**
☐ **HUMIRA**	☐ **ORENCIA**	☐ **OTEZLA**
☐ **REMICADE**	☐ **RINVOQ**	☐ **SKYRIZI**
☐ **STELARA**	☐ **TALTZ**	☐ **TREMFYA**
☐ **SIMPONI**	☐ **XELJANZ**	☐ **OTHER_____**

☐ Initial Dose: _____ Frequency: _____

☐ Maintenance Dose: _____ Frequency: _____

Will medication be self-injected? ☐ Yes ☐ No

For reauthorization:

-Patient continues to meet initiation criteria? ☐ Yes ☐ No

-Absence of inexplicable toxicity from the drug? ☐ Yes ☐ No

-Ongoing monitoring for TB as noted under criteria for authorization? ☐ Yes ☐ No

-Clinical response or remission of disease maintained with continued use? ☐ Yes ☐ No

©2022 Reliance Rx