



PRIOR AUTHORIZATION REQUEST FORM
Psoriasis Drugs
 (Amevive, Enbrel, Humira & Remicade)
REQUEST FOR CONTINUATION OF THERAPY

DATE OF REQUEST: _____

MEMBER INFORMATION

NAME _____

ID# _____

BIRTHDATE _____

PLEASE NOTE: By signing this form, you are attesting to the accuracy of the information provided, and that medical record documentation is available if requested.

PROVIDER INFORMATION

NAME _____

NPI# _____

ADDRESS _____

PHONE# _____ FAX# _____

CONTACT NAME _____

PROVIDER SIGNATURE _____

Drug Requested : Amevive Enbrel Humira Remicade

Dose/frequency/duration of therapy: _____

Diagnosis _____ **ICD-9 code** _____

Please check one **Initial Therapy Request** **Continuation of Therapy Request**

If *not* obtained at a pharmacy for self administration:

- Obtain at MVP's specialty pharmacy (CuraScript) for office administration (*may be required*)
- Office/Hospital/ Infusion Center: Place of Service _____
- Other _____

Request for Continuation of Therapy:

BSA involvement (current)	%
BSA involvement (average over past 6 months)	%
Change in BSA involvement since initiation of therapy	%
PASI or PGA score (current)	
History or current symptoms of arthritis, psoriatic arthritis or other arthropathy	<input type="checkbox"/> YES <input type="checkbox"/> NO
Current weight (efalizumab only): _____ kg (date: _____)	

LIST OR PROVIDE CHART NOTES IDENTIFYING CURRENT AND PAST THERAPIES (e.g. UV therapy, methotrexate), DOSE, DURATION OF USE, AND RESPONSE. PROVIDE CONTRAINDICATIONS FOR USE OF OTHER THERAPIES.

THERAPY/DOSE	START DATE	STOP DATE	RESPONSE/COMMENTS

PLEASE NOTE: ALL CHART NOTES/LAB REPORTS IN REFERENCE TO THIS REQUEST MUST BE RECEIVED BEFORE A REVIEW CAN BEGIN. REQUESTS SUBMITTED WITHOUT THIS DOCUMENTATION MAY BE DENIED.

Refer to the MVP Formulary at www.mvphealthcare.com for those drugs that require prior authorization or are subject to quantity limits or step therapy.

FAX THIS REQUEST TO:

Commercial **1-800-376-6373**
 (HMO, EPO/PPO, Option Child, Healthy NY,
 Personal Plan, CompCare, ASO)

Medicare Part D **1-800-401-0915**
 (Preferred Gold, GoldAnywhere, GoldValue, USA Care, MVP RxCare)