UnitedHealthcare Community Plan

Siliq - Arizona
Prior Authorization Request Form

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826.**
This form may contain multiple pages. Please complete all pages to avoid a delay in our decision.
Allow at least 24 hours for review.

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance Information (if any):		

Is the requested medication: □ New or □ Continuation of Therapy? If continuation, list start date: _____

Is this patient currently hospitalized? □ Yes □ No If recently discharged, list discharge date: _____

Section B - Provider Information

First Name:		Last Name:		M.D./D.O.
Address:		City:	State:	ZIP code:
NPI #:	Phone:	Fax:	Specialty:	
Office Contact Name / Fax attention to:				

Section C - Medical Information

Medication:	**Strength:**
Directions for use:	**Quantity:**
Diagnosis (Please be specific & provide as much information as possible)**:**	**ICD-10 CODE:**

Is this member pregnant? □ Yes □ No If yes, what is this member's due date? _____

Section D – Previous Medication Trials

Medication Name	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs: Please refer to the patient's PDL for a list of preferred alternatives

UnitedHealthcare Community Plan

Siliq - Arizona
Prior Authorization Request Form

Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information

ALL REQUESTS:

- **Is the patient currently on Siliq therapy? □ Yes □ No If yes, list start date: _____**

- **Does the patient have a diagnosis of chronic moderate to severe plaque psoriasis? □ Yes □ No**
  If no, list diagnosis: _____
  (must submit medical documentation)

- **Does the patient have greater than or equal to 5% body surface area involvement, palmoplantar, facial, or genital involvement, or severe scalp psoriasis? □ Yes □ No *(must submit medical documentation)***

- **Does the patient have a history of failure, contraindication, or intolerance to one of the following topical therapies (Corticosteroids (e.g., betamethasone, clobetasol, desonide), Vitamin D analogs (e.g., calcitriol, calcipotriene), Tazarotene, Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus), Anthralin, Coal tar)? □ Yes □ No**
  (If yes, complete Section D above with medication information, including dose, date of trial, and reason for discontinuation)
  (must submit medical documentation)

- **Does the patient have a history of failure, contraindication, or intolerance to systemic therapy of at least 3 months duration with methotrexate? □ Yes □ No *(must submit medical documentation)***
  (If yes, complete Section D above with medication information, including dose, date of trial, and reason for discontinuation)

- **Does the patient have a history of failure, contraindication, or intolerance to Humira (adalimumab) and/or Enbrel (etanercept)? □ Yes □ No *(must submit medical documentation)***
  (If yes, complete Section D above with medication information, including dose, date of trial, and reason for discontinuation)

- **Will the patient receive Siliq in combination with any of the following: □ Yes □ No (check which apply)**
  - □ Biologic DMARD [e.g., Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab), Cosentyx (secukinumab), Orencia (abatacept)]
  - □ Janus kinase inhibitor [e.g., Xeljanz (tofacitinib)]
  - □ Phosphodiesterase 4 (PDE4) inhibitor [e.g. Otezla (apremilast)]

Requests for CONTINUATION OF THERAPY:

- **Does the patient have a documented positive clinical response to Siliq therapy? □ Yes □ No**
  If yes, list response: _____
  _____

Provider Signature: _____ Date: _____