UnitedHealthcare Community Plan

SORIATANE

PRIOR AUTHORIZATION REQUEST

Complete ENTIRE form and Fax to: 866-940-7328

Today's Date:		
SECTION A - PATIENT INFORMATION		
First Name:	Last Name:	Member ID:
Address:		
City:	State:	Zip:
Phone:	DOB:	Allergies:
Primary Insurance:	Policy #:	Group #:

Is the requested medication NEW ☐ or a CONTINUATION of THERAPY☐? If so, start date:_____

Is this patient currently hospitalized? ☐ Yes ☐ No

SECTION B - PHYSICIAN INFORMATION				
First Name:		Last Name:		M.D./D.O.
Address:		City:	State:	Zip:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax Attention to:				

SECTION C - MEDICAL INFORMATION		
Medication:		Strength:
Directions for use:		
Diagnosis:	**ICD-10 CODE:**	Frequency of Administration:

Does the patient have a confirmed diagnosis of psoriasis? **Yes** **or** **No** *(circle response)*

Is the prescriber a dermatologist? **Yes** **or** **No** *(circle response)*

Did the patient have treatment failure, an intolerance, or contraindication to one of the following? **Yes** **or** **No** *(circle response)*

☐ **High potency steroids** ☐ **Dovonex (calcipotriene)**

☐ **Methotrexate** ☐ **Cyclosporine**

List therapy tried and dates: _____

Intolerance or contraindication: _____

What percent of body surface area involvement does this patient have? _____

Does the psoriasis involvement affect critical areas of the body such as the palms, soles, face, or genitalia which causes interference of the patient's daily activities? **Yes** **or** **No** *(circle response)* **If yes, what areas?** _____

_____

If continuation of therapy, Has documentation been submitted showing the clinical benefit of Soriatane therapy? **Yes** **or** **No** *(circle response)*

Physician Signature: _____ **Date:** _____