

SORIATANE

PRIOR AUTHORIZATION REQUEST

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

Today's Date: _____			
SECTION A - PATIENT INFORMATION			
First Name:		Last Name:	
Address:		Member ID:	
City:		State:	Zip:
Phone:		DOB:	Allergies:
Primary Insurance:		Policy #:	Group #:
Is the requested medication NEW <input type="checkbox"/> or a CONTINUATION of THERAPY <input type="checkbox"/> ? If so, start date: _____			
Is this patient currently hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> 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)			
<input type="checkbox"/> High potency steroids		<input type="checkbox"/> Dovonex (calcipotriene)	
<input type="checkbox"/> Methotrexate		<input type="checkbox"/> 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:** _____

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