SENDERO HEALTH PLANS

Prior Authorization Request Form	Siliq
Sendero Fax: 512-901-9724	**Phone:** 855-297-9191
URGENCY: ☐ **STANDARD**	☐ **URGENT (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health or ability to regain maximum function)**

Provider Information	Patient Information
Referring/Prescribing Physician: ☐ **PCP** ☐ **Specialist** **Name:** **Please identify SPECIALTY:** **DEA, NPI or TIN:** **Contact:** **Phone: ( ) Fax: ( )**	**Patient's Name:** **Birth Date:** **ID Number:** **Phone Number:** **Patient Height:** **Patient Weight:**
Indicate where the drug is being DISPENSED	**Indicate where the drug is being ADMINISTERED**
☐ **Ambulatory Surgery Center** ☐ **Home Care Agency** ☐ **Inpatient Hospital** ☐ **Long Term Care** ☐ **Outpatient Hospital** ☐ **Patient's Home** ☐ **Pharmacy** ☐ **Physician's Office** ☐ **Other (explain):**	☐ **Ambulatory Surgery Center** ☐ **Inpatient Hospital** ☐ **Long Term Care** ☐ **Outpatient Hospital** ☐ **Patient's Home** ☐ **Pharmacy** ☐ **Physician's Office** ☐ **Other (explain):** **Anticipated Date of Service:**

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

PATIENT CLINICAL INFORMATION

CRITERIA QUESTIONS:

1. Has the patient been diagnosed with any of the following?
   ☐ Psoriasis
   ☐ Psoriatic arthritis (PsA)
   ☐ Other: _____

2. What is the HCPCS code? _____ What is the ICD-10 code? _____
   What is the NDC#: _____

3. Will the requested drug be used in combination with any other biologic or targeted synthetic DMARD (e.g., Olumiant, Xeljanz)? ☐ Yes ☐ No

4. Has the patient had a TB screening test (e.g., a tuberculosis skin test [PPD] or an interferon-release assay [IGRA]) within 6 months of initiating therapy? ☐ Yes ☐ No

5. What were the results of the TB screening test? ☐ Positive ☐ Negative

6. Does the patient have latent or active tuberculosis (TB)? ☐ Latent ☐ Active ☐ No/Neither

7. If the patient has latent or active tuberculosis, has treatment been initiated or completed?
   ☐ Yes - treatment initiated ☐ Yes - treatment completed ☐ No

8. Is this request for continuation of therapy? ☐ Yes ☐ No If No, skip to diagnosis section.

9. For continuation of therapy requests, has the patient achieved or maintained positive clinical response as evidenced by low disease activity or improvement in signs and symptoms since starting treatment with the requested drug? ☐ Yes ☐ No

10. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program? ☐ Yes ☐ No

DIAGNOSIS SECTION ***Please only complete sections below that are relevant to the patient's diagnosis.***

Section A: Psoriasis

11. The patient is diagnosed with psoriasis and treatment is prescribed by or in consultation with a dermatologist or rheumatologist ☐ Yes ☐ No

12. Has the patient previously received Otezla or any other biologic medication indicated for the treatment of moderate to severe plaque psoriasis? ☐ Yes ☐ No If Yes, please indicate the drug, duration, response, and intolerance/contraindication if applicable:
    _____

13. Has the patient had an inadequate response to 1 or more of the following topical therapies?
    - ☐ Corticosteroids (e.g., betamethasone, clobetasol, desonide) (4-week trial)
    - ☐ Vitamin D analogs (e.g., calcitriol, calcipotriene)
    - ☐ Tazarotene
    - ☐ Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)
    - ☐ Anthralin
    - ☐ Coal tar

14. Has the patient had an inadequate response to a minimum 3 month trial of methotrexate at a minimum dose of 15mg po weekly within the last 6 months? ☐ Yes ☐ No

15. Does the patient have a contraindication or intolerance to methotrexate? ☐ Yes ☐ No If Yes, indicate contraindication/intolerance and no further questions. _____

16. Does the patient have severe psoriasis that warrants a biologic DMARD as first-line therapy (i.e. at least 10% of the body surface area (BSA) or crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) are affected)? ☐ Yes ☐ No

* Please note, the preferred anti-IL-17 drug is Taltz. Please consider prescribing one of these drugs if clinically appropriate. If Cosentyx is preferred, please provide additional clinical reasoning documentation here:
_____

Section B: Psoriatic Arthritis

17. The patient is diagnosed with psoriatic arthritis and treatment is prescribed by or in consultation with a rheumatologist ☐ Yes ☐ No

18. Has the patient previously received a biologic medication, apremilast (Otezla), or targeted synthetic DMARD (e.g., Xeljanz) indicated for the treatment of psoriatic arthritis? ☐ Yes ☐ No ☐ Yes ☐ No If Yes, please indicate the drug, duration, response, and intolerance/contraindication if applicable:
    _____

19. Has the patient experienced an inadequate response after at least 3 months of treatment with 1 or more of the following medications at the maximally tolerated dose?
    - ☐ Methotrexate – minimum dose 15mg po weekly
    - ☐ Sulfasalazine – minimum dose 2g po weekly
    - ☐ Cyclosporine
    - ☐ Leflunomide
    - ☐ Apremilast (Otezla)

Does the patient have a contraindication or intolerance to at least 2 options listed above? ☐ Yes ☐ No
If yes, please document medications and respective contraindications/intolerances:

* Please note, the preferred anti-IL-17 drug is Taltz. Please consider prescribing one of these drugs if clinically appropriate. If Cosentyx is preferred, please provide additional clinical reasoning documentation here:

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by Sendero Health Plans.	
Prescriber or Authorized Signature	DATE