BlueCross BlueShield of North Carolina | HealthyBlue

Plaque Psoriasis — Adult (Enbrel, Humira, Cosentyx, Cimzia, Ilumya, Inflectra, Otezla, Remicade, Renflexis, Siliq, Skyrizi, Stelara, Taltz and Tremfya) Prior Authorization Form

Member Information

1. Member Last Name:_____ 2. First Name:_____
3. Member ID #:_____ 4. Member Date of Birth:_____ 5. Member Gender:_____

Prescriber Information

6. Prescribing Provider NPI #:_____
7. Requester Contact Information

Name:_____ Phone #:_____ Ext:_____

Drug Information

8. Med Requested:_____ 9a. Strength:_____ 9b. Quantity Per 30 Days:_____
9c. Length of Therapy:_____
10. Is the member 18 years old or older? ☐ Yes ☐ No
11. Does the member have a diagnosis of moderate to severe Plaque Psoriasis? ☐ Yes ☐ No
12. Is the member on any other injectable immunomodulator? ☐ Yes ☐ No
13. Has the member been screened for latent tuberculosis infection? ☐ Yes ☐ No
14. Has the member been tested with Hep B SAG and Core Ab? ☐ Yes ☐ No
    Date of lab and result:_____
15. Has the member experienced a therapeutic failure/inadequate response with methotrexate? ☐ Yes ☐ No
16. Is the member unable to take methotrexate due to contraindications or intolerabilities? ☐ Yes ☐ No
    Explain_____
17. Does the member have a body surface area (BSA) involvement of at least 3%? ☐ Yes ☐ No
    Please list the member's BSA (body surface area) of involvement. _____%
18. Does the member have involvement of the palms, soles, head and neck, or genitalia, causing disruption in normal daily activities and/or employment? ☐ Yes ☐ No
19. Has the beneficiary failed to respond to or is unable to tolerate phototherapy and ONE of the following meds- Soriatane (acitretin), methotrexate, cyclosporin? ☐ Yes ☐ No
    List medications failed or reason beneficiary cannot use other treatments: _____
    _____
20. If requesting a non-preferred, list preferred tried or reason beneficiary cannot use one preferred.
    _____
21. If requesting Siliq, are the beneficiary, provider, and pharmacy registered appropriately in the Siliq Risk Evaluation and Mitigation Strategy Program (REMS program)? ☐ Yes ☐ No

Signature of Prescriber:_____ Date:_____
(Prescriber signature mandatory)
I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to **1-844-376-2318**
Healthy Blue Pharmacy PA Call Center: **1-844-594-5072**

https://provider.healthybluenc.com

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