PRO ACT PHARMACY BENEFIT MANAGEMENT

1230 US Highway 11
Gouverneur, NY 13642
Phone: 1-877-635-9545
Prior Authorization Fax: 1-844-712-8129

# Antipsoriatic Agents Prior Authorization Request Form (Page 1 of 2)

| Member Information (required) | | | Provider Information (required) | | |
|---|---|---|---|---|---|
| Member Name: | | | Provider Name: | | |
| Insurance ID#: | | | NPI#: | Specialty: | |
| Date of Birth: | | | Office Phone: | | |
| Street Address: | | | Office Fax: | | |
| City: | State: | Zip: | Office Street Address: | | |
| Phone: | | | City: | State: | Zip: |

| Medication Information (required) | | |
|---|---|---|
| Medication Name: | Strength: | Dosage Form: |
| ❑ Check if requesting **brand** | Directions for Use: | |
| ❑ Check if request is for **continuation of therapy** | | |

## Clinical Information (required)

**Select the diagnosis below:**

❑ Psoriasis
❑ Scalp psoriasis [**calcipotriene solution** only]
❑ Other diagnosis:_____ICD-10 Code(s): _____

**Select the medications the patient has a failure, contraindication, or intolerance to:**

❑ Calcipotriene cream
❑ Calcipotriene ointment
❑ Calcipotriene solution
❑ Vectical (calcitriol) ointment

**Select the corticosteroid topical treatments the patient has a failure, contraindication, or intolerance to:**

**Medium potency**:
❑ Betamethasone dipropionate (Diprosone)
❑ Betamethasone valerate (Valisone)
❑ Betamethasone valerate (Luxiq)
❑ Clocortolone pivalate (Cloderm)
❑ Desoximetasone (Topicort)
❑ Fluocinolone acetonide (Synalar)
❑ Fluticasone propionate (Cutivate)
❑ Flurandrenolide (Cordran)
❑ Hydrocortisone butyrate (Locoid)
❑ Hydrocortisone butyrate (Westcort)
❑ Mometasone furmoate (Elocon)
❑ Triamcinolone acetonide (Aristocort, Kenalog)

**High potency**:
❑ Amcinonide (Cyclocort)
❑ Augmented betamethasone dipropionate (Diprolene, Diprolene AF)
❑ Betamethasone dipropionate (Diprosone)
❑ Betamethasone valerate (Valisone)
❑ Desoximetasone (Topicort)
❑ Diflorasone diacetate (Florone, Maxiflor)
❑ Fluocinolone acetonide (Synalar)
❑ Fluocinonide (Lidex)
❑ Halcinonide (Halog)

**Very high potency**:
❑ Augmented betamethasone dipropionate (Diprolene)
❑ Clobetasol propionate (Temovate)
❑ Diflorasone diacetate (Psorcon)
❑ Halobetasol propionate (Ultravate)

**Quantity limit requests:**

What is the quantity requested per MONTH? _____

**What is the reason for exceeding the plan limitations?**

❑ Patient requires a larger quantity to cover a larger surface area
❑ Other: _____

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# Antipsoriatic Agents Prior Authorization Request Form (Page 2 of 2)

**Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?**

Please note: This request may be denied unless all required information is received.

**Please fax this form to 1-844-712-8129 to initiate a prior authorization review for the member and medication above.**

**Please note: plan benefits may limit or exclude coverage of specific medications including those requested on this form.**

**I certify, to the best of my knowledge, the statements and information provided on this form are factual and correct.**

**Provider/Representative (and Title): _____ Date: _____**

| **PROACT INTERNAL USE ONLY:** | | | | | |
|---|---|---|---|---|---|
| **Clinical Review Decision** | | | | | |
| | **Approved, through** | | | | |
| | **Denied (documentation attached, if necessary)** | | | | |
| **Tracking:** | | | | | |
| 1st Attempt | | 2nd Attempt | | Letter Mailed: | |