North Carolina Department of Health and Human Services
NC Medicaid and NC Health Choice
Immunomodulators Temporary PA Request Form

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

Beneficiary Information
1. Beneficiary Last Name: ____________________________ 2. First Name: __________________

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 beneficiary 18 years old or older? YES___ NO____

11. Does the beneficiary have a diagnosis of moderate to severe Plaque Psoriasis? YES___ NO____

12. Is the beneficiary on any other injectable immunomodulator? YES___ NO____

13. Has the beneficiary been screened for latent tuberculosis infection? YES___ NO____

14. Has the beneficiary been tested with Hep B SAG and Core Ab? YES___ NO____

   Date of lab and result______________________________________________________

15. Has the beneficiary experienced a therapeutic failure/inadequate response with methotrexate? YES___ NO____

16. Is the beneficiary unable to take methotrexate due to contraindications or intolerabilities? YES___ NO____

   Explain______________________________________________________________

17. Does the beneficiary have a body surface area (BSA) involvement of at least 3%? YES___ NO____

   Please list the beneficiary’s BSA (body surface area) of involvement. _________%

18. Does the beneficiary 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- Soriata (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 CSC at: (855) 710-1969 Pharmacy PA Call Center: (866) 246-8505