United Healthcare Community Plan

Cytokine & CAM Antagonists: Oral PDE-4 inhibitors - Washington
Prior Authorization Request Form

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826.**
This form may contain multiple pages. Please complete all pages to avoid a delay in our decision.
Allow at least 24 hours for review.

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance Information (if any):		

Is the requested medication: □ New or □ Continuation of Therapy? If continuation, list start date: _____

Is this patient currently hospitalized? □ Yes □ No If recently discharged, list discharge date: _____

Section B - Provider Information

First Name:		Last Name:		M.D./D.O.
Address:		City:	State:	ZIP code:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax attention to:				

Section C - Medical Information

Medication:	**Strength:**
Directions for use:	**Quantity:**
Diagnosis (Please be specific & provide as much information as possible)**:**	**ICD-10 CODE:**

Is this member pregnant? □ Yes □ No If yes, what is this member's due date? _____

Section D – Previous Medication Trials

Medication Name	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs: Please refer to the patient's PDL for a list of preferred alternatives

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Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information

1. Is this request for a continuation of therapy? ☐ Yes ☐ No
   If yes, does patient have clinical documentation demonstrating disease stability or a positive clinical response? ☐ Yes ☐ No

2. Is this prescribed by, or in consultation with, any of the following? Check all that apply:
   ☐ Dermatologist ☐ Ophthalmologist ☐ Rheumatologist
   ☐ Other. Specify: _____

3. Will the requested medication be used in combination with another Cytokine and CAM medication?
   ☐ Yes ☐ No

4. If request is non-preferred, has patient had treatment with one or more preferred Cytokine and CAM medications on the Apple Health Preferred Drug List (AHPDL) that was ineffective, contraindicated or not tolerated?

☐ Yes. List each medication and duration of trial:

Medication Name: _____ Duration: _____
Medication Name: _____ Duration: _____
Medication Name: _____ Duration: _____

☐ No. Explain why a preferred product(s) have not been tried: _____

5. What is patient current weight: _____kg Date taken: _____

6. Indicate patient's diagnosis and answer the associated questions as indicated:
   ☐ Behcet's disease (questions 7 - 9)
   ☐ Plaque Psoriasis (questions 10 - 14)
   ☐ Psoriatic Arthritis (PsA) (questions 15 - 18)

For diagnosis of Behcet's disease:

7. Does patient have recurrent Behcet Syndrome manifesting as oral ulcers of the mouth?

☐ Yes ☐ No

8. Has patient had a history of failure, contraindication, or intolerance to the following? Check all that apply:

☐ Topical corticosteroids (e.g., triamcinolone) [minimum trial of 7 days]
☐ Sucralfate mouthwash [minimum trial of 7 days]
☐ Colchicine [minimum trial of 3 months]
☐ Oral corticosteroids (e.g., prednisone) [minimum trial of 1 month]

9. **For continuation of therapy:** Has documentation been submitted demonstrating disease stability or a positive clinical response (e.g., improvement in oral lesions, vitreous haze, visual acuity, corticosteroid usage, etc.)?

☐ Yes ☐ No

For diagnosis of Plaque Psoriasis

10. Does patient have presence of ongoing disease for greater than 6 months? ☐ Yes ☐ No

11. Please indicate the following for patient:
☐ Disease affects at least 10% body surface area ☐ Disease affects the face, ears, hands, feet, or genitalia

12. Have baseline assessments been submitted (e.g., body surface area (BSA), Psoriasis Area and Severity Index (PASI), Psoriasis Physician's Global Assessment (PGA), itch numeric rating scale, etc.)?
☐ Yes ☐ No

13. Has patient had a history of failure, contraindication, or intolerance to the following? Check all that apply:
☐ Phototherapy (UVB or PUVA) [minimum trial of 12 weeks]
☐ Treatment with at least one non-Cytokine and CAM DMARD (e.g., methotrexate, cyclosporine, acitretin, azathioprine, etc.) [minimum trial of 12 weeks]

14. **For continuation of therapy:** Has documentation been submitted demonstrating disease stability or a positive clinical response (e.g., improvement in BSA, PSAI, Psoriasis PGA, itch numeric rating scale)?
☐ Yes ☐ No

For diagnosis of Psoriatic Arthritis

15. Has patient had treatment with at least one non-Cytokine and CAM disease-modifying antirheumatic drug (DMARD) that has been ineffective, contraindicated or not tolerated [minimum trial of 3 months]?
☐ Yes ☐ No

16. Does patient have presence of active, severe disease indicated by provider assessment?
☐ Yes ☐ No

17. Does patient have presence of any of the following? Check all that apply:
☐ Erosive disease
☐ Elevated C-reactive protein (CRP) or erythrocyte sedimentation rate (ESR)
☐ Long-term damage interfering with function (e.g., joint deformities, vision loss)
☐ Major impairment of quality of life due to high disease activity at many sites (including dactylitis, enthesitis) or functionally limiting arthritis at a few sites.

18. **For continuation of therapy:** Has documentation been submitted demonstrating disease stability or a positive clinical response (e.g., improvement in joint pain, swelling, activities of daily living, reduction in diseases flares, etc.)? ☐ Yes ☐ No

CHART NOTES ARE REQUIRED WITH THIS REQUEST		
Prescriber signature	Prescriber specialty	Date