UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

RAPTIVA (efalizumab) Plaque Psoriasis

Patient name:____________________________________Medicaid ID #:________________________________

Prescriber Name:_________________Prescriber NPI#:_____________ Contact person:___________________

Prescriber Phone#:___________________Extension/Option:________________ Fax#:____________________

Pharmacy:______________________Pharmacy Phone#:________________Pharmacy Fax #:______________

Requested Medication:______________________________Strength:__________Frequency/Day:___________

All information to be legible, complete and correct or form will be returned

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FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF MEDICAL NECESSITY TO 855-828-4992 note the new fax number

CRITERIA:

- **Age requirement:** 18 years old and older
- **Diagnosis:** Moderate to severe Plaque Psoriasis.
- History of incomplete response or intolerance to at least one appropriate systemic agent or photo therapy.
- Negative TB skin test or history of treatment for latent TB infection.
- Absence of active bacterial or viral infection, malignancy, or immunosuppressive condition.
- Dermatology consultation within the last 60 days.
- Documented failure on or intolerance to a preferred product (Enbrel, Humira, or Cimzia).
- Raptiva may not be given with other biologic agents

NOTES:

Available as a Non-Traditional Medicaid Benefit.

AUTHORIZATION:

1 year

RE- AUTHORIZATION:

An updated letter of medical necessity or progress notes showing improvement or maintenance with medication.

09/20/10