Siliq (brodalumab)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

MEMBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PHONE NUMBER:	**DATE OF BIRTH:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
PATIENT INSURANCE ID NUMBER:	

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: PRIMETHERAPEUTICS.COM/NOPP

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____

AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**
NPI NUMBER:	**DEA NUMBER:**
PHONE NUMBER:	**FAX NUMBER:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
REQUESTOR (if different than prescriber)**:**	**OFFICE CONTACT PERSON:**

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL** DURATION OF THERAPY (SPECIFIC DATES):		**IF RENEWAL:** DATE THERAPY INITIATED:	

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1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ YES (if yes, complete below) ☐ NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE)**:**	**DURATION OF THERAPY** (SPECIFY DATES)**:**	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
☐ Plaque psoriasis ☐ Other Diagnosis_____ICD-10 Code(s):_____	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Clinical information:

Is drug being used as part of a clinical trial? ☐ Yes ☐ No

Initial Request:

Will the patient be using Siliq concurrently with another biologic response modifier or other immunomodulatory agent? ☐ Yes ☐ No

Has the patient had a 3-month trial and inadequate response to the biosimilar for Humira-adalimumab-aacf? ☐ Yes ☐ No*Must provide documentation, including trial dates.*

Does patient have a absolute contraindication to the biosimilar for Humira-adalimumab-aacf ? ☐ Yes ☐ No Please submit documentation

Has the patient tried and had an inadequate response to a 4- month trial of the biosimilar for Stelara-Otulfi(ustekinumb-aauz)? ☐ Yes ☐ No Please submit documentation.

Does patient have a absolute contraindication to the biosimilar for Stelara-Otulfi(ustekinumb-aauz)? ☐ Yes ☐ No Please submit documentation.

Is prescriber a dermatologist? ☐ Yes ☐ No

Does the patient have plaques covering at least 10% of their body surface area (BSA) or less than 10% of BSA with involvement of palms, soles, head and neck, or genitalia which cause disruption of normal activities? ☐ Yes ☐ No

Has the patient had an inadequate response to topical therapy (e.g., corticosteroids, anthralin, calcipotriene, tazarotene)? ☐ Yes ☐ No
Must provide documentation, including trial dates.

Select if the patient has had a trial and inadequate response to the following phototherapy options:
☐ Psoralens with UVA light (PUVA) ☐ UVB with coal tar

Select if the patient has had a trial and inadequate response to the following systemic therapies:
☐ Acitretin ☐ Cyclosporine ☐ Methotrexate

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Must provide documentation, including trial dates.

Does the patient have documentation of a contraindication to all oral systemic therapies? □ Yes □ No
Must provide documentation.

Renewal Request:
Is prescriber a dermatologist? □ Yes □ No

Is patient continuing to respond to therapy? □ Yes □ No ***Please submit documentation.***

Is patient continuing to respond to therapy? □ Yes □ No ***Please submit documentation.***

Will patient use requested medication in combination with another biologic response modifier or immunomodulatory agent? □ Yes □ No

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: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ **Date:** _____

FAX THIS FORM TO: 800-424-7640
MAIL REQUESTS TO: Prime Therapeutics Management Prior Authorization Program
Attn: CP – 4201
P.O. Box 64811
St. Paul, MN 55164-0811