Cytokine and CAM Antagonists: IL-36 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.

Date of request:	Reference #:	MAS:	
Patient	Date of birth	ProviderOne ID	
Pharmacy name	Pharmacy NPI	Telephone number	Pharmacy name
Prescriber	Prescriber NPI	Telephone number	Prescriber

Medication and strength	Directions for use	Qty/Days supply

1. Is this request for a continuation of existing therapy? ☐ Yes ☐ No
   If yes, is there documentation of a positive clinical response? ☐ Yes ☐ No

2. What is the patient's diagnosis?
   ☐ Generalized Pustular Psoriasis (GPP)
   ☐ Other Specify: _____

3. Provide the following for the patient:
   Indicate disease stage:
   Indicate disease type (i.e. New onset, refractory, etc.):

4. Indicate if prescribed by or in consultation with:
   ☐ Dermatologist ☐ Other Specify: _____

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

6. Is the patient currently experiencing an acute, moderate-to-severe intensity disease flare? ☐ Yes ☐ No

   If yes, please check all that apply:
   - ☐ Generalized Pustular Psoriasis Physician Global Assessment (GPPGA) total score of at least 3
   - ☐ At least 5% body surface area (BSA) covered with erythema and presence of pustules
   - ☐ Presence of fresh pustules
   - ☐ The request is for the intravenous formulation
   - ☐ Other Specify: _____

   If no, please check all that apply:
   - ☐ GPPGA total score of 0 or 1
   - ☐ History of 2 GPP flares of moderate-to-severe intensity with fresh pustulation in the past
   - ☐ The request is for the subcutaneous formulation
   - ☐ Other Specify: _____

7. Indicate for patient: Height (cm): **Date taken:** Weight (kg): **Date taken:** Body surface area (m^2): **Date taken:**		
Chart notes, labs and all diagnostic tests confirming diagnosis are required with this request		
Prescriber signature	Prescriber specialty	Date