

Other:

(3) Chronic to Moderate to Severe Plaque Psoriasis

- Individual is 18 years of age or older and has chronic moderate to severe plaque psoriasis
- Individual failed to respond to, is intolerant of, or has a medical contraindication to phototherapy or other systemic therapies [acitretin, cyclosporine, methotrexate]

Please list therapies tried; _____

- Greater than 5% of the body surface area present with plaque psoriasis **OR**
- Less than or equal to 5% of the body surface area present with plaque psoriasis involving sensitive areas or areas that would significantly impact daily function (e.g. palms, soles of feet, head/neck, or genitalia)
- Other:

(4) Psoriatic Arthritis

- Individual is 18 years of age or older and has active psoriatic arthritis
- Individual has failed to respond to, is intolerant of, or has a medical contraindication to conventional therapy nonbiologic DMARDs such as methotrexate, sulfasalazine (Azulfidine®), hydroxychloroquine (Plaquenil®), corticosteroids ([i.e. hydrocortisone, prednisone), or leflunomide (Arava®)]

Please list therapies tried: _____

Other:

(5) Ankylosing Spondylitis

- Individual is 18 years of age or older and has active ankylosing spondylitis
- Individual has failed to respond to, is intolerant of, or has a medical contraindication to conventional therapy [e.g. nonsteroidal anti-inflammatory drugs (NSAIDS) (e.g., ibuprofen, Motrin®), or nonbiologic DMARDS (methotrexate, sulfasalazine (Azulfidine®), hydroxychloroquine (Plaquenil®), corticosteroids (e.g., hydrocortisone, prednisone)].

Please list therapies tried: _____

Other:

(6) Other (Please submit all supporting documents including labs, progress notes, imaging, etc., for review.)

This request is being submitted:

- Pre-Claim
- Post-Claim. If checked, please attach the claim or indicate the claim number _____

I attest the information provided is true and accurate to the best of my knowledge. I understand that the health plan or its designees may perform a routine audit and request the medical documentation to verify the accuracy of the information reported on this form.

Name & Title of Provider or Provider Representative Completing Form
& attestation (Please Print)*

/ /
Date

***The attestation fields must be completed by a provider or provider representative in order for the tool to be accepted**

Anthem UM Services, Inc., a separate company, is the licensed utilization review agent that performs utilization management services on behalf of your health benefit plan or the administrator of your health benefit plan.