State of Maine Department of Health & Human Services
MaineCare/MEDEL Prior Authorization Form
Psoriasis- Biologicals

Phone: 1-888-445-0497 **www.mainecarepdl.org** Fax: 1-888-879-6938

Member ID #: |__|__|__|__|__|__|__|__|__|__|__| (NOT MEDICARE NUMBER) Patient Name: _____ DOB: _____

Patient Address:_____

Provider DEA: |__|__|__|__|__|__|__|__|__| Provider NPI: __|__|__|__|__|__|__|__|__|__|

Provider Name:_____ Phone:_____

Provider Address:_____ Fax:_____

Pharmacy Name:_____Rx Address:_____Rx phone:_____

Provider must fill all information above. It must be legible, correct and complete or form will be returned.

(Pharmacy use only): NPI: __|__|__|__|__|__|__|__|__|__| NABP: |__|__|__|__|__|__|__| NDC: |__|__|__|__|__|__|__|__|__|__|__|

Enbrel and Humira are preferred if prior trial of at least one of the following is in member's drug profile: methotrexate, cyclosporine, methoxsalen or acitretin.

Drug Name	Strength	Dosage Instructions	Quantity	Days Supply (34 retail / 84 mail order)	Circle Refills
❑ Enbrel (8)	**50**	**BIW**	**8**	**28**	1 2 3 4 5
❑ Amevive® (8)					1 2 3 4 5
❑ Stelara (8)					1 2 3 4 5
❑ Other					1 2 3 4 5

Medical Necessity Documentation

1.) Diagnosis: _____

2.) Requirements: **(Must meet ALL requirements)**

- ❑ Must have topical or systemic psoriasis treatment in history within past 6 months
- ❑ Failed trial of Enbrel (for Amevive)
- ❑ Several topicals (list): _____
  _____
- ❑ Oral agent (list): _____
  _____
- ❑ Phototherapy UVA_____
  _____

3.) Enbrel (high dose)

- ❑ Met all requirements listed above
- ❑ Failure on Enbrel 25mg BIW or 50mg QW dosing
- ❑ High dose Enbrel 50mg BIW will be allowed 12 weeks approval only after failure of all traditional psoriasis therapies.

Pursuant to the MaineCare Benefits Manual, Chapter I, Section 1.16, The Department regards adequate clinical records as essential for the delivery of quality care, such comprehensive records are key documents for post payment review. Your authorization certifies that the above request is medically necessary, meets the MaineCare criteria for prior authorization, does not exceed the medical needs of the member and is supported in your medical records.

Provider Signature: _____ Date of Submission: _____

***MUST MATCH PROVIDER LISTED ABOVE**