BlueCross BlueShield of North Carolina | HealthyBlue

Immunomodulators: Plaque Psoriasis - Pediatric Prior Authorization Form (Enbrel, Stelara, and Taltz)

Member Information		
1. Member last name:	2. Member first name:	
3. Member ID #:	4. Member date of birth:	5. Member gender:
Prescriber Information		
6. Prescribing provider NPI#:		
7. Requester contact information		
Name:		
Phone:	Ext:	
Drug Information		
8. Drug name:	9. Strength:	
10. Quantity per 30 days:		
11. Length of therapy (in days): ☐ up to 30 days ☐ 60 days ☐ 90 days ☐ 120 days ☐ 180 days ☐ 365 days ☐ Other:		
Clinical Information		
1. Is the member age 6 or older? ☐ Yes ☐ No		
2. Does the member have a diagnosis of moderate to severe Plaque Psoriasis and is a candidate for systemic therapy or phototherapy? ☐ Yes ☐ No		
3. Is the member on any other injectable immunomodulator? ☐ Yes ☐ No		
4. Has the member been screened for latent tuberculosis infection? ☐ Yes ☐ No		
5. Has the member been tested with Hep B SAG and Core Ab? ☐ Yes ☐ No		
6. Has the member experienced a therapeutic failure or inadequate response with, or has a contraindication or intolerance to methotrexate? ☐ Yes ☐ No		
7. Does the member have a body surface area (BSA) involvement of at least 3%? ☐ Yes ☐ No		
8. Does the member have involvement of the palms, soles, head and neck, or genitalia; causing disruption in normal daily activities and/or employment? ☐ Yes ☐ No		
9. Has the member tried and failed Enbrel? ☐ Yes ☐ No		
9a. If no, please provide the clinical reason why the member has not tried Enbrel:		
Signature of prescriber:	Date:	
(Prescriber signature mandatory) I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.		

Fax this form to **844-376-2318**
Healthy Blue Pharmacy PA Call Center: **844-594-5072**

https://provider.healthybluenc.com

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