pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

SILIQ (brodalumab) [non-preferred] PRIOR AUTHORIZATION FORM

Cytokine and CAM Antagonists and **Quantity Limits/Daily Dose Limits** prior authorization guidelines are accessible on the DHS Pharmacy Services website at http://www.dhs.pa.gov/provider/pharmacyservices/index.htm.

PRIOR AUTHORIZATION REQUEST INFORMATION		PRESCRIBER INFORMATION	
☐New request ☐Renewal request	# of pages: _________	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
BENEFICIARY INFORMATION		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Product requested: ☐Siliq 210 mg/1.5 ml syringe	☐Siliq: ___________________________		
Directions:		Quantity:	Refills:
Diagnosis (*submit documentation*):		Diagnosis code (*required*):	
Siliq is part of the DHS Specialty Pharmacy Drug Program and is only available from of one of the two DHS specialty pharmacies – Walgreen's Specialty Pharmacy.			

INITIAL requests

1.	Check all that apply to the beneficiary and *submit documentation for each*. ☐vaccinated for hepatitis B ☐screened for hepatitis B (surface antigen & core antibody) ☐has been using Siliq in the past 90 days ☐screened for tuberculosis ☐up-to-date with all age-appropriate immunizations		
2.	Did the beneficiary undergo a mental health evaluation?	☐Yes ☐No	*Submit documentation.*
3.	Is the prescriber enrolled in the Siliq REMS Program?	☐Yes ☐No	*Submit documentation.*
4.	Is the beneficiary authorized to receive Siliq by the Siliq REMS Program?	☐Yes ☐No	*Submit documentation.*
5.	If the beneficiary has a history of prior suicide attempt, bipolar disorder, or major depressive disorder, was the beneficiary evaluated and treated by a psychiatrist?	☐Yes ☐No or n/a	*Submit documentation.*
6.	***Plaque psoriasis:*** Does at least one of the following apply to the beneficiary? ☐at least 5% of body surface area (BSA) is affected ☐critical areas of the body are involved (face, palms, soles, and/or genitals)	☐Yes ☐No	*Submit documentation.*
7.	***Plaque psoriasis:*** Does the beneficiary have a history of trial and failure, contraindication, or intolerance of a 3-month trial of phototherapy? *Check all that apply.* ☐PUVA ☐UVB light ☐other: _______________	☐Yes ☐No	*Submit documentation of all treatments tried and outcomes.*
8.	***Plaque psoriasis:*** Does the beneficiary have a history of trial and failure, contraindication, or intolerance of the following medications? *Check all that apply.* ☐acitretin ☐cyclosporine ☐methotrexate	☐Yes ☐No	*Submit documentation of all medications tried and outcomes.*
9.	***Plaque psoriasis:*** Does the beneficiary have a history of trial and failure, contraindication, or intolerance of the preferred agents? *Check all that apply.* ☐Cosentyx ☐Humira	☐Yes ☐No	*Submit documentation of all medications tried and outcomes.*
10.	***For a diagnosis other than the approved indication(s)***, submit documentation supporting the use of Siliq for the beneficiary's diagnosis & other treatments tried.		

RENEWAL requests

1.	Since starting Siliq, did the beneficiary experience a positive clinical response and/or improved level of functioning?	☐Yes ☐No	*Submit documentation of clinical response.*
2.	If the Beneficiary has a history of prior suicide attempt, bipolar disorder, or major depressive disorder, does the Beneficiary continue to receive treatment?	☐Yes ☐No or n/a	*Submit documentation.*

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	**Date**:

Confidentiality Notice: The documents accompanying this telecopy may contain confidential information belonging to the sender. The information is intended only for the use of the individual named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking of any telecopy is strictly prohibited.