

2. Does the patient have a diagnosis of **moderate to severe plaque psoriasis**? Yes No

AND

Is this for initial therapy (i.e., is patient naïve to this medication)? Yes No

If no, did the patient achieve or maintain clear or minimal disease or experience a decrease in PASI (Psoriasis Area and Severity Index) of at least 50% or more? Yes No

AND

Does the plaque psoriasis involve at least 10% body surface area (BSA) or are there psoriatic lesions affecting the hands, feet, or genital area? Yes No

AND

Has this medication been prescribed by or in consultation with a dermatologist? Yes No

AND

Is this patient a candidate for phototherapy or systemic therapy? Yes No

AND

Has the patient tried or have a contraindication to at least **ONE** of the following preferred therapies?

PUVA (Phototherapy Ultraviolet Light A) Yes No

UVB (Ultraviolet Light B) Yes No **If yes**, describe the response/reaction or CI to that treatment below:

topical corticosteroids Yes No _____

acitretin Yes No _____

calcipotriene Yes No _____

methotrexate Yes No _____

cyclosporine Yes No

3. Please attach additional information which may indicate **why this specific medication** is being requested for this patient.