Soriatane
(acitretin)

Express Scripts
Prior Authorization
Phone 800-417-8164
Fax 877-837-5922

Please have the information below ready when calling in the authorization.

Member's Last Name	Member's First Name
SCAN ID number	Date of Birth
Prescriber's Name	Contact Person
Office phone	Office Fax

Medication:	Diagnosis:

1. **Is the indication for the treatment of severe psoriasis in adults?**

2. **Has the patient tried and failed a 3-month trial of formulary topical corticosteroids for the current condition (For example: betamethasone, hydrocortisone, triamcinolone, alclometasone, fluticasone, mometasone, desonide, fluocinolone, or clobetasol)?**

3. **Are there any other comments, diagnoses, symptoms, and/or any other information the caller feels is important to this review?**

Notice: **Failure to provide all information requested on this form may result in delayed processing or an adverse determination for insufficient information.** Our response time for prescription drug coverage requests is 72 hours. View our formulary and Prior Authorization forms online at http://www.scanhealthplan.com.