



**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
VH ID number	Date of Birth
Prescriber's Name	Contact Person
Office phone	Office Fax

Medication:	Diagnosis:
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<b>1. Is the patient diagnosed with psoriasis?</b>
<b>2. Has the patient tried and failed a 3-month trial of topical corticosteroids? If so, please specify the names and dates.</b>
<b>3. Are there any other comments, diagnoses, symptoms, relevant lab values, and/or additional pertinent information that you feel is important to this review?</b>

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>.