

**Physician's Prior Authorization Questionnaire
Vectical™**

Patient:

ID#:

DOB:

Patient Address:

Vectical™ is covered under certain clinical conditions. The following information will help determine if this patient is eligible for coverage of treatment with this drug.

1. What is the patients diagnosis? (*Please do not use codes and be specific. Psoriasis is not specific.*)

2. The patient's disease is: Mild Moderate Severe

3. Is the patient 18 years of age or older? Yes No

4. Does the patient have erythrodermic, exfoliative, or pustular psoriasis? Yes No

5. What percent of the patient's body surface area is involved? _____ %

Physician's Signature

Date

Please **Print** Physician's Name & Specialty

Phone Number

Fax Number

Thank you for your assistance and should you have any questions or wish to discuss, please feel free to contact the pharmacy department at (501) 378-3392. For your convenience, you may fax your response(s) back to (501) 378-6980.

Forms are also available online at www.usableadmin.com/providers/PharmacyForms.aspx