PriorityHealth

Medicaid Pharmacy Prior Authorization Form

Fax completed form to: 877-974-4411 toll free, or 616-942-8206

Otezla® (apremilast)

Patient Information

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Prescriber Information

Prescriber Name: _____ Phone: _____ Fax: _____

Prescriber Address: _____

Prescriber NPI: _____ Office Contact Name: _____

Prescriber Signature: _____ Date: _____

Product Information

Requested Drug:

- ☐ Otezla 30mg tablet
- ☐ Otezla 14-day Starter Pack
- ☐ Otezla 28-day Starter Pack

Requested dose: _____

Requested frequency: _____

Clinical Documentation

A. This request is for:

- ☐ New therapy
- ☐ Continuation of therapy

When did the patient first start using this medication? _____

B. What diagnosis is this drug being requested for? _____

C. What medications has the patient previously used for this condition?

Drug	Dose	Dates	Clinical Outcome

D. Supporting Information:

_____

_____

_____

_____

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All fields must be complete and legible for review. Your office will receive a response via fax.

Last reviewed 12/2019

Otezla Drug Policy

Criteria contained in this policy only applies to drugs covered on the Priority Health Medicaid formulary. Before coverage of the requested medication is approved, all the following requirements must be met. Documentation supporting the following criteria must be included with this request.

- Must be prescribed by, or in consultation with, a rheumatologist or dermatologist.
- Patient must not use this medication in combination with additional biologic DMARD therapy.
- Patient must be age 18 years or older

Initial Criteria

Psoriatic Arthritis (PsA)
- Trial and clinical failure with at least one non-biologic DMARD (methotrexate, sulfasalazine, cyclosporine, hydroxychloroquine or leflunomide) for at least 90 consecutive days

Plaque Psoriasis
- Clinically diagnosed with moderate to severe chronic Plaque Psoriasis
- Involvement of greater than 10% of body surface area (unless hands, feet, head, neck, or genitalia are involved)
- Trial and clinical failure with at least one topical agent
- Trial and clinical failure with methotrexate for at least 3 consecutive months
- Trial and clinical failure with at least one topical agent plus one additional systemic treatment (acitretin, cyclosporine)
- Trial and clinical failure with UVB or PUVA therapy or contraindication to therapy

Continuation Criteria
- Must be prescribed for one of the diagnosis listed above.
- Documentation showing the patient has experienced symptomatic improvement or maintained stable clinical status.

Additional Information
- Approvals for both initial therapy and continuation of therapy will be issued for 2 years.
- Therapy may be discontinued if patient is noncompliant with medical or pharmacologic therapy **OR** no demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.
- If a contraindication or intolerance to a qualifying medication exists, detailed supporting documentation must be submitted.

Note: Authorization for indications, dosing, or a route of administration not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the appropriateness of the drug, the dosing of the drug, or the route of administration to be used for the identified indication.

All fields must be complete and legible for review. Your office will receive a response via fax. Last reviewed 12/2019