Pharmacy Prior Authorization Form

For Prior Authorization, please fax to: 877 974-4411 toll free, or 616 942-8206

This form applies to: ☐ **Commercial (Traditional)** ☐ **Commercial (Individual/Optimized)** ☒ **Medicaid**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Otezla® (apremilast)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____

Provider Address: _____

Provider NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Product Information

☐ New request ☐ Continuation request

Drug product: ☐ Otezla starter pack
☐ Otezla 30 mg tablet

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Dosing frequency: _____

OTEZLA COVERAGE POLICY

- Otezla will not be covered in combination with another biologic drug.
- Must be 18 years and older
- Please provide rationale when requesting any dose or dosing interval not listed in the FDA label.

Initiation Criteria

Specific Initiation Criteria for Individual Diagnoses:

1. Plaque Psoriasis – moderate to severe
   - **a)** Involvement of greater than 10% of body surface area (unless hands, feet, head, neck of genitalia are involved); AND
   - **b)** Trial and failure of at least one topical agent; AND
   - **c)** Trial and failure of UVB or PUVA therapy or contraindication to therapy; AND
   - **d)** Trial and failure of methotrexate for at least 3 consecutive months or contraindication/intolerance to methotrexate, AND
   - **e)** Trial and failure of at least one additional systemic treatment (azathioprine, cyclosporine, or acitretin) or contraindication/intolerance to systemic treatment

2. Psoriatic Arthritis
   - **a)** Trial and failure of methotrexate for at least 3 consecutive months in the previous 120 day period or contraindication/intolerance to methotrexate; AND

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

Updated 02/2018
Last reviewed 05/2019

b) Trial and failure of one additional non-biologic DMARD (such as leflunomide, hydroxychloroquine, or sulfasalazine) as sequential monotherapy for 3 months each OR in combination with methotrexate for at least 3 months unless contraindication/intolerance.

Priority Health Precertification Documentation

A. What condition is this drug being requested for?

- ☐ Plaque psoriasis
- ☐ Psoriatic arthritis
- ☐ Other – the patient's condition is: _____

Rationale for use: _____

B. Which of the following has the patient had a documented therapeutic trial with (please fill in dates of use)?

- ☐ Topical agent, please list which drug used: _____ dates of use: _____
- ☐ Methotrexate, dates of use: _____
- ☐ Azathioprine, dates of use: _____
- ☐ Acitretin, dates of use: _____
- ☐ Cyclosporine, dates of use: _____
- ☐ Sulfasalazine, dates of use: _____
- ☐ Leflunomide, dates of use: _____
- ☐ Hydroxychloroquine, dates of use: _____
- ☐ PUVA/UVB, dates of use: _____
- ☐ Other, please list: _____

C. Will the patient be receiving other biologic therapy in combination with Otezla?

☐ No ☐ Yes, rationale for use: _____

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