# Priority Health Medicare prior authorization form

**Fax completed form to: 877.974.4411 toll free, or 616.942.8206**

This form applies to: ☐ **Medicare Part B** ☒ **Medicare Part D**
This request is: ☐ **Expedited request** ☐ **Standard request**

Your request will be expedited if you haven't gotten the prescription and Priority Health Medicare determines, or your prescriber tells us, that your life or health may be at risk by waiting.

# 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 30 mg tablet
☐ Otezla Titration Pack

**Start date** (or date of next dose): _____
**Date of last dose** (if applicable): _____
**Dosing frequency:** _____

## Precertification Requirements

The following requirements need to be met before this drug is covered by Priority Health Medicare. These requirements have been approved by the Centers for Medicare and Medicaid Services (CMS), but you may ask us for an exception if you believe one or more of these requirements should be waived.

**Before this drug is covered, the patient must meet all of the following criteria:**

1. Must have plaque psoriasis or psoriatic arthritis
    a. For plaque psoriasis, must first try one systemic non-biologic treatment (i.e. cyclosporine, cyclosporine modified methotrexate, methylprednisolone, prednisone, or Soriatane)
    b. For psoriatic arthritis, must first try one non-biologic DMARD (i.e. methotrexate, sulfasalazine, hydroxychloroquine, leflunomide, azathioprine, or cyclosporine)

## Medically accepted indication

This drug is only covered under Medicare Part D when it is used for a medically accepted indication. A medically accepted indication is a use of the drug that is *either*:

- approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)
- — *or* — supported by certain reference books. (These reference books are the American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and the USPDI or its successor.)


**All fields must be complete and legible for review. Your office will receive a response via fax.** No changes made since 01/2017
Last reviewed 05/2019

## Priority Health Precertification Documentation

**A. What condition is this drug being requested for?**

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

**B. Patient had a therapeutic trial and clinical failure with one of the following:**

| Category | Drug | Dates of Use |
|---|---|---|
| Traditional non-biologic systemic DMARDs & immunosuppressives | ☐ Acitretin ☐ Leflunomide<br>☐ Azathioprine ☐ Methotrexate<br>☐ Cyclosporine ☐ Sulfasalazine<br>☐ Hydroxychloroquine | _____<br>_____<br>_____<br>_____ |
| Corticosteroids | ☐ Methylprednisolone ☐ Prednisone | _____<br>_____ |
| Other (please specify) | ☐ _____<br>☐ _____ | _____<br>_____ |

## **Priority Health** Medicare exception request

**Do you believe one or more of the prior authorization requirements should be waived?** ☐ Yes ☐ No
If yes, you must provide a statement explaining the medical reason why the exception should be approved.

**Would Otezla likely be the most effective option for this patient?**

☐ No
☐ Yes, because: _____

_____

_____

**If the patient is currently using Otezla, would changing the patient's current regimen likely result in adverse effects for the patient?**

☐ No
☐ Yes, because: _____

_____

_____


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