PriorityHealth

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 Starter Pack

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

Prior authorization criteria

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.

For this drug to be covered, the patient must meet the following criteria:

1. Must be used for a medically accepted indication*
2. For moderate to severe plaque psoriasis:
   - Must try one systemic non-biologic treatment (cyclosporine, cyclosporine modified, methotrexate, methylprednisolone, prednisone, or acitretin [Soriatane]).
3. For psoriatic arthritis:
   - Must try one non-biologic DMARD (methotrexate, sulfasalazine, hydroxychloroquine, leflunomide, azathioprine, cyclosporine)
4. For oral ulcers associated with Behcet's disease:
   - Must have tried one other systemic therapy (colchicine, systemic corticosteroids, azathioprine, thalidomide, interferon alpha, tumor necrosis factor inhibitors)

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 08/2020
Last reviewed 08/2020

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 Lexi-Drugs.)

Additional information

Note: When criteria are met, coverage duration is 1 year

Priority Health Precertification Documentation

A. What condition is this drug being requested for?

☐ Plaque psoriasis, moderate to severe

1. **Has the patient tried 1 systemic non-biologic treatment (cyclosporine, cyclosporine modified, methotrexate, methylprednisolone, prednisone, or acitretin)?**
   - ☐ Yes.
   - ☐ No. **Are you asking for an exception to this requirement?**
     - ☐ Yes. ***Rationale for exception***: _____
     - ☐ No

☐ Psoriatic arthritis, active

1. **Has the patient tried 1 non-biologic DMARD (methotrexate, sulfasalazine, hydroxychloroquine, leflunomide, azathioprine, cyclosporine)?**
   - ☐ Yes.
   - ☐ No. **Are you asking for an exception to this requirement?**
     - ☐ Yes. ***Rationale for exception***: _____
     - ☐ No

☐ Treatment of oral ulcers associated with Behcet's disease

1. **Has the patient tried 1 one other systemic therapy (colchicine, systemic corticosteroids, azathioprine, thalidomide, interferon alpha, tumor necrosis factor inhibitors)?**
   - ☐ Yes.
   - ☐ No. **Are you asking for an exception to this requirement?**
     - ☐ Yes. ***Rationale for exception***: _____
     - ☐ No

☐ Other – the patient's condition is: _____

Rationale for other use: _____

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Priority Health Medicare Exception Request *(exceptions to the above criteria)*

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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