



Request for Prior Authorization
APREMILAST (OTEZLA®)

(PLEASE PRINT - ACCURACY IS IMPORTANT)

Form with fields for IA Medicaid Member ID #, Patient name, DOB, Patient address, Provider NPI, Prescriber name, Phone, Prescriber address, Fax, Pharmacy name, Address, Phone, Pharmacy NPI, Pharmacy fax, NDC.

Prior authorization is required for apremilast (Otezla®). Payment will be considered under the following conditions: 1) Patient is 18 years of age or older; and 2) Patient has a diagnosis of active psoriatic arthritis (≥ 3 swollen joints and ≥ 3 tender joints) with documentation of a trial and inadequate response to therapy with the preferred oral DMARD, methotrexate (leflunomide or sulfasalazine may be used if methotrexate is contraindicated); or 3) Patient has a diagnosis of moderate to severe plaque psoriasis and has documentation of a trial and inadequate response to phototherapy, systemic retinoids, methotrexate, or cyclosporine; and 4) Patient does not have severe renal impairment (CrCl < 30mL/min); and 5) Patient has documentation of trials and therapy failures with two preferred biological agents indicated for the submitted diagnosis. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

Non-Preferred

Form with checkboxes for Otezla and columns for Strength, Dosage Instructions, Quantity, Days Supply.

Diagnosis: _____

Does patient have severe renal impairment (CrCl < 30mL/min)? [] Yes [] No (attach labs)

[] Psoriatic Arthritis

Treatment failure with oral methotrexate (leflunomide or sulfasalazine if methotrexate is contraindicated):

Drug Name & Dose: _____ Trial dates: _____

Reason for failure: _____

[] Plaque Psoriasis

Treatment failure with phototherapy, systemic retinoids, methotrexate, or cyclosporine:

Drug Name & Dose: _____ Trial dates: _____

Reason for failure: _____

Treatment failure with two preferred biological agents indicated for the submitted diagnosis:

Trial 1: Drug name & dose: _____ Trial dates: _____

Reason for failure: _____

Trial 2: Drug name & dose: _____ Trial dates: _____

Reason for failure: _____

Possible drug interactions/conflicting drug therapies: _____

Attach lab results and other documentation as necessary.

Form with fields for Prescriber signature (Must match prescriber listed above.) and Date of submission.

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.