pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

OTEZLA (apremilast) [non-preferred] PRIOR AUTHORIZATION FORM

Cytokine and CAM Antagonists and **Quantity Limits/Daily Dose Limits** prior authorization guidelines: http://www.dhs.pa.gov/provider/pharmacyservices/index.htm.

PRIOR AUTHORIZATION REQUEST INFORMATION		PRESCRIBER INFORMATION	
☐New request ☐Renewal request	# of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
BENEFICIARY INFORMATION		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Product requested: **Otezla**	Strength or package requested:	Pre-treatment weight: _____ lbs/kg	Current weight: _____ lbs/kg
Directions:		Quantity:	Refills:
Diagnosis (*submit documentation*):		Diagnosis code (*required*):	

1. **Specialty Pharmacy Drug Program:** Which specialty pharmacy will be used?	☐Diplomat Specialty	☐Walgreen's Specialty
2. Is the beneficiary taking a strong cytochrome P450 enzyme inducer?	☐Yes ☐No	*Submit beneficiary's medication list.*
3. Does the beneficiary have documentation of recent renal function monitoring?	☐Yes ☐No	*Submit lab test results.*

INITIAL requests – complete questions applicable to beneficiary's diagnosis

1. ***All diagnoses:*** Did the beneficiary undergo a mental health evaluation?	☐Yes ☐No	*Submit documentation.*
2. ***All diagnoses:*** If the beneficiary has a history of prior suicide attempt, bipolar disorder, or major depressive disorder, was the beneficiary evaluated and treated by a psychiatrist?	☐Yes ☐No or n/a	*Submit documentation.*
3. ***All diagnoses:*** Has the beneficiary been using Otezla in the past 90 days?	☐Yes ☐No	*Submit documentation.*
4. ***Psoriatic arthritis***: Does the beneficiary have a history of trial and failure, contraindication, or intolerance of the following? ☐4-week trial each of at least 2 different NSAIDs ☐8-week trial of methotrexate/other DMARD *(for peripheral disease only)*	☐Yes ☐No	*Submit documentation of all medications tried and outcomes.*
5. ***Psoriatic arthritis*:** Does the beneficiary have a history of trial and failure, contraindication, or intolerance of the preferred agents? *Check all that apply.* ☐Cosentyx ☐Humira ☐Xeljanz	☐Yes ☐No	*Submit documentation of all drugs tried and outcomes.*
6. ***Plaque psoriasis:*** Does at least one of the following apply to the beneficiary? ☐at least 5% of body surface area (BSA) is affected ☐critical areas of the body are involved (face, palms, soles, and/or genitals)	☐Yes ☐No	*Submit documentation.*
7. ***Plaque psoriasis:*** Does the beneficiary have a history of trial and failure, contraindication, or intolerance of a 3-month trial of the following treatments? *Check all that apply.* ☐PUVA ☐UVB light ☐other: _____	☐Yes ☐No	*Submit documentation of all treatments tried and outcomes.*
8. ***Plaque psoriasis:*** Does the beneficiary have a history of trial and failure, contraindication, or intolerance of the following medications? *Check all that apply.* ☐acitretin ☐cyclosporine ☐methotrexate	☐Yes ☐No	*Submit documentation of all medications tried and outcomes.*
9. ***Plaque psoriasis*:** Does the beneficiary have a history of trial and failure, contraindication, or intolerance of the preferred agents? *Check all that apply.* ☐Cosentyx ☐Humira	☐Yes ☐No	*Submit documentation of all medications tried and outcomes.*
10. ***For all other diagnoses,*** submit documentation supporting the use of Otezla for the beneficiary's diagnosis & other treatments tried.		

RENEWAL requests

1. *Submit documentation of how Otezla has helped the beneficiary's condition and level of functioning AND pre-treatment and current weight.*		
2. If the beneficiary has a history of prior suicide attempt, bipolar disorder, or major depressive disorder, does the Beneficiary continue to receive treatment?	☐Yes ☐No or n/a	*Submit documentation.*

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	**Date**: