

OTEZLA (Non-Preferred)
PRIOR AUTHORIZATION FORM

Otezla is a Non-Preferred agent on the Medical Assistance Preferred Drug List (PDL). To review the prior authorization guidelines, please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter-Cytokine & CAM Antagonists (accessible at: <http://www.dhs.state.pa.us/publications/bulletinsearch/index.htm>).

PRIOR AUTHORIZATION REQUEST INFORMATION

New Renewal Additional Information (PA#: _____)
pages in this request: _____ Office Contact Name: _____ Phone: (____) _____

RECIPIENT INFORMATION

Name: _____ Recipient ID#: _____ Date of Birth: _____

PRESCRIBER INFORMATION

Prescriber Name: _____ Specialty: _____
NPI#: _____ OR MA Provider ID#: _____ State License#: _____
Prescriber Address: _____ Suite #: _____
City/State/Zip: _____ Phone: (____) _____ Fax: (____) _____
Long-term care facility (if applicable) contact name: _____ Phone: (____) _____

MEDICAL INFORMATION

Otezla Strength: _____ Dose: _____ Quantity: _____ Refills: _____

Weight: _____ kg Diagnosis: _____ Diagnosis Code: _____ (Required)

Specialist Type: Dermatologist Rheumatologist Other: _____

Which specialty pharmacy will be used? Diplomat Specialty Pharmacy Walgreens Specialty Pharmacy

INITIAL REQUEST:

Submit documentation of the following:

- Is the recipient up-to-date with immunizations (If less than 21 years old, in accordance with EPSDT guidelines)? Yes No
- Has the Recipient undergone a mental health evaluation? Yes No
- If the Recipient has a history of prior suicide attempt, bipolar disorder, or major depressive disorder, has the Recipient been evaluated and treated by a psychiatrist? Yes No
- Is the Recipient currently taking any potent CYP3A4 inducers (**submit documentation of Recipient's current medications**)? Yes No
- What is Recipient's pre-treatment weight? _____

Plaque Psoriasis: Check all that apply and submit documentation

- At least 10% of the body surface area (BSA) is affected
- Less than 10% of the BSA is affected but involves critical areas of the body (face, palms, soles and/or genitals)
- Tried & failed (or has a contraindication or intolerance to) at least 3 months of treatment with either of the following:
 - PUVA UVB light with either coal tar or dithranol
- Tried & failed (or has a contraindication or intolerance to) any of the following: acitretin cyclosporine methotrexate
- Tried & failed (or has a contraindication or intolerance to) the Preferred agents: Enbrel Humira

Psoriatic Arthritis: Check all that apply and submit documentation

- Tried & failed (or has a contraindication or intolerance to) a 6-week trial of at least 2 NSAIDs: _____
- Tried & failed (or has a contraindication or intolerance to) at least 3 months of treatment with methotrexate or other DMARD:
 - methotrexate Other DMARD: _____
- Tried & failed (or has a contraindication or intolerance to) the Preferred agents: Enbrel Humira

Other Indications: Submit clinical documentation of diagnosis, supporting medical literature, and therapies that have been tried

ALL RENEWAL REQUESTS:

Please **submit documentation** of how Otezla has helped the Recipient's condition & level of functioning, as well as documentation of Recipient's pre-treatment weight and current weight.

PLEASE FAX COMPLETED FORM & SUPPORTING CLINICAL INFORMATION TO DHS – PHARMACY DIVISION

Prescriber Signature: _____ Date: _____

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