PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Otezla (apremilast)

Phone: 800-728-7947 Fax back to: 866-880-4532

The Scott & White Health Plan Pharmacy Department manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:** **Supervising Physician:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. What diagnosis is this drug being prescribed for (pick one)?

☐ Psoriatic arthritis ☐ Psoriasis ☐ Other

Q2. Please provide ICD code(s) for diagnosis.

Q3. Is the prescriber a Rheumatologist?

☐ Yes ☐ No

Q4. Is the prescriber a Dermatologist?

☐ Yes ☐ No

Q5. Is the patient a new start?

☐ Yes ☐ No (please provide start date)

Q6. If for psoriatic arthritis, does the member have documented spinal involvement?

☐ Yes ☐ No

Q7. If for psoriatic arthritis, does the patient have failure of an adequate trial of or clinically significant intolerance to

PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Otezla (apremilast)

Phone: 800-728-7947 **Fax back to: 866-880-4532**

The Scott & White Health Plan Pharmacy Department manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:** **Supervising Physician:**

methotrexate?

☐ Yes ☐ No

Q8. For psoriatic arthritis, does the patient have a CONTRAINDICATION to methotrexate?

☐ Yes ☐ No

Q9. If request is for psoriatic arthritis and patient has a contraindication to methotrexate, does the patient have failure of an adequate trial to the following? Please select all that apply

☐ hydroxychloroquine ☐ sulfasalazine ☐ leflunomide

Q10. If request is for psoriatic arthritis and patient has a contraindication to methotrexate, does the patient have contraindication to the following? Please select all that apply

☐ hydroxychloroquine ☐ sulfasalazine ☐ leflunomide

Q11. Does the patient have moderate to severe plaque psoriasis affecting greater than 10% of body surface area (BSA)?

☐ Yes ☐ No

Q12. Does the patient have moderate to severe plaque psoriasis affecting crucial body areas such as hands, feet, face, or genitals?

☐ Yes ☐ No

Q13. If for psoriasis, has the patient failed an adequate trial of at least TWO TOPICAL treatments [including but not limited to corticosteroids, Vitamin D analogues, Vitamin D analogue/corticosteroid combinations, Tazorac® (tazarotene)]?

☐ Yes ☐ No

Q14. If for psoriasis, does the patient have failure of an adequate trial of or contraindication to phototherapy (UVB or PUVA)?

☐ Yes ☐ No

Q15. If request is for plaque psoriasis, does the patient have failure of an adequate trial to any of the following? Please select all that apply.

☐ methotrexate
☐ cyclosporine

PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Otezla (apremilast)

Phone: 800-728-7947 **Fax back to: 866-880-4532**

The Scott & White Health Plan Pharmacy Department manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:** **Supervising Physician:**

- ☐ acitretin
- ☐ leflunomide
- ☐ sulfasalazine
- ☐ tacrolimus

Q16. If request is for plaque psoriasis, does the patient have contraindication to the following? Please select all that apply.

- ☐ methotrexate
- ☐ cyclosporine
- ☐ acitretin
- ☐ leflunomide
- ☐ sulfasalazine
- ☐ tacrolimus

Q17. Select the agents the patient has failed an adequate trial of at least 8 weeks of, clinically significant intolerance, or contraindication to

- ☐ Enbrel
- ☐ Humira
- ☐ Cimzia
- ☐ Cosentyx
- ☐ Orencia
- ☐ Remicade or Renflexis
- ☐ Simponi
- ☐ Stelara
- ☐ Tremfya
- ☐ Other (please specify)
- ☐ None

Q18. Will Otezla be used in combination with other biologics?

- ☐ Yes
- ☐ No

Q19. Additional Comments

PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Otezla (apremilast)

Phone: 800-728-7947 Fax back to: 866-880-4532

The Scott & White Health Plan Pharmacy Department manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:** **Supervising Physician:**

Prescriber Signature _____ Date _____

□ Expedited/Urgent - By checking this box and signing above, I certify that applying the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function

Lack of the necessary documentation may result in a medical necessity denial. Requesting providers may speak to a SWHP pharmacist or medical director at 1-800-728-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage has been decided.