OPTIMA HEALTH COMMUNITY CARE
AND
OPTIMA FAMILY CARE
(MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **Incomplete form will delay authorization process**.

Drug Requested: **Otezla™** (apremilast)

DRUG INFORMATION: Complete information below or authorization will be delayed.

Drug Form/Strength/Quantity: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable**: _____

CLINICAL CRITERIA: Complete information below or authorization will be delayed**.**

DIAGNOSES: Check the diagnosis below that applies. If boxes are **NOT** checked, the authorization process will be delayed**.**

❑ **Active Psoriatic Arthritis (PsA):** **ALL** appropriate boxes **must** be checked to qualify**.**

- ❑ Patient **must** have diagnosis of psoriatic arthritis.

AND

- ❑ Medication **must** be prescribed by or in consultation with a rheumatologist or dermatologist

AND

- ❑ Not receiving Otezla™ in combination with a biologic DMARD [e.g., Enbrel® (etanercept), Humira® (adalimumab), Simponi® (golimumab), Orencia® (abatacept)]

AND

- ❑ Trial and failure of **TWO (2)** of the following:

❑ Humira®	❑ Enbrel®	❑ methotrexate

❑ **Moderate to Severe Chronic Plaque Psoriasis:** **ALL** appropriate boxes **must** be checked to qualify.

- ❑ Patient **must** have diagnosis of moderate to severe chronic plaque psoriasis

OR

- ❑ **One** of the following criteria **must** be met:
  - ❑ Greater than 10% body surface area involvement
  - ❑ Palmoplantar involvement
  - ❑ Severe scalp psoriasis
- ❑ Medication **must** be prescribed by or in consultation with a dermatologist

(Continued on next page)

AND

- ❑ Must have a previous failure on a topical psoriasis agent and be a candidate for phototherapy or systemic therapy
- ❑ Not receiving Otezla™ in combination with a biologic DMARD [e.g., Enbrel® (etanercept), Humira® (adalimumab), Simponi® (golimumab), Orencia® (abatacept)]

AND

- ❑ Trial and failure of **TWO (2)** of the following:

❑ Humira®	❑ Enbrel®	❑ methotrexate

Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name**:** _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

REVISED/UPDATED: ~~10/31/2018;~~ ~~11/18/2018;~~ **12/9/2018**;