OPTIMA HEALTH PLAN

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. Lines not completed will delay authorization process.

Drug Form/Strength/Quantity: ____

Dosing Schedule: ______________________________ **Length of Therapy**: __________________

Diagnosis: ______________________________ ***ICD Code, if applicable***: __________________

- ***The recommended initial dosage of Otezla™ from Day 1 to Day 5 is a titration. See table below.***

Day 1	**Day 2**		**Day 3**		**Day 4**		**Day 5**		**Day 6 & thereafter**	
AM	**AM**	**PM**	**AM**	**PM**	**AM**	**PM**	**AM**	**PM**	**AM**	**PM**
10 mg	10 mg	10 mg	10 mg	20 mg	20 mg	20 mg	20 mg	30 mg	30 mg	30 mg

***CLINICAL CRITERIA**: ALL appropriate boxes must be checked to qualify or authorization process will be delayed.*

- **Prescriber is a:** ❑ **Dermatologist** ❑ **Rheumatologist**
  - ❑ **Trial and failure of Optima Health preferred *two (2) TNFs*:**
    - ❑ Enbrel® **AND** ❑ Humira®

DIAGNOSES: Check one (1) of the diagnoses below that applies. If boxes are NOT checked, this might affect the outcome and authorization process could be delayed.

❑ **Active Psoriatic Arthritis**

❑ Patient has tried and failed at least **one DMARD** for **at least three (3) months *AND* two (2) TNFs** (***check each tried***):

❑ methotrexate	❑ sulfasalazine	❑ azathioprine
❑ leflunomide	❑ auranofin	❑ hydroxychloroquine
❑ Other ____________________		

OR

❑ **Moderate to Severe Chronic Plaque Psoriasis**

❑ Tried and failure of:

❑ **Phototherapy**
- ❑ **UV Light Therapy**
  - ❑ NB UV-B
  - ❑ PUVA

OR

❑ **Alternative Systemic Therapy**
- ❑ Oral Alternative Systemic Therapy
  - ❑ acitretin
  - ❑ methotrexate
  - ❑ cyclosporine

*****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 #: ____

***Approved by Pharmacy and Therapeutics Committee**: 8/17/2014
REVISED/UPDATED: 8/20/2014; 9/5/2014; 9/29/2014; 11/2/2014; 11/20/2014; 5/22/2015; 12/28/2015; 12/19/2016; **9/22/2017**