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) ***(PREFERRED)***

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***: _____

CLINICAL CRITERIA*: *Complete information below or authorization process 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)]

❑ ***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

AND

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

AND

- ❑ ***One*** of the following criteria ***must*** be met:
  - ❑ Greater than 10% body surface area involvement
  - ❑ Palmoplantar involvement
  - ❑ Severe scalp psoriasis

AND

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

(continued on next page)

*****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~~; ~~8/16/2017~~; ~~12/11/2017~~; ~~1/9/2018~~, **2/26/2018**;