

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):

<input type="checkbox"/> methotrexate	<input type="checkbox"/> sulfasalazine	<input type="checkbox"/> azathioprine
<input type="checkbox"/> leflunomide	<input type="checkbox"/> auranofin	<input type="checkbox"/> hydroxychloroquine
<input type="checkbox"/> Other _____		

OR

- Moderate to Severe Chronic Plaque Psoriasis**
- Tried and failure of:
 - Phototherapy** **OR** **Alternative Systemic Therapy**
 - UV Light Therapy**
 - NB UV-B
 - PUVA
 - 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 #: _____