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*: *Complete information below or authorization process will be delayed.

DIAGNOSES: ***Check one (1) of the diagnoses 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.***

- **Prescriber is or in consultation with:** ❑ **Dermatologist** ❑ **Rheumatologist**

- **Initial Authorization:** ***12 months Prior Authorization***

❑ Trial and failure, contraindication, or intolerance to a 3-month trial of methotrexate.

AND

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

AND

❑ Not receiving Otezla™ in combination with a Janus kinase inhibitor [e.g., Xeljanz® (tofacitinib)/Xeljanz® XR® (tofacitinib xr)]

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

- **Prescriber is or in consultation with a Dermatologist**

- **Initial Authorization:** ***12 months Prior Authorization***

❑ Trial and failure, contraindication, or intolerance to a 3-month trial of methotrexate.

AND

(continued on next page)

❑ Trial and failure of topical therapy for ***at least three (3) months*** with one of the following ***(check each tried)***:

❑ corticosteroids (e.g., betamethasone, clobetasol, desonide)	❑ Vitamin D analogs (e.g., calcitriol, calcipotriene)	❑ tazarotene
❑ calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)	❑ anthralin	❑ coal tar

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

*****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**;