Please note: All information below is required to process this request.
Mon-Fri: 6am to 6pm Eastern / Sat: 6am to 6pm Eastern

Otezla® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Active psoriatic arthritis
❑ Moderate to severe chronic plaque psoriasis
❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical Information:

Has the patient tried and failed at least 3 months of methotrexate? ❑ **Yes** ❑ **No**

Is the patient receiving Otezla in combination with a biologic DMARD [e.g., Enbrel (etanercept), Humira (adalimumab), Simponi (golimumab), Orencia (abatacept)]? ❑ **Yes** ❑ **No**

Select if Otezla is prescribed by one of the following specialists:
❑ Dermatologist ❑ Rheumatologist

For active psoriatic arthritis, also answer the following:

Is the patient receiving Otezla in combination with a Janus kinase inhibitor [e.g., Xeljanz (tofacitinib)/Xeljanz XR (tofacitinib XR)]? ❑ **Yes** ❑ **No**

For moderate to severe chronic plaque psoriasis, also answer the following:

Select if the patient has had trial and failure of topical therapy for at least three (3) months with the following:

❑ Anthralin Coal tar
❑ Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)
❑ Coal tar
❑ Tazarotene
❑ Vitamin D analogs (e.g., calcitriol, calcipotriene)
❑ Corticosteroids (e.g., betamethasone, clobetasol, desonide)

****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.

Prescriber Signature: _____ **Date:** _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

Office use only: Otezla_Optima_2018Feb-W