Otezla (Apremilast)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

MEMBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PHONE NUMBER:	**DATE OF BIRTH:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
PATIENT INSURANCE ID NUMBER:	

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: HTTPS://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI_DISCLOSURE_AUTHORIZATION.PDF

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**
NPI NUMBER:	**DEA NUMBER:**
PHONE NUMBER:	**FAX NUMBER:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
REQUESTOR (if different than prescriber)**:**	**OFFICE CONTACT PERSON:**

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL** **IF RENEWAL:** DATE THERAPY INITIATED: DURATION OF THERAPY (SPECIFIC DATES):			

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MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ YES (if yes, complete below) ☐ NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE):	**DURATION OF THERAPY** (SPECIFY DATES):	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
☐ Plaque psoriasis ☐ Psoriatic arthritis ☐ Recurrent ulcers due to Behcet's disease ☐ Other diagnosis: _____ICD-10_____	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Clinical information:

Is this drug being prescribed to this patient as part of a treatment regimen specified within a sponsored clinical trial? ☐ Yes ☐ No

Has patient had a trial with a conventional DMARD, such as methotrexate, cyclosporine, sulfasalazine/Azulfidine®, leflunamide(Arava), and/or acitretin? ☐ Yes ☐ No

Does patient have a contraindication to a conventional DMARD, such as methotrexate? ☐ Yes ☐ No *Please submit documentation/rationale*.

Has patient had a trial of phototherapy? ☐ Yes ☐ No

If no prior trial of phototherapy, is one planned for this patient before initiating Otezla? ☐ Yes ☐ No *Please submit documentation/rationale*.

Has patient had a trial with Enbrel? ☐ Yes ☐ No

Does patient have a contraindication to Enbrel? ☐ Yes ☐ No

Has patient had a trial with Humira? ☐ Yes ☐ No

Does patient have a contraindication to Humira? ☐ Yes ☐ No

<u>For recurrent ulcers due to Behcet's disease, answer the following</u>:

Has patient had active ulcers at least three times in the past 12 months? ☐ Yes ☐ No *Please submit documentation*.

Is patient positive for at least 2 of the following four findings? ☐ Yes ☐ No *Please submit documentation.*

- ☐ **Genital ulcerations in the form of active genital lesions and/or genital scars**
- ☐ **Skin lesions in the form of erythema nodosum, folliculitis or other non-genital ulcerations**
- ☐ **Eye involvement in the form of anterior uveitis, posterior uveitis, cells in vitreous on slit-lamp examination and/or retinal vasculitis**
- ☐ **Postive pathergy test, as demonstrated by the formation of a sterile pustule 24-48hrs after pinprick**

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Has patient tried and failed at least one nonbiologic therapy for oral ulcers (such as topical glucocorticoids, systemic glucocorticoids, NSAIDs, colchicine or immunosuppressants)? □ **Yes** □ **No** ***Please submit documentation***

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: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ **Date:** _____

FAX THIS FORM TO: 800-424-7640
MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program; c/o Magellan Health, Inc.
4801 E. Washington Street, Phoenix, AZ 85034
Phone: 877-228-7909