Otezla (apremilast)

Prior Authorization of Benefits Form

CONTAINS CONFIDENTIAL PATIENT INFORMATION
Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 1-844-512-9004
Provider Help Desk 1-800-454-3730

1. Patient information	2. Physician information
Patient Name: ______	Prescribing Physician: ______
Patient ID #: ______	Physician Address: ______
Patient DOB: ______	Physician Phone #: ______
Date of Rx: ______	Physician Fax #: ______
Patient Phone #: ______	Physician Specialty: ______
Patient Email Address: ______	Physician DEA: ______
	Physician NPI #: ______
	Physician Email Address: ______

3. Medication	4. Strength	5. Directions	6. Quantity per 30 days
Otezla (apremilast)	______	______	Specify: ______

7. Diagnosis: ______

8. Approval criteria: **CHECK ALL BOXES THAT APPLY**
NOTE: Any areas not filled out are considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request.

□ Yes □ No Patient has a diagnosis of active psoriatic arthritis (≥ 3 swollen joints and ≥ 3 tender joints) **If Yes:**
- □ Yes □ No Patient has documentation* of a trial and inadequate response to therapy with the preferred oral DMARD, methotrexate (leflunomide or sulfasalazine may be used if methotrexate is contraindicated)
- □ Yes □ No Patient has documentation* of trials and therapy failures with two preferred** biological agents used for psoriatic arthritis
- □ Yes □ No Documented* evidence is provided that the use of these agents would be medically contraindicated

□ Yes □ No Patient has a diagnosis of moderate to severe plaque psoriasis **If Yes:**
- □ Yes □ No Patient has documentation* of a trial and inadequate response to phototherapy, systemic retinoids, methotrexate, or cyclosporine
- □ Yes □ No Patient has documentation* of trials and therapy failures with two preferred** biological agents
- □ Yes □ No Documented* evidence is provided that the use of these agents would be medically contraindicated

□ Yes □ No Patient has severe renal impairment (CrCl < 30 mL/min)

□ Yes □ No Patient is 18 years of age or older

CONTINUED ON PAGE 2

Patient Name: ________________________________ **Patient ID#:** ________________________________

9. Physician signature

______________________________ Prescriber or Authorized Signature	______________________________ Date

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

The document(s) accompanying this transmission may contain confidential health information that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation.
If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents.