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Otezla (apremilast) Prior Authorization of Benefits (PAB) Form

CONTAINS CONFIDENTIAL PATIENT INFORMATION
Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 1-844-474-3341.

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 and may affect the outcome of this request.)

□ Yes	□ No	Patient has had a diagnosis of psoriatic arthritis (PsA) and/or moderate to severe plaque psoriasis (Ps) in the last 730 days.
□ Yes	□ No	Patient has had a claim for a strong CYP3A4 inducer in the last 90 days. (PLEASE NOTE: Strong CYP3A4 inducers are Actoplus Met XR, Actos, Aptiom, Atripla, bexarotene, carbamazepine, carbamazepine ER, Carbatrol ER, Dilantin, Duetact, Epitol, Equetro, Intelence, Lysodren, modafinil, Mycobutin, Mysoline, nevirapine, Orkambi, Oseni, phenobarbital, Phenytek, phenytoin, pioglitazone, Priftin, primidone, Provigil, rifabutin, Rifadin, Rifamate, rifampin, Rifater, Sustiva, Tafinlar, Targretin, Tegretol, Tegretol XR, Tracleer, Viramune, Viramune XR and Xtandi.)
□ Yes	□ No	Patient has had a claim for a TNF-blocker or Interleukin-17 (IL-17) inhibitor in the last 30 days. (PLEASE NOTE: TNF-blocker or IL-17 inhibitors are Cimzia, Cosentyx, Enbrel, Humira, Simponi.)
□ Yes	□ No	Patient has had a diagnosis of chronic kidney disease (stage 4 or 5) in the last 365 days.
□ Yes	□ No	Requested dose is less than or equal to 30 mg per day.
□ Yes	□ No	Patient has failed a 30-day treatment trial with at least one preferred agent(s) within the past 180 days. (PLEASE NOTE: The preferred agents include Enbrel and Humira.)
□ Yes	□ No	Patient has a documented allergy or contraindication to preferred agents in this class. (PLEASE NOTE: The preferred agents include Enbrel and Humira.)

□ Yes □ No	Does the client have a diagnosis of oral ulcers associated with Bechet's disease in the last 730 days?

For the Texas Medicaid *Preferred Drug List*, please refer to the Texas Medicaid Vendor Drug Program website at: http://www.txvendordrug.com/formulary/preferred-drugs.shtml.

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.