Otezla XR® (apremilast extended-release)
Prior Authorization Request Form

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

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

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: PRIMETHERAPEUTICS.COM/NOPP

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:**
REQUESTER (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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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 Code(s):	

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

Is patient going to be using drug in combination with a clinical trial? ☐ **Yes** ☐ **No**

Will the patient be on concurrent treatment with another biologic response modifier or other immunomodulatory agent? ☐ **Yes** ☐ **No**

<u>Initial Request</u>:
Is the prescriber a dermatologist? ☐ **Yes** ☐ **No**
Is the prescriber a rheumatologist? ☐ **Yes** ☐ **No**

Has the patient tried and had an inadequate response to a six month trial of Otezla IR? ☐ **Yes** ☐ **No** ***Please submit documentation***
Does the patient have an absolute contraindication to Otezla IR? ☐ **Yes** ☐ **No** ***Please submit documentation***

For <u>plaque psoriasis</u>, also answer the following:

If the patient is 12 years of age or less:
Does the patient have plaques covering 3% or more of their body surface area (BSA)? ☐ **Yes** ☐ **No**
Does the patient have less than 3% BSA, but with involvement of palms, soles, head and neck, or genitalia that causes disruption of normal activities? ☐ **Yes** ☐ **No Please submit documentation.**

If the patient is 13 years of age or older:
Does the patient have plaques covering 10% or more of their body surface area (BSA)? ☐ **Yes** ☐ **No**
Does the patient have less than 10% BSA, but with involvement of palms, soles, head and neck, or genitalia that causes disruption of normal activities? ☐ **Yes** ☐ **No Please submit documentation.**

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Has the patient had a trial and inadequate response to therapy with a conventional disease-modifying antirheumatic agent (DMARD, e.g., methotrexate, acitretin, sulfasalazine/Azulfidine, leflunomide (Arava) or cyclosporine) or phototherapy? ☐ **Yes** ☐ **No** ***Please provide documentation***

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

For <u>psoriatic arthritis</u>, also answer the following:

Has the patient had a trial and inadequate response to therapy with a conventional disease-modifying antirheumatic agent (DMARD, e.g., methotrexate, acitretin, sulfasalazine/Azulfidine, leflunomide (Arava) or cyclosporine? ☐ **Yes** ☐ **No** ***Please provide documentation***

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

For <u>Behcet's disease</u>, also answer the following:
Has the patient had active ulcers at least three times in the past 12 months? ☐ **Yes** ☐ **No** ***Please submit documentation***
Is the 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**

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***
Does the patient have an absolute contraindication to nonbiologic therapy for oral ulcers?
☐ **Yes** ☐ **No** ***Please submit documentation/rationale***

<u>Renewal Request</u>:
Is the patient continuing to have a positive clinical response? ☐ **Yes** ☐ **No** ***Please submit documentation***
Will the patient be on concurrent treatment with another biologic response modifier or other immunomodulatory agent? ☐ **Yes** ☐ **No**

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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:** _____

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FAX THIS FORM TO: 800-424-7640
MAIL REQUESTS TO: Prime Therapeutics Management Prior Authorization Program
Attn: CP-4201
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St. Paul, MN 55164-0811
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