iowa total care | ia health link | Hawki | envolve Pharmacy Solutions

FAX Completed Form To
1.833.404.2392
Pharmacy Help Desk
1.800.460.8988
Prescriber Help Desk
1.833.587.2012

Request for Prior Authorization
APREMILAST (OTEZLA®)

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone

Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.

Pharmacy NPI	Pharmacy fax	NDC

Prior authorization is required for apremilast (Otezla®). Payment will be considered under the following conditions: 1) Patient is 18 years of age or older; and 2) Patient has a diagnosis of active psoriatic arthritis (≥ 3 swollen joints and ≥ 3 tender joints) with 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); or 3) Patient has a diagnosis of moderate to severe plaque psoriasis and has documentation of a trial and inadequate response to phototherapy, systemic retinoids, methotrexate, or cyclosporine; and 4) Patient does not have severe renal impairment (CrCl < 30mL/min);and 5) Patient has documentation of trials and therapy failures with two preferred biological agents indicated for the submitted diagnosis. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

Non-Preferred

☐ Otezla	**Strength**	**Dosage Instructions**	**Quantity**	**Days Supply**
	_____	_____	_____	_____

Diagnosis: _____

Does patient have severe renal impairment (CrCl < 30mL/min)? ☐ Yes ☐ No (attach labs)

☐ **Psoriatic Arthritis**

Treatment failure with oral methotrexate (leflunomide or sulfasalazine if methotrexate is contraindicated):

Drug Name & Dose: _____ Trial dates: _____

Reason for failure: _____

☐ **Plaque Psoriasis**

Treatment failure with phototherapy, systemic retinoids, methotrexate, or cyclosporine:

Drug Name & Dose: _____ Trial dates: _____

Reason for failure: _____

Treatment failure with two preferred biological agents indicated for the submitted diagnosis:

Trial 1: Drug name & dose: _____ Trial dates: _____

Reason for failure: _____

Trial 2: Drug name & dose: _____ Trial dates: _____

Reason for failure: _____

Possible drug interactions/conflicting drug therapies: _____

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission

IMPORTANT NOTE: *In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.*