

**PRIOR AUTHORIZATION REQUEST FORM
OTEZLA® FOR BEHCET'S DISEASE**

For authorization, please answer each question and fax this form PLUS chart notes back to Real Rx at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance 385-425-5094.

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:

Height/Weight:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: Otezla® (apremilast), Otezla® XR (apremilast)

Dosing/Frequency: _____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
1. Is the request by a rheumatologist?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does the member have Bechet's Disease with recurrent oral ulcerations defined as 3 or more ulceration flare ups in a 12-month period?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
3. Has the member tried colchicine at a dose of 1.8mg/day for at least 90 days?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
4. Has the member tried topical steroids (e.g. dexamethasone or betamethasone rinses, triamcinolone acetonide oral paste) for at least 7 days?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation

REAUTHORIZATION

1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does updated documentation show that the member has a continued medical need and that the therapy is tolerable and effective?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.

Additional information:

PRESCRIBER CERTIFICATION

I hereby certify this treatment is indicated, necessary and meets the guidelines for use.

Physician's Signature:

Date:

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Policy: PHARM-169
Origination Date: 11/04/2025
Reviewed/Revised Date: 11/12/2025
Next Review Date: 11/12/2026
Current Effective Date: 12/01/2025

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