

PRIOR AUTHORIZATION REQUEST FORM

Otezla

For authorization, please answer each question and fax this form PLUS chart notes back to RealRx Medicaid Prior Authorization Department 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 Pharmacy Customer Service for assistance.

- Healthy U: 855-856-5694
- Healthy U CHIP: 855-203-3633
- Health Choice Utah: 855-864-1404

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:

Product Requested: Otezla (apremilast)

Directions for Use: _____

| PART I: Criteria for Approval: (All of the following criteria must be met) - Then move to PART II | Yes | No |
|---|--------------------------|--------------------------|
| 1. Is the medication being prescribed by or in consultation with a provider specializing in the disease treatment? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Does the patient have any of the following diagnoses? (check the applicable) <input type="checkbox"/> Oral Ulcers Associated with Behçet's Disease <input type="checkbox"/> Plaque Psoriasis (PsO) <input type="checkbox"/> Psoriatic Arthritis (PsA) <input type="checkbox"/> Rheumatoid Arthritis (RA) <input type="checkbox"/> Other - Off Label or Compendia Use (specify): _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Does the requested medication and diagnosis follow FDA-approved age, dosing, monitoring and contraindications? If answer is No, go to Part II, section 4 | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Does the provider attest that the patient is not taking concurrent treatment or that the medication will not be used in combination with other TNF-inhibitor, biologic response modifier or other biologic DMARDs, Janus kinase Inhibitors, or Phosphodiesterase 4 inhibitor (i.e., apremilast, tofacitinib, baricitinib) as verified by prescriber attestation, member medication fill history, or submitted documentation? | <input type="checkbox"/> | <input type="checkbox"/> |

PART II: Select and fill out applicable sections:

| Section 1: Additional criteria for Oral Ulcers Associated with Behçet's Disease (All of the following criteria must be met) | | |
|---|--------------------------|--------------------------|
| 1. Is the patient at least 18 years of age or older? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Does the patient have a diagnosis of Oral Ulcers Associated with Behçet's Disease demonstrated by description of baseline symptoms present in the chart notes? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Has the patient tried and failed a topical steroid for at least 7 days, unless intolerant or contraindicated? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Has the patient failed treatment of at least ONE conventional immunosuppressant therapy (e.g., systemic corticosteroids, interferon alfa, colchicine)? | <input type="checkbox"/> | <input type="checkbox"/> |
| Section 2: Additional criteria for Plaque Psoriasis (PsO) (All of the following criteria must be met) | | |
| 1. Is the patient at least 6 years of age or older? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Does the patient weigh at least 20 kg? | <input type="checkbox"/> | <input type="checkbox"/> |

| | | |
|---|--------------------------|--------------------------|
| 3. Has the patient been diagnosed with moderate to severe plaque psoriasis involving greater than 3% body surface area? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. If less than 3% of the body is involved, is there scalp, palmar, foot, or groin involvement causing significant disability? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Has the patient tried and failed at least ONE of the following medications for at least 3 months, or does the patient have a contraindication to all 3, if clinically appropriate? <input type="checkbox"/> methotrexate <input type="checkbox"/> cyclosporine <input type="checkbox"/> acitretin therapy | <input type="checkbox"/> | <input type="checkbox"/> |
| Section 3: Additional criteria for Psoriatic Arthritis (PsA) (All of the following criteria must be met) | | |
| 1. Is the patient at least 6 years of age or older? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Does the patient weigh at least 20 kg? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Does the patient have a diagnosis of active psoriatic arthritis demonstrated by description of baseline symptoms present in the chart notes? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Has the patient had an adequate trial and failure of at least ONE of the following disease-modifying antirheumatic drugs (DMARDs) for at least 3 months, unless all are contraindicated: methotrexate, leflunomide, sulfasalazine, azathioprine, if clinically appropriate? | <input type="checkbox"/> | <input type="checkbox"/> |
| Section 4: Other - Off Label or Compendia Use of FDA-Approved Drugs Additional Criterion: | | |
| 1. Does the clinical documentation show an adequate trial and failure with at least ONE FDA-labeled and Medicaid preferred medication, if applicable? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Provider attest the requested drug is being used for a medically accepted indication that is supported by information from the appropriate compendia* of current literature. Including at least (1) major multi-site study or three (3) smaller studies published in JAMA, NEJM, Lancet, or other peer review specialty medical journals in the most recent years? * Compendia use must be recommended by generally accepted compendia such as American Hospital Formulary Service Drug Information (AHFS), United States Pharmacopeia-Drug Information (USP-DI), the Micromedex Information System, Pediatric and Neonatal Lexi-Drugs, or clinical guidelines. | <input type="checkbox"/> | <input type="checkbox"/> |
| Reauthorization | | |
| 1. Has the provider submitted an updated letter with medical justification and updated chart notes demonstrating positive clinical response? | <input type="checkbox"/> | <input type="checkbox"/> |
| PRESCRIBER CERTIFICATION | | |
| I hereby certify this treatment is indicated, necessary and meets the guidelines for use. | | |
| Physician's Signature: | Date: | |

Initial Authorization: Up to six (6) months

Reauthorization: Up to one (1) year

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

Policy: PHARM-HYB-184

Origination Date: 01/01/2026

Reviewed/Revised Date:

Next Review Date:

Current Effective Date: 01/01/2026

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