**Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.**
**Otezla (apremilast) Prior Authorization (PA)**
**Pharmacy Benefits Prior Authorization Help Desk**
**Length of Authorizations: Initial- 6 months; Continuation- 12 months**

**Instructions:**

This form is used by Kaiser Permanente and/or participating providers for coverage of **Otezla (apremilast) .** Please complete and fax this form back to Kaiser Permanente within 24 hours [fax: 1-866-331-2104]. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless this form is complete.**

**KP-MAS Formulary can be found at:** Pharmacy | Community Provider Portal | Kaiser Permanente

## 1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

## 2 – Prescriber Information

Is the prescriber a Rheumatologist or Dermatologist? □ No □ Yes

If consulted with a specialist, specialist name and specialty: _____

Prescriber Name: _____ Specialty: _____ NPI: _____

Prescriber Address: _____

Prescriber Phone #: _____Prescriber Fax #: _____

## 3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #_____ Pharmacy Fax #: _____

## 4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: _____
Sig: _____

Drug 2: Name/Strength/Formulation: _____
Sig: _____

## 5– Diagnosis/Clinical Criteria

1. Is this request for initial or continuing therapy?
   □ Initial therapy □ Continuing therapy, state start date: _____

2. Indicate the patient's diagnosis for the requested medication: _____

**Clinical Criteria:**

**Rheumatology:**

1. Member has diagnosis of active psoriatic arthritis
   □ No □ Yes

2. **AND** documented inadequate response after a 3-month trial or intolerance to TWO non-biologic DMARDs (e.g., methotrexate, leflunomide, sulfasalazine)
   □ No □ Yes

**Dermatology:**

1. Member has diagnosis of moderate to severe plaque psoriasis (>3% body surface area unless palmar-plantar involvement is severe)
   □ No □ Yes

2. **AND** failed at least a 1-month trial of high or ultra-high potency topical corticosteroids, unless clinically significant adverse effects, contraindication or clinical reason to avoid treatment
   □ No □ Yes

3. **AND** failed at least a 3-month trial of **1 of the following** unless clinically significant adverse effects, contraindication or clinical reason to avoid treatment (i.e. pregnancy/breastfeeding, history of alcoholism or alcoholic liver disease, chronic liver disease, immunodeficiency syndrome, pre-existing blood dyscrasia, hemodialysis, or end-stage renal disease):
   - Methotrexate
   - Acitretin
   □ No □ Yes

4. **AND** inadequate response to at least a 3-month trial or contraindication to phototherapy unless involvement in sensitive areas (e.g., face, body folds, etc.)
   □ No □ Yes

**Behcet's Disease:**

1. Diagnosis of Behcet's Disease with mucocutaneous (oral or genital ulcers)
   □ No □ Yes

2. **AND** failed at least a 1-month trial of topical corticosteroids, unless clinically significant adverse effects, contraindication or clinical reason to avoid treatment
   □ No □ Yes

3. **AND** failed at least a 1-month trial of colchicine, unless clinically significant adverse effects, contraindication or clinical reason to avoid treatment
   □ No □ Yes

4. **AND** failed at least a 1-month trial of azathioprine, unless clinically significant adverse effects, contraindication or clinical reason to avoid treatment
   □ No □ Yes

**For continuation of therapy, please respond to <u>additional questions</u> below:**

1. Documentation of positive clinical response to Otezla therapy
   □ No □ Yes

2. **AND** member is not receiving Otezla in combination with either biologic DMARD OR janus kinase inhibitor
   □ No □ Yes

3. **AND** member is NOT using Otezla starter pack for maintenance therapy
   □ No □ Yes

4. **AND** specialist follow-up occurred since last review
   □ No □ Yes

**7 – Prescriber Sign-Off**

**Additional Information –**

1. **Please submit chart notes/medical records for the patient that are applicable to this request.**
2. **If member has not tried preferred agent(s) please provide rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:**

_____

_____

_____

**I certify that the information provided is accurate. Supporting documentation is available for State audits.**

| **Prescriber Signature:** | **Date:** |
|---|---|
| | |