PRIOR AUTHORIZATION REQUEST
Otezla

PATIENT: Name_____
Address: _____
City, State, Zip_____
D.O.B. _____
Member ID:_____

Prescriber: Name_____
Address _____
City, State, Zip_____
Phone _____
Fax _____
NPI _____

Medication Requested: *Otezla* **Qty Requested: _____**

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A Please answer the following questions

1. Is this a request for INITIAL or CONTINUATION of therapy with the requested medication?
   - θ INITIAL → ***please answer questions 2 – 14***
   - θ CONTINUATION → ***please answer questions 15 – 17***
2. What is the indication/diagnosis?
   - θ Psoriatic Arthritis (PsA) → ***please answer questions 3 – 8***
   - θ Plaque Psoriasis → ***please answer questions 9 – 14***
   - θ All other indications/diagnosis ***(please specify):***_____

3.	θ Yes	θ No	Is this medication being prescribed by or in consultation with a rheumatologist?
4.	θ Yes	θ No	Is the patient currently receiving an NSAID and NSAID therapy will be continued when Otezla is initiated?
5.	θ Yes	θ No	Does the patient have a contraindication to NSAID use?
6.	θ Yes	θ No	Does the patient have an active PsA (GREATER THAN or EQUAL TO 3 swollen/tender joins) despite a 3-month trial of an adequate dose of methotrexate?
7.	θ Yes	θ No	Is the patient contraindicated to therapy with methotraxate?
8.	θ Yes	θ No	Does the patient have an active PsA (GREATER THAN or EQUAL TO 3 swollen/tender joins) despite a 3-month trial of an adequate dose of leflunomide or sulfasalazine?
9.	θ Yes	θ No	Is this medication being prescribed by or in consultation with a dermatologist?
10.	θ Yes	θ No	Are the patient's symptoms controlled with topical therapy?

Continued on Page 2

If you have any questions, call: 800-753-2851

PRIOR AUTHORIZATION REQUEST

Otezla

Continued from Page 1

11.	θ Yes	θ No	Does the disease have a significant impact on the patient's physical, psychological or social wellbeing?
12.	θ Yes	θ No	Has the patient failed a 3-month compliant trial with methotrexate or cyclosporine OR has a true contraindication to BOTH methotrexate and cyclosporine?
13.	θ Yes	θ No	Is the patient's condition severe and extensive (for example, MORE THAN 10% of body surface area affected or a PASI score of MORE THAN 10)?
14.	θ Yes	θ No	Has the patient gone through phototherapy that has been ineffective, cannot be used or has resulted in rapid relapse? ***Note: Rapid relapse is defined as GREATER THAN 50% of baseline disease severity within 3 months.***
15.	θ Yes	θ No	Have the patient's symptoms improved by AT LEAST by 20%?
16.	θ Yes	θ No	Has the patient been experiencing depression and/or suicidal thoughts?
17.	θ Yes	θ No	Is the patient's body mass index (BMI), GREATER THAN or EQUAL to 18.5?

Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 877-251-5896

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

If you have any questions, call: 800-753-2851