PRIOR AUTHORIZATION REQUEST

OTEZLA

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

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 note that supporting clinical documentation is required for **ALL** PA requests. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1	Will the requested medication be used in combination with other biologics or with a targeted synthetic disease-modifying antirheumatic drugs (DMARDs)? [Note: Examples of biologics include but not limited to adalimumab SC products (for example, Humira, biosimilars), Actemra (IV or SC), Cimzia, Cosentyx, an etanercept SC product (for example, Enbrel, biosimilars), Ilumya, Skyrizi, Kevzara, Kineret, Orencia (IV or SC), an infliximab IV product (for example, Remicade, biosimilars), a rituximab IV product (for example, Rituxan, biosimilars), Siliq, Stelara (IV or SC), Taltz, Tremfya, Entyvio, or Simponi (Aria or SC). Examples of targeted synthetic disease-modifying antirheumatic drugs (DMARDs) include but	Yes	No

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	not limited to Cibinqo, Olumiant, Rinvoq, Xeljanz, or Xeljanz XR.] [If yes, no further questions.]		
2	Is the request an INITIAL or CONTINUATION of therapy? [] Initial (If checked, go to 8) [] Continuation (If checked, go to 3)		
3	Is the patient currently receiving the requested medication? [If no, skip to question 8.]	Yes	No
4	Has the patient been receiving medication samples for the requested medication? [If yes, skip to question 8.]	Yes	No
5	Does the patient have a previously approved prior authorization (PA) on file with the current plan? [Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If no, skip to question 8.]	Yes	No
6	Has the patient been established on therapy for AT LEAST 3 months? [If no, skip to question 8.]	Yes	No
7	Has documentation been provided to confirm that the patient has had a clinically significant response to therapy, as determined by the prescriber? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
8	What is the indication or diagnosis? [] Behcet's disease (If checked, go to 9) [] Plaque psoriasis (If checked, go to 14) [] Psoriatic arthritis (If checked, go to 21) [] Ankylosing spondylitis (If checked, no further questions) [] Rheumatoid arthritis (If checked, no further questions) [] Other (If checked, no further questions)		
9	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
10	Is the requested medication being prescribed by or in consultation with a rheumatologist or dermatologist? [If no, no further questions.]	Yes	No

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11	Does the patient have oral ulcers or other mucocutaneous involvement? [If no, no further questions.]	Yes	No
12	Has the patient tried AT LEAST TWO other systemic therapies for AT LEAST 3 months OR has documentation been provided to confirm that the patient had an intolerance to AT LEAST TWO systemic agents for Behcet's disease? ACTION REQUIRED: Submit supporting documentation. [Note: Examples of systemic therapies include colchicine, azathioprine, thalidomide, interferon alpha, tumor necrosis factor (TNF) inhibitors (for example, an adalimumab product {Humira, biosimilars}, an etanercept product {Enbrel, biosimilars}, Cimzia {certolizumab pegol subcutaneous injection}, Simponi {golimumab subcutaneous injection}, Simponi Aria {golimumab intravenous infusion}, or an infliximab product {Remicade, biosimilars}).] [If no, no further questions.]	Yes	No
13	Does the requested dose exceed Food and Drug Administration (FDA) approved label dosing for the requested indication? [Note: FDA approved dosing: 10 mg to 30 mg twice daily.] [No further questions.]	Yes	No
14	Is the patient greater than or equal to 6 years of age? [If no, no further questions.]	Yes	No
15	Is the requested medication being prescribed by or in consultation with a dermatologist? [If no, no further questions.]	Yes	No
16	Has the patient tried AT LEAST TWO traditional systemic agents for psoriasis for AT LEAST 3 months OR has documentation been provided to confirm that the patient had an intolerance to AT LEAST TWO traditional systemic agents for psoriasis? ACTION REQUIRED: Submit supporting documentation. [Note: Examples of traditional systemic agents for psoriasis include methotrexate, cyclosporine, and acitretin tablets.] [If no, no further questions.]	Yes	No
17	Has documentation been submitted to confirm that the patient has had treatment failure with daily use of Zoryve for at least 56 consecutive days, or is the patient intolerant, or the medication contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
18	Has the patient tried a preferred tumor necrosis factor (TNF) Inhibitor, an adalimumab product (Hadlima, Simlandi, Yusimry, adalimumab-adbm) for psoriasis for AT LEAST 3 months OR has documentation been provided to confirm that the patient had an intolerance or has a contraindication? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No

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19	Has the patient tried a preferred ustekinumab product (Pyzchiva, Steqeyma, Yesintek,) for psoriasis AT LEAST 3 months OR has documentation been provided to confirm that the patient had an intolerance or has a contraindication? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
20	Does the requested dose exceed Food and Drug Administration (FDA) approved label dosing for the requested indication? [Note: FDA Approved dosing: patients weighing greater than 50 kg: 10 mg to 30 mg twice daily, patients weighing 20 kg to 50 kg: 20 mg twice daily.] [No further questions.]	Yes	No
21	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
22	Has the patient tried AT LEAST TWO conventional synthetic disease-modifying antirheumatic drugs (DMARDs) for AT LEAST 3 months OR has documentation been provided to confirm that the patient had an intolerance to AT LEAST TWO conventional DMARDs? [Note: Examples of conventional synthetic DMARDs include methotrexate (oral or injectable), leflunomide, hydroxychloroquine, and sulfasalazine.] [If no, no further questions.]	Yes	No
23	Has the patient tried a preferred adalimumab product (Hadlima, Simlandi, Yusimry, adalimumab-adbm) for AT LEAST 3 months OR has documentation been provided to confirm that the patient had an intolerance or has a contraindication? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
24	Has documentation been provided to confirm that the patient has had a treatment failure with a preferred ustekinumab product (Pyzchiva, Steqeyma, Yesintek) for AT LEAST 3 months OR has documentation been provided to confirm that the patient had an intolerance or has a contraindication? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
25	Has documentation been provided to confirm that the patient has had a treatment failure with Xeljanz (tofacitinib) for AT LEAST 3 months OR has documentation been provided to confirm that the patient had an intolerance or has a contraindication? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
26	Is the requested medication being prescribed by or in consultation with a rheumatologist or dermatologist? [If no, no further questions.]	Yes	No

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27	Does the requested dose exceed Food and Drug Administration (FDA) approved label dosing for the requested indication? [Note: FDA approved dosing: 10 mg to 30 mg twice daily.]	Yes	No

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: 1-833-896-0656

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.

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