Pharmacy Prior Authorization

AETNA BETTER HEALTH ILLINOIS (MEDICAID)

Otezla (Medicaid)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health Illinois at **1-855-684-5250**.
When conditions are met, we will authorize the coverage of Otezla (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name ***(please circle)***

Otezla (apremilast)

Other, please specify____

Quantity ___________ Frequency ________________ Strength ____________

Route of Administration ___________ Expected Length of therapy _______________

Patient Information

Patient Name: ____________________________________

Patient ID: ____________________________________

Patient Group No.: ____________________________________

Patient DOB: ____________________________________

Patient Phone: ____________________________________

Prescribing Physician

Physician Name: ____

Specialty: ___________________________ NPI Number: _________________________

Physician Fax: ___________________________ Physician Phone: _________________________

Physician Address: ___________________________ City, State, Zip: _________________________

Diagnosis:_____________________________ **ICD Code:**_____________________________

Please circle the appropriate answer for each question.

1. Has this plan authorized Otezla in the past for this patient (i.e., previous authorization is on file under this plan)? Y N

   [If no, skip to question 3.]

2. Has the patient had at least a 20% improvement in symptoms? Y N

   [No further questions.]

3. Does the patient have a diagnosis of severe and extensive plaque psoriasis (i.e., more than 10% of body surface area is affected OR patient has a PASI score of more than 10)? Y N

[If no, skip to question 9.]

4. Has the patient failed standard topical therapies? Y N

   List topical therapies tried: ______________________________

   [If no, then no further questions.]

5. Has the patient tried and had an insufficient response to phototherapy (UVB or PUVA) or is unable to receive phototherapy? Y N

   If yes, please provide rationale:___________________________

   [If no, then no further questions.]

6. Has the patient had failure to an adequate trial (3 months) of methotrexate or cyclosporine? Y N

   [If yes, then skip to question 8.]

7. Does the patient have a contraindication to both methotrexate and cyclosporine? Y N

   Note: Contraindications such as Pregnancy, alcoholism, Chronic liver disease, Leukopenia, thrombocytopenia, or anemia.

   If yes, please document contraindications: _________________

   [If no, then no further questions.]

8. Does the plaque psoriasis have a significant impact on physical, psychological, or social wellbeing? Y N

   [If no, then no further questions.]

   [If yes, skip to question 18.]

9. Does the patient have a diagnosis of psoriatic arthritis (PsA)? Y N

   [If no, then no further questions.]

10. Does the patient have primarily axial disease (involving the spine) or active enthesitis/dactylitis? Y N

    [If no, skip to question 12.]

11. Has the patient tried an adequate trial (3 months) with at least 2 Y N

different NSAIDs and had inadequate response?

If yes, please list medications tried:______________________

[If yes, skip to question 16.]

[If no, skip to question 17.]

12. Does the patient have active psoriatic arthritis? Y N

[If no, then no further questions.]

13. Has the patient had failure to an adequate trial (3 months) of methotrexate? Y N

[If yes, skip to question 16.]

14. Does the patient have contraindications to methotrexate? Y N

Note: Contraindications such as Pregnancy, alcoholism, Chronic liver disease, Leukopenia, thrombocytopenia, or anemia.

If yes, please document contraindication:_________________

[If no, then no further questions]

15. Has the patient failed an adequate (3months) trial of sulfasalazine or leflunomide? Y N

[If no, then no further questions.]

16. Is the patient currently on or will continue taking an NSAID with requested medication? Y N

[If yes, then skip to question 18.]

17. Does the patient have contraindications to NSAIDs? Y N

Note: Contraindications such as true allergic reaction to NSAIDs, history of worsening asthma symptoms after taking aspirin or NSAIDs, current GI bleed, severe renal dysfunction.

If yes, please document contraindication:_________________

[If no, then no further questions.]

18. Is therapy being prescribed by, or in consultation with an appropriate specialist (i.e., rheumatologist or dermatologist)? Y N

[If no, no further questions.]

19. Is the patient 18 years of age or older? Y N

Comments:

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I affirm that the information given on this form is true and accurate as of this date.

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Prescriber (Or Authorized) Signature **Date**