

US Family Health Plan

Prior Authorization Request Form for apremilast (**Otezla**)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be **faxed** to **617-562-5296**

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Step 1 Please complete patient and physician information (please print):

Patient Name: _____ Address: _____ Sponsor ID #: _____ Date of Birth: _____	Physician Name: _____ Address: _____ Phone #: _____ Secure Fax #: _____
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Step 2 Please complete clinical assessment:

1. Humira is the Department of Defense's preferred targeted biologic agent. Has the patient tried Humira?	<input type="checkbox"/> Yes proceed to question 3	<input type="checkbox"/> No proceed to question 2
2. Does the patient have a diagnosis of oral ulcers associated with Behcet's disease?	<input type="checkbox"/> Yes proceed to question 6	<input type="checkbox"/> No proceed to question 5
3. Has the patient had an inadequate response to Humira?	<input type="checkbox"/> Yes proceed to question 6	<input type="checkbox"/> No proceed to question 4
4. Has the patient experienced an adverse reaction to Humira that is not expected to occur with the requested agent?	<input type="checkbox"/> Yes proceed to question 6	<input type="checkbox"/> No STOP Coverage not approved
5. Does the patient have a contraindication to Humira?	<input type="checkbox"/> Yes proceed to question 6	<input type="checkbox"/> No STOP Coverage not approved
6. Is the patient 18 years of age or older?	<input type="checkbox"/> Yes proceed to question 7	<input type="checkbox"/> No STOP Coverage not approved
7. What is the indication or diagnosis?	<input type="checkbox"/> Active psoriatic arthritis – proceed to question 8 <input type="checkbox"/> Moderate to severe plaque psoriasis in a patient who is a candidate for phototherapy or systemic therapy – proceed to question 8 <input type="checkbox"/> Oral ulcers associated with Behcet's disease – proceed to question 8 <input type="checkbox"/> Other indication or diagnosis – STOP: Coverage not approved.	
8. Has the patient had an inadequate response to non-biologic systemic therapy? (For example: methotrexate, aminosalicylates [e.g. sulfasalazine, mesalamine], corticosteroids, immunosuppressants [e.g. azathioprine], etc.)	<input type="checkbox"/> Yes proceed to question 9	<input type="checkbox"/> No STOP Coverage not approved

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9. Will the patient be receiving other targeted immunomodulatory biologics with Otezla, including but not limited to the following: Actemra, Cimzia, Cosentyx, Enbrel, Humira, Ilumya, Kevzara, Kineret, Olumiant, Orencia, Remicade, Rituxan, Siliq, Simponi, Stelara, Taltz, Tremfya, Xeljanz/Xeljanz XR, Skyrizi, or Rinvoq ER?	<input type="checkbox"/> Yes proceed to question 10	<input type="checkbox"/> No Sign and date below
10. Please explain referencing literature to support combination use with Otezla, and attests that the patient will be monitored closely for adverse effects.	Sign and date below	

Step I certify the above is true to the best of my knowledge. Please sign and date:

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Prescriber Signature

Date