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 855-273-5735

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**

Clinical documentation may be required for approval.

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

Patient Name:		Physician Name:	
Address:		Address:	
Sponsor ID #		Phone #:	
Date of Birth:		Secure Fax #:	

Step 2 **Please complete clinical assessment:**

1. Is the patient 18 years of age or older?	☐ Yes proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. What is the indication or diagnosis?	☐ Active **psoriatic arthritis** – proceed to question **5** ☐ Mild **plaque psoriasis** in a patient who is a candidate for systemic therapy or phototherapy– proceed to question **3** ☐ Moderate to severe **plaque psoriasis** in a patient who is a candidate for phototherapy or systemic therapy – proceed to question **5** ☐ Oral ulcers associated with Behcet's disease – proceed to question **9** ☐ Other indication or diagnosis – **STOP: Coverage not approved.**	
3. Does the patient have a contraindication to, intolerability to, or has failed treatment with medications from at least TWO of these THREE categories: • **Moderate to High Potency Topical Corticosteroids (class 1 - class 5) for example, clobetasol propionate 0.05% ointment/cream, fluocinonide 0.05% ointment/cream, betamethasone dipropionate 0.05% cream/lotion/ointment, etc.;** • **Steroid Sparing Agents: Vitamin D analogs (for example, calcipotriene and calcitriol), tazarotene, or topical calcineurin inhibitors (for example, tacrolimus and pimecrolimus);** • **Other Topicals: emollients, salicylic acid, anthralin, or coal tar?**	☐ Yes proceed to question **4**	☐ No **STOP** **Coverage not approved**

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4. Does the patient have a contraindication to, intolerability to, inability to access treatment, or has failed treatment with phototherapy?	☐ Yes proceed to question **10**	☐ No **STOP** **Coverage not approved**
5. Humira is the Department of Defense's preferred targeted biologic agent. Has the patient tried Humira?	☐ Yes proceed to question **6**	☐ No proceed to question **8**
6. Has the patient had an inadequate response to Humira?	☐ Yes proceed to question **9**	☐ No proceed to question **7**
7. Has the patient experienced an adverse reaction to Humira that is not expected to occur with the requested agent?	☐ Yes proceed to question **9**	☐ No **STOP** **Coverage not approved**
8. Does the patient have a contraindication to Humira?	☐ Yes proceed to question **9**	☐ No **STOP** **Coverage not approved**
9. Has the patient had an inadequate response to non-biologic systemic therapy? (For example: methotrexate, aminosalicylates [for example, sulfasalazine, mesalamine], corticosteroids, immunosuppressants [for example, azathioprine], etc.)	☐ Yes proceed to question **10**	☐ No **STOP** **Coverage not approved**
10. 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?	☐ Yes proceed to question **11**	☐ No **Sign and date below**
11. 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**	

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Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

Prescriber Signature _____ Date _____

[09 December 2022]