IOWA Health and Human Services

Iowa Department of Human Services

Request for Prior Authorization
APREMILAST (OTEZLA®)
(PLEASE PRINT – ACCURACY IS IMPORTANT)

FAX Completed Form To
1 (800) 574-2515

Provider Help Desk
1 (877) 776-1567

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI	Pharmacy fax	NDC

Prior authorization is required for apremilast (Otezla®). Payment will be considered under the following conditions:

1. **Request adheres to all FDA approved labeling for indication, including age, dosing and contraindications; and**
2. **Patient has a diagnosis of active psoriatic arthritis (≥ 3 swollen joints and ≥ 3 tender joints); with documentation of a trial and inadequate response to therapy with the preferred oral DMARD, methotrexate (leflunomide or sulfasalazine may be used if methotrexate is contraindicated); or**
3. **Patient has a diagnosis of plaque psoriasis; with documentation of a trial and inadequate response to phototherapy, systemic retinoids, methotrexate, or cyclosporine; or**
4. **Patient has a diagnosis of Behçet disease; with**
   a. **Documentation of active oral ulcers associated with Behçet disease; and**
   b. **Documentation of a previous trial and inadequate response, at a therapeutic dose, to colchicine.**

The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

Preferred
☐ Otezla

Non-Preferred
☐ Otezla XR

Strength:_____ **Dosage Instructions:**_____ **Quantity**:_____ **Days Supply:** _____

Diagnosis: _____

☐ **Psoriatic Arthritis**

Treatment failure with oral methotrexate (leflunomide or sulfasalazine if methotrexate is contraindicated):

Drug Name & Dose: _____ Trial dates: _____

Reason for failure: _____

☐ **Plaque Psoriasis**

Treatment failure with phototherapy, systemic retinoids, methotrexate, or cyclosporine:

Drug Name & Dose: _____ Trial dates: _____

Reason for failure: _____

☐ **Behçet Disease**

Does patient have active oral ulcers associated with Behçet disease? ☐ Yes ☐ No

Treatment failure with colchicine: Drug Name & Dose:_____ Trial dates: _____

Reason for failure: _____

Possible drug interactions/conflicting drug therapies: _____

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission

IMPORTANT NOTE: *In evaluating requests for prior authorization, the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary, by contact with the county Department of Health and Human Services, that the member continues to be eligible for Medicaid.*