

OTEZLA

PRIOR AUTHORIZATION REQUEST

PRESCRIBER FAX FORM

Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.

The following documentation is REQUIRED. Incomplete forms will be returned for additional information. For formulary information please visit www.myprime.com. Start saving time today by filling out this form electronically. Visit covermy meds.com to begin using this free service.

What is the priority level of this request?

- Standard review
- Expedited/Urgent review – prescriber certifies that waiting for a standard review could seriously harm the patient’s life, health or ability to regain maximum function

Today’s Date: _____

PATIENT AND INSURANCE INFORMATION

Date of Service (if differs from Today’s Date): _____

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:	Patient Telephone:	
Member ID Number:	Group Number:		

PRESCRIBER/CLINIC INFORMATION

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient’s Diagnosis: <input type="checkbox"/> Behcet’s disease (BD) <input type="checkbox"/> Plaque psoriasis (PS) <input type="checkbox"/> Active psoriatic arthritis (PsA) <input type="checkbox"/> Other (ICD code and description): _____	
Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:
For all requests: 1. What is the patient’s weight? _____ (kg) 2. Is the patient currently being treated with the requested agent? <input type="checkbox"/> Yes <input type="checkbox"/> No 3. Has the patient been treated with the requested agent within the past 90 days (starting on samples is not approvable)? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, is the patient at risk if therapy is changed? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify risk: _____ 4. Is the patient an adult with mild to severe plaque psoriasis? <input type="checkbox"/> Yes <input type="checkbox"/> No 5. Does the patient have a diagnosis of mild severity plaque psoriasis? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, is the prescriber a specialist in the area of the patient’s diagnosis (e.g., dermatologist, rheumatologist) or has the prescriber consulted with a specialist in the area of the patient’s diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No 6. Does the patient have any FDA labeled contraindications to the requested agent? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify FDA labeled contraindications: _____ 7. Does the patient’s medication history (excluding sample use) indicate use of a biologic immunomodulator agent or a systemic targeted synthetic small molecule drug (e.g., oral JAK inhibitor) that is FDA labeled or supported in compendia (AHFS, DrugDex 1 or 2a level of evidence, or NCCN 1 or 2a recommended use) for the treatment of the requested indication <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify: _____ 8. Is the patient’s age within FDA labeling for the requested indication for the requested agent? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please give rationale in support for using the requested agent for the patient’s age for the requested indication: _____ _____	
Please continue to the next page.	

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
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9. Will the patient be using the requested agent in combination with another immunomodulatory agent (e.g., TNF inhibitors, JAK inhibitors, IL-4 inhibitors) [Abrilada (adalimumab-afzb), Actemra (tocilizumab), Adalimumab, Adbry (tralokinumab-ldrm), Amjevita (adalimumab-atto), Arcalyst (rilonacept), Avsola (infliximab-axxq), Benlysta (belimumab), Bimzelx (bimekizumab-bkzx), Cibirgo (abrocitinib), Cimzia (certolizumab), Cinqair (reslizumab), Cosentyx (secukinumab), Cyltezo (adalimumab-adbm), Dupixent (dupilumab), Enbrel (etanercept), Entyvio (vedolizumab), Fasenna (benralizumab), Hadlima (adalimumab-bwwd), Hulio (adalimumab-fkjp), Humira (adalimumab), Hyrimoz (adalimumab-adaz), Idacio (adalimumab-aacf), Ilaris (canakinumab), Ilumya (tildrakizumab-asmn), Inflectra (infliximab-dyyb), Infliximab, Kevzara (sarilumab), Kineret (anakinra), Leqselvi (deuruxolitinib), Liltfulo (ritlectinib), Nemluvio (nemolizumab-ilto), Nucala (mepolizumab), Olumiant (baricitinib), Omvoh (mirikizumab-mrkz), Opzelura (ruxolitinib), Orenzia (abatacept), Otezla (apremilast), Otezla XR (apremilast extended-release), Pyzchiva (ustekinumab-ttwe), Remicade (infliximab), Renflexis (infliximab-abda), Rhapsido (remibrutinib), Riabni (rituximab-arrx), Rinvoq (upadacitinib), Rituxan (rituximab), Rituxan Hycela (rituximab/hyaluronidase human), Ruxience (rituximab-pvvr), Saphnelo (anifrolumab-fnia), Selarsdi (ustekinumab-aekn), Siliq (brodalumab), Simlandi (adalimumab-ryvk), Simponi (golimumab), Simponi ARIA (golimumab), Skyrizi (risankizumab-rzaa), Sotyktu (deucravacitinib), Spevigo (spesolimab-sbzo) subcutaneous injection, Stelara (ustekinumab), Taltz (ixekizumab), Tezspire (tezepelumab-ekko), Tofidence (tocilizumab-bavi), Tremfya (guselkumab), Truxima (rituximab-abbs), Tyenne (tocilizumab-aazg), Tyruko (natalizumab-sztn), Tysabri (natalizumab), Velsipity (etrasimod), Wezlana (ustekinumab-auub), Xeljanz (tofacitinib), Xeljanz XR (tofacitinib extended release), Xolair (omalizumab), Yuflyma (adalimumab-aaty), Yusimry (adalimumab-aqvh), Zeposia (ozanimod), Zymfentra (infliximab-dyyb)]? Yes No
- If yes, does the prescribing information for the requested agent limit the use with another immunomodulatory agent? Yes No
- If no, is there information in support of combination therapy? **Please note, a submitted copy is required (e.g., clinical trials, phase III studies, guidelines required)**..... Yes No
10. Has the patient has been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat the cancer?..... Yes No
11. Has the patient been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat an associated condition related to stage four advanced metastatic cancer? **Please note, chart notes are required**..... Yes No
12. If yes to either of the previous questions, is the use of the requested agent consistent with best practices for the treatment of stage four advanced, metastatic cancer, or an associated condition; supported by peer-reviewed, evidence-based literature; and approved by the United States Food and Drug Administration? Yes No
13. Is the requested quantity (dose) greater than the maximum FDA labeled dose for the requested indication? Yes No
- If yes, please provide information in support of therapy with a higher dose for the requested indication (e.g., clinical trials, phase III studies, guidelines required): _____
- _____
- If no, can the requested quantity (dose) be achieved with a lower quantity of a higher strength?..... Yes No
- If no, please explain: _____
- _____
14. Please list all reasons for selecting the requested agent for the indicated diagnosis, strength, dosing schedule, and quantity over alternatives (e.g., compendia support, journal articles, contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max). **Please note, documentation may be required:** _____
- _____
- _____
- For psoriatic arthritis (PsA) requests:**
15. Has the patient tried and had an inadequate response to ONE conventional agent (i.e., cyclosporine, leflunomide, methotrexate, sulfasalazine) used in the treatment of PsA for at least 3 months? Yes No
- If no, does the patient have an intolerance or hypersensitivity to ONE of the conventional agents used in the treatment of PsA? Yes No
- If yes, please explain intolerance/hypersensitivity: _____
- _____
- If no, does the patient have an FDA labeled contraindication to ALL of the conventional agents used in the treatment of PsA?..... Yes No
- If yes, please specify FDA labeled contraindication: _____
- _____

Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
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For plaque psoriasis (PS) requests:

16. Is the patient an adult with mild to severe plaque psoriasis? Yes No
17. Does the patient have moderate to severe plaque psoriasis? Yes No
18. Has the patient tried and had an inadequate response to ONE conventional agent (i.e., acitretin, anthralin, calcipotriene, calcitriol, coal tar products, cyclosporine, methotrexate, pimecrolimus, PUVA [phototherapy], tacrolimus, tazarotene, topical corticosteroids) used in the treatment of PS for at least 3 months? Yes No
- If no, does the patient have an intolerance or hypersensitivity to ONE conventional agent used in the treatment of PS? Yes No
- If yes, please explain intolerance/hypersensitivity: _____
- If no, does the patient have an FDA labeled contraindication to ALL conventional agents used in the treatment of PS? Yes No
- If yes, please specify FDA labeled contraindication: _____

For Behcet's disease (BD) requests:

19. Does the patient have active oral ulcers associated with BD? Yes No
20. Has the patient had at least three occurrences of oral ulcers in the last 12 months? Yes No
21. Has the patient tried and had an inadequate response to ONE conventional agent (i.e., topical oral corticosteroids [i.e., triamcinolone dental paste], colchicine, azathioprine) used in the treatment of BD? Yes No
- If no, does the patient have an intolerance or hypersensitivity to ONE conventional agent used in the treatment of BD? Yes No
- If yes, please explain intolerance/hypersensitivity: _____
- If no, does the patient have an FDA labeled contraindication to ALL conventional agents used in the treatment of BD? Yes No
- If yes, please specify FDA labeled contraindication: _____

For renewal requests:

22. Has the patient had clinical benefit with the requested agent? Yes No

Please fax or mail this form to:
 Prime Therapeutics LLC
 Clinical Review Department
 2900 Ames Crossing Road Suite 200
 Eagan, MN 55121

TOLL FREE

Phone: **Fax: 877.243.6930**
BCBSIL: 800.285.9426
BCBSMT: 888.723.7443
BCBSNM: 800.544.1378
BCBSOK: 800.991.5643
BCBSTX: 800.289.1525

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