# 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 covermymeds.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:
☐ Behcet's disease (BD) ☐ Plaque psoriasis (PS) ☐ Active psoriatic arthritis (PsA)
☐ 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? ☐ Yes ☐ No
3. Has the patient been treated with the requested agent within the past 90 days (starting on samples is not approvable)? ☐ Yes ☐ No
   If yes, is the patient at risk if therapy is changed? ☐ Yes ☐ No
   If yes, please specify risk: _____
4. Is the patient an adult with mild to severe plaque psoriasis? ☐ Yes ☐ No
5. Does the patient have a diagnosis of mild severity plaque psoriasis? ☐ Yes ☐ 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? ☐ Yes ☐ No
6. Does the patient have any FDA labeled contraindications to the requested agent? ☐ Yes ☐ No
   If yes, please specify FDA labeled contraindications: _____
7. Does the patient's medication history indicate use of another biologic immunomodulator agent that is FDA labeled or supported in compendia (AHFS or DrugDex 1 or 2a level of evidence) for the treatment of the requested indication ☐ Yes ☐ No
   If yes, please specify: _____
8. Is the patient's age within FDA labeling for the requested indication for the requested agent? ☐ Yes ☐ 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.**


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| Patient Name (First): | Last: | M: | DOB (mm/dd/yyyy): |
|---|---|---|---|

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), Cibinqo (abrocitinib), Cimzia (certolizumab), Cinqair (reslizumab), Cosentyx (secukinumab), Cyltezo (adalimumab-adbm), Dupixent (dupilumab), Enbrel (etanercept), Entyvio (vedolizumab), Fasenra (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), Litfulo (ritlecitinib), Nemluvio (nemolizumab-ilto), Nucala (mepolizumab), Olumiant (baricitinib), Omvoh (mirikizumab-mrkz), Opzelura (ruxolitinib), Orencia (abatacept), Otezla (apremilast), Pyzchiva (ustekinumab-ttwe), Remicade (infliximab), Renflexis (infliximab-abda), 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), 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: _____
       _____

**For psoriatic arthritis (PsA) requests:**

14. 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: _____
          _____

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|---|---|---|---|

**For plaque psoriasis (PS) requests:**

15. Is the patient an adult with mild to severe plaque psoriasis? ☐ Yes ☐ No
16. Does the patient have moderate to severe plaque psoriasis? ☐ Yes ☐ No
17. 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:**

18. Does the patient have active oral ulcers associated with BD? ☐ Yes ☐ No
19. Has the patient had at least three occurrences of oral ulcers in the last 12 months? ☐ Yes ☐ No
20. 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:**

21. 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**

**Aetna/Cigna + Prime: 800.421.6022**

**BCBSIL/Prime: 888.802.8776**

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