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

JOHNS HOPKINS
MEDICINE
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HEALTHCARE
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USFHP Pharmacy Prior Authorization Form

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

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, intolerabilityto, 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**
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**

Question	Yes	No
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**	

Step 3

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

______________________ Prescriber Signature   __________ Date

[09 September 2022]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#: