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

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

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. Humira is the Department of Defense's preferred targeted biologic agent. Has the patient tried Humira?	☐ Yes proceed to question **3**	☐ No proceed to question **2**
2. Does the patient have a diagnosis of oral ulcers associated with Behcet's disease?	☐ Yes proceed to question **6**	☐ No proceed to question **5**
3. Has the patient had an inadequate response to Humira?	☐ Yes proceed to question **6**	☐ No proceed to question **4**
4. Has the patient experienced an adverse reaction to Humira that is not expected to occur with the requested agent?	☐ Yes proceed to question **6**	☐ No **STOP** **Coverage not approved**
5. Does the patient have a contraindication to Humira?	☐ Yes proceed to question **6**	☐ No **STOP** **Coverage not approved**
6. Is the patient 18 years of age or older?	☐ Yes proceed to question **7**	☐ No **STOP** **Coverage not approved**
7. What is the indication or diagnosis?	☐ Active **psoriatic arthritis** – proceed to question **8** ☐ Moderate to severe **plaque psoriasis** in a patient who is a candidate for phototherapy or systemic therapy – proceed to question **8** ☐ Oral ulcers associated with Behcet's disease – proceed to question **8** ☐ Other indication or diagnosis – **STOP: Coverage not approved.**	
8. Has the patient had an inadequate response to non-biologic systemic therapy? (For example: methotrexate, aminosalicylates [e.g. sulfasalazine, mesalamine], corticosteroids, immunosuppressants [e.g. azathioprine], etc.)	☐ Yes proceed to question **9**	☐ No **STOP** **Coverage not approved**

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9. 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 **10**	☐ No **Sign and date below**
10. 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

[31 January 2020]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: