AvMed

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-305-671-0200**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: (Select drug below)

❑ **Otezla®** (apremilast)	❑ **Otezla XR™** (apremilast)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member AvMed #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy:** _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

NOTE: The Health Plan considers the use of concomitant therapy with more than one biologic immunomodulator (e.g., Dupixent, Entyvio, Humira, Rinvoq, Stelara) prescribed for the same or different indications to be experimental and investigational. Safety and efficacy of these combinations has **NOT** been established and will **NOT** be permitted.

❑ Will the member be discontinuing a previously prescribed biologic if approved for requested medication?

❑ Yes **OR** ❑ No

❑ If yes, please list the medication that will be discontinued and the medication that will be initiated upon approval along with the corresponding effective date.

Medication to be discontinued: _____ **Effective date:** _____

Medication to be initiated: _____ **Effective date:** _____

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CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied. **Check the diagnosis below that applies.**

❑ Diagnosis: Active Psoriatic Arthritis (PsA)

Dosing: Oral:

- For adults and patients weighing 50 kg or more: Recommended maintenance dosage is Otezla 30 mg twice daily or Otezla XR 75 mg once daily
- For patients weighing 20 kg to less than 50 kg: Recommended maintenance dosage is Otezla 20 mg twice daily

- ❑ Member has a diagnosis of active **psoriatic arthritis**
- ❑ Member is 6 years of age or older and weighs at least 20 kg
- ❑ Prescriber is a **Rheumatologist or Dermatologist**
- ❑ Member meets **ONE** of the following:
  - ❑ Member has tried and failed at least **ONE** of the following **DMARD** therapies for at least **three (3) months**:
    - ❑ cyclosporine
    - ❑ leflunomide
    - ❑ methotrexate
    - ❑ sulfasalazine
  - ❑ Member has previously tried and failed another biologic medication other than the requested medication (e.g., adalimumab, Otezla, Skyrizi)
- ❑ Member is **NOT** receiving requested medication in combination with a biologic DMARD [e.g., Enbrel® (etanercept), Humira® (adalimumab), Simponi® (golimumab), Orencia® (abatacept)]

❑ Diagnosis: Plaque Psoriasis

Dosing: Oral:

- For adults and patients weighing 50 kg or more: Recommended maintenance dosage is Otezla 30 mg twice daily or Otezla XR 75 mg once daily
- For patients weighing 20 kg to less than 50 kg: Recommended maintenance dosage is Otezla 20 mg twice daily

- ❑ Member must meet **ONE** of the following age and diagnosis requirements:
  - ❑ Member is 18 years of age or older with plaque psoriasis
  - ❑ Member is 6 years of age or older and weighs at least 20 kg with moderate to severe plaque psoriasis
- ❑ Prescriber is a **Dermatologist**

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- ❑ Member meets **ONE** of the following:
  - ❑ Member tried and failed at least **ONE** of either Phototherapy or Alternative Systemic Therapy for at least **three (3) months**, unless member has a contraindication or intolerance to both phototherapy and alternative systemic therapies **(check each tried below)**:

❑ **Phototherapy:**	❑ **Alternative Systemic Therapy:**
❑ **UV Light Therapy**	❑ **Oral Medications**
❑ NB UV-B	❑ acitretin
❑ PUVA	❑ methotrexate
	❑ cyclosporine

  - ❑ Member has tried and failed another biologic medication other than the requested medication (e.g., adalimumab, Enbrel, ustekinumab)
- ❑ Member is **NOT** receiving requested medication in combination with a biologic DMARD [e.g., Enbrel® (etanercept), Humira® (adalimumab), Simponi® (golimumab), Orencia® (abatacept)]

❑ **Diagnosis: Behçet's Disease**
Dosing: Oral: Otezla 30 mg twice daily or Otezla XR 75 mg once daily

Initial Authorization: 6 months

- ❑ Medication must be prescribed by or in consultation with a **Rheumatologist** or **Dermatologist**
- ❑ Member must have active oral ulcers associated with Behcet's Disease (Active oral ulcers defined as two or more oral ulcers)
  - ❑ Number of ulcers at baseline: _____
- ❑ Member has a history of recurring oral ulcers (defined as at least three occurrences within a 12-month period)
- ❑ Member has had an inadequate response to or is intolerant of conventional therapy such as topical or systemic corticosteroids, immunosuppressants, colchicine or NSAIDs **(verified by chart notes or pharmacy paid claims)**
- ❑ Medication will **NOT** be used in combination with other systemic therapies for Behçet's Disease
- ❑ Member does **NOT** have active major organ involvement (defined as currently being treated for active uveitis or vascular or CNS involvement)

❑ **Diagnosis: Behçet's Disease**
Dosing: Oral: Otezla 30 mg twice daily or Otezla XR 75 mg once daily

Reauthorization: 6 months

- ❑ Member has had a reduction of oral ulcers by at least ≥ 1 since beginning therapy with requested medication or since last approval of requested medication

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Medication being provided by a Specialty Pharmacy – Proprium Rx

Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*
****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****

***Approved by Pharmacy and Therapeutics Committee**: ~~8/17/2014; 7/25/2024; 9/25/2025; 11/20/2025;~~ ~~3/26/2026;~~ **9/24/2026**
REVISED/UPDATED/REFORMATTED: ~~11/2017; 1/9/2018; 2/26/2018; 11/21/2018; 11/20/2019; 1/22/2020; 8/31/2020; 12/3/2020; 1/27/2021; 10/11/2021; 2/24/2022; 6/15/2022; 6/16/2022; 12/21/2022; 11/1/2023; 8/21/2024; 10/16/2025, 12/8/2025;~~ **8/6/2026**