Prescriber Criteria Form Otezla 2024 PA Fax 1129-A v1 010124.docx Otezla (apremilast) Coverage Determination
This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673**. Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Otezla (apremilast).

Drug Name: Otezla (apremilast)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Has the patient previously received the requested drug for one of the following conditions: A) plaque psoriasis, B) psoriatic arthritis, C) oral ulcers associated with Behcet's disease? [If yes, then no further questions.]	Yes	No
2	Does the patient have a diagnosis of active psoriatic arthritis (PsA)? [If yes, then no further questions.]	Yes	No
3	Does the patient have a diagnosis of oral ulcers associated with Behcet's disease? [If yes, then no further questions.]	Yes	No
4	Does the patient have a diagnosis of plaque psoriasis? [If no, then no further questions.]	Yes	No
5	Does the patient meet any of the following criteria: A) patient has experienced an inadequate treatment response or intolerance to any of the following: 1) a topical therapy (e.g., a topical corticosteroid, calcineurin inhibitor, vitamin D analog), 2) phototherapy (e.g., UVB, PUVA), 3) pharmacologic treatment with methotrexate, cyclosporine, or acitretin OR B) pharmacologic treatment with methotrexate, cyclosporine, or acitretin is contraindicated?	Yes	No

Comments:	

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.
Prescriber (or Authorized) Signature: _____ Date:_____