



Otezla® Prior Authorization Request Form

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Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
<input type="checkbox"/> Check if requesting brand	Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy		

Clinical Information (required)
<p>Select the diagnosis below:</p> <p><input type="checkbox"/> Active psoriatic arthritis (PsA)</p> <p><input type="checkbox"/> Moderate to severe chronic plaque psoriasis (PsO)</p> <p><input type="checkbox"/> Aphtholous Ulcer associated with Behcet's syndrome</p> <p><input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____</p>
<p>Clinical information:</p> <p>Select if the requested medication is prescribed by or in consultation with one of the following specialists:</p> <p><input type="checkbox"/> Dermatologist <input type="checkbox"/> Gastroenterologist <input type="checkbox"/> Rheumatologist <input type="checkbox"/> Other _____</p> <p>Will the requested medication be used in combination with another biologic agent? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>For active psoriatic arthritis (PsA), also answer the following:</p> <p>Has the patient had an inadequate response, contraindication, or intolerance to methotrexate? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>For moderate to severe plaque psoriasis (PsO), also answer the following:</p> <p>Has the patient had an inadequate response, contraindication, or intolerance to conventional therapy with at least one of the following: phototherapy or one or more oral systemic treatments (i.e., methotrexate, calcipotriene, cyclosporine, acitretin, sulfasalazine, tazarotene, corticosteroid)? <input type="checkbox"/> Yes <input type="checkbox"/> No List _____</p>
<p>Quantity limit requests:</p> <p>What is the quantity requested per MONTH? _____</p> <p>What is the reason for exceeding the plan limitations?</p> <p><input type="checkbox"/> Titration or loading dose purposes</p> <p><input type="checkbox"/> Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)</p> <p><input type="checkbox"/> Requested strength/dose is not commercially available</p> <p><input type="checkbox"/> Other: _____</p>

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-844-403-1029.

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