PROACT
PHARMACY BENEFIT MANAGEMENT

1230 US Highway 11
Gouverneur, NY 13642
Phone: 1-877-635-9545
Prior Authorization Fax: 1-844-712-8129

Otezla® Prior Authorization Request Form (Page 1 of 2)

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:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Active psoriatic arthritis
❑ Moderate to severe plaque psoriasis
❑ Other diagnosis:_____ICD-10 Code(s): _____

Clinical information:

Select if Otezla is prescribed by or in consultation with one of the following specialists:
❑ Dermatologist ❑ Rheumatologist

Will the patient be receiving Otezla in combination with a biologic DMARD [e.g., Enbrel (etanercept), Humira (adalimumab), Simponi (golimumab), Orencia (abatacept)]? ❑ **Yes** ❑ **No**

For active psoriatic arthritis, also answer the following:

Reauthorization:

Is there documentation the patient has had a positive clinical response to Otezla therapy (e.g., improvement in number of swo llen/tender joints, pain, or stiffness)? ❑ **Yes** ❑ **No**

Is the patient receiving Otezla in combination with a biologic DMARD [e.g., Enbrel (etanercept), Humira (adalimumab), Simponi (golimumab), Orencia (abatacept)]? ❑ **Yes** ❑ **No**

For moderate to severe plaque psoriasis, also answer the following:

Select if the following applies to the patient:
❑ Greater than 10% body surface area involvement
❑ Palmoplantar involvement
❑ Severe scalp psoriasis

Reauthorization:

Is there documentation the patient has had a positive clinical response to Otezla therapy (e.g., improvement in body surface area involvement, or Psoriasis Area and Severity Index [PASI] 75 scoring)? ❑ **Yes** ❑ **No**

Is the patient receiving Otezla in combination with a biologic DMARD [e.g., Enbrel (etanercept), Humira (adalimumab), Simponi (golimumab), Orencia (abatacept)]? ❑ **Yes** ❑ **No**

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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.

Please fax this form to 1-844-712-8129 to initiate a prior authorization review for the member and medication above.

Please note: plan benefits may limit or exclude coverage of specific medications including those requested on this form.

I certify, to the best of my knowledge, the statements and information provided on this form are factual and correct.

Provider/Representative (and Title): _____ **Date:** _____

PROACT INTERNAL USE ONLY:					
Clinical Review Decision					
	Approved, through				
	Denied (documentation attached, if necessary)				
Tracking:					
1st Attempt		2nd Attempt		Letter Mailed:	