AmeriHealth Caritas Iowa

AmeriHealth Caritas Iowa
Request for Prior Authorization
Apremilast (Otezla®)

Form applies to IA Health Link and ***hawk-i*** plans.

Please print – accuracy is important.

Fax completed form to 1-855-825-2714. Provider Help Desk: 1-855-328-1612.

AmeriHealth Caritas Iowa member ID #:		Patient name:	
Patient address:			DOB:
Provider NPI:	Prescriber name:		Phone:
Prescriber address:			Fax:
Pharmacy name:			
Address:			Phone:
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.			
Pharmacy NPI:		Pharmacy fax:	NDC:

Prior authorization is required for apremilast (Otezla®). Payment will be considered under the following conditions: 1) Patient is 18 years of age or older; and 2) Patient has a diagnosis of active psoriatic arthritis (≥ 3 swollen joints and ≥ 3 tender joints) with documentation of a trial and inadequate response to therapy with the preferred oral DMARD, methotrexate (leflunomide or sulfasalazine may be used if methotrexate is contraindicated; or 3) Patient has a diagnosis of moderate to severe plaque psoriasis and has documentation of a trial and inadequate response to phototherapy, systemic retinoids, methotrexate, or cyclosporine; and 4) Prescribed by a rheumatologist or a dermatologist; and 5) Patient does not have severe renal impairment (CrCl < 30mL/min); and 6) Patient has documentation of trials and therapy failures with two preferred biological agents. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

Please note: AmeriHealth Caritas Iowa uses Iowa Medicaid Enterprise criteria. For complete criteria, please consult www.iowamedicaidpdl.com/pa_criteria.

Non-Preferred:

☐ **Otezla**

Strength: Dosage Instructions: Quantity: Days Supply:

Diagnosis:

Prescriber Specialty: ☐ Dermatologist ☐ Rheumatologist ☐ Other

Does patient have severe renal impairment (CrCl < 30mL/min)? ☐ Yes ☐ No (attach labs)

☐ **Psoriatic Arthritis**

Treatment failure with oral methotrexate (leflunomide or sulfasalazine if methotrexate is contraindicated):

Drug Name and Dose: Trial Dates: Reason for failure:

☐ **Plaque Psoriasis**

Treatment failure with phototherapy, systemic retinoids, methotrexate, or cyclosporine:

Drug Name and Dose: Trial Dates: Reason for failure:

Treatment failure with two preferred biological agents:

Trial 1:

Drug Name and Dose: Trial Dates: Reason for failure:

Trial 2:

Drug Name and Dose: Trial Dates: Reason for failure:

Possible drug interactions/conflicting drug therapies:

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Attach lab results and other documentation as necessary.

By signing this document, I attest that the information contained herein is true and accurate to the best of my knowledge and belief. By submitting this form, I acknowledge that I am submitting a request for authorization of health care services, and I agree to abide by and adhere to established federal and Iowa fraud, waste and abuse (FWA) rules and regulations and to remain in compliance with AmeriHealth Caritas Iowa's Program Integrity rules. I further attest that any claim I submit is subject to investigations, review or audit as determined by AmeriHealth Caritas Iowa. I further acknowledge that an authorization is not a guarantee of payment.	
Prescriber signature: (Must match prescriber listed above.)	Date of submission:

Important note: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.

Check www.amerihealthcaritasia.com/Provider to confirm your version of this form.