Otezla® (apremilast) Medication Precertification Request

(Please complete all fields and return both pages for precertification review)

Aetna Precertification Notification
Phone: 1-855-240-0535
FAX: 1-877-269-9916

For Medicare Advantage Part B:
FAX: 1-844-268-7263

Please indicate: ☐ Start of treatment: Start Date: ____/____/____ ☐ Continuation of therapy: Date of last treatment: ____/____/____

Precertification Requested By: ____________________ Phone: ____________ Fax: ____________

A. PATIENT INFORMATION

First Name:	Last Name:	DOB:	
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	Email:
Current Weight: ____ lbs or ____ kgs Height: ____ inches or ____ cms	Allergies:		

B. INSURANCE INFORMATION

Aetna Member ID #: ________________
Group #: ________________
Insured:

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: ____________ Carrier Name: ____________
Insured:

Medicare: ☐ Yes ☐ No If yes, provide ID #: **Medicaid:** ☐ Yes ☐ No If yes, provide ID #:

C. PRESCRIBER INFORMATION

First Name:		Last Name: (*Check One*): ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.			
Address:		City:		State:	ZIP:
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider Email:		Office Contact Name:		Phone:	

Specialty (*Check one*): ☐ **Rheumatologist** ☐ **Dermatologist** ☐ **Gastroenterologist** ☐ **Other**:

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: ____________
Center Name: ____________
☐ Home Infusion Center Phone: ____________
Agency Name: ____________
☐ Administration code(s) (CPT): ____________
Address: ____________

Dispensing Provider/Pharmacy: (*Patient selected choice*)
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Mail Order
☐ Other: ____________
Name: ____________
Address: ____________
Phone: ____________ Fax: ____________
TIN: ____________ PIN: ____________

E. PRODUCT INFORMATION

Request is for Otezla: Dose: ____________ **Frequency:** ____________

F. DIAGNOSIS INFORMATION - Please indicate primary ICD Code and specify any other where applicable.

Primary ICD Code: ____________ Secondary ICD Code: ____________ Other ICD Code: ____________

G. CLINICAL INFORMATION - Required clinical information must be completed in its entirety for all precertification requests.

***For All Requests* (clinical documentation required):**
☐ Yes ☐ No Will apremilast (Otezla) be used concomitantly with tofacitinib or biologic DMARDs (e.g., adalimumab, infliximab)?

Plaque Psoriasis
What is the severity of the patient's disease? ☐ Mild ☐ Moderate ☐ Severe
☐ Yes ☐ No Is there evidence that the disease is active?
☐ Yes ☐ No Is there clinical documentation of chronic disease?
Please provide the patient's Psoriasis Area and Severity Index (PASI) score: _____
Please indicate the percentage of body surface area affected by plaque psoriasis: _____%

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

G. CLINICAL INFORMATION *(Continued)* - Required clinical information must be completed in its entirety for all precertification requests.

Plaque Psoriasis *(continued)*

☐ Yes ☐ No Does the plaque psoriasis involve sensitive areas? ***If yes***, please select: ☐ hands ☐ feet ☐ face ☐ genitals

☐ Yes ☐ No Is the patient a candidate for systemic treatment with conventional DMARD(s)?

- ☐ Yes ☐ No Was the trial with systemic conventional DMARD(s) (e.g., methotrexate, acetretin, or cyclosporine) ineffective?
  Provide the name and date range: Name: ______________ Date range: ___/___/___ to ___/___/___
- ☐ Yes ☐ No Was the trial with systemic conventional DMARD(s) not tolerated?
- ☐ Yes ☐ No Are systemic conventional DMARDs contraindicated?

☐ Yes ☐ No Is the patient a candidate for phototherapy?

- ☐ Yes ☐ No Was the trial with phototherapy ineffective?
  Please check all that apply:
  - ☐ Psoralens (methoxsalen, trioxsalen) with UVA light (PUVA)
  - ☐ UVB with coal tar or dithranol
  - ☐ UVB (standard or narrow-band)
  - ☐ Home UVB

  Date range of phototherapy use: ___/___/___ to ___/___/___
- ☐ Yes ☐ No Was the trial with phototherapy not tolerated?
- ☐ Yes ☐ No Is phototherapy contraindicated?

Psoriatic Arthritis

☐ Yes ☐ No Is there evidence that the disease is active?

☐ Yes ☐ No Does the patient have **non-axial** psoriatic arthritis?

- → ☐ Yes ☐ No Has the patient had an inadequate response to methotrexate?
  If yes, date range: ___/___/___ to ___/___/___
- ☐ Yes ☐ No Does the patient have an intolerance or contraindication to methotrexate? ***If yes***, please explain:____________
- ☐ Yes ☐ No Has the patient had an inadequate response to at least 1 (other than methotrexate) non-biologic disease-modifying anti-rheumatic drug (DMARD)? If yes, provide the name and date range used:
  Name: ______________________________ Date range: ___/___/___ to ___/___/___

☐ Yes ☐ No Does the patient have **axial** psoriatic arthritis?

- → ☐ Yes ☐ No Has the patient had an inadequate response to at least 2 non-steroidal anti-inflammatory drugs (NSAIDs)?
  If yes, provide the names and date ranges: NSAID #1: ______________ Date range: ___/___/___ to ___/___/___
  NSAID #2: ______________ Date range: ___/___/___ to ___/___/___

For Continuation Requests

Please indicate the length of time on apremilast (Otezla) therapy: ______________________________

☐ Yes ☐ No Is this continuation request a result of the patient receiving samples apremilast (Otezla)?
(Sampling of apremilast (Otezla) does not guarantee coverage under the provisions of the pharmacy benefit)

☐ Yes ☐ No Is there clinical documentation supporting disease stability?

☐ Yes ☐ No Is there clinical documentation supporting disease improvement?

H. ACKNOWLEDGEMENT

Request Completed By *(Signature Required)*: ______________________________ **Date:** ___/___/___

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.