BlueCross BlueShield Federal Employee Program

OTEZLA
PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

Otezla (apremilast)

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its **entirety** for processing

1. Has the patient been on this medication continuously for the last **6 months** excluding samples? ***Please select answer below:***
   ❑ **YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the questions on **PAGE 3**
   ❑ **NO** – this is **INITIATION** of therapy, please answer the questions below:

2. Is this request for brand or generic? ❑Brand ❑Generic

3. Will the patient need more than 180 tablets every 90 days? ❑Yes* ❑No
   If YES, please specify the requested quantity: _____ tablets every 90 days

4. Will Otezla be used in combination with another biologic DMARD or targeted synthetic DMARD? ❑Yes* ❑No
   If YES, please specify medication: _____
   DMARDs: Actemra, Avsola, Cimzia, Cosentyx, Enbrel, Entyvio, Humira, Ilumya, Inflectra, Kevzara, Kineret, Olumiant, Orencia, Remicade, Renflexis, Riabni, Rinvoq, Rituxan, Ruxience, Siliq, Simponi/Simponi Aria, Skyrizi, Sotyktu, Spevigo, Stelara, Taltz, Tremfya, Truxima, Xeljanz/Xeljanz XR

5. What is the patient's diagnosis?
   ❑Oral ulcers associated with Behcet's Disease (BD)
   a. Are the oral ulcers associated with Behcet's disease active? ❑Yes ❑No
   b. Has the patient been previously treated with at least one non-biologic medication for Behcet's disease? ❑Yes ❑No
   ❑Plaque Psoriasis (PsO)
   a. **Age 6-17**: Please answer the following questions:
      i. Does the patient have moderate to severe plaque psoriasis (PsO)? ❑Yes ❑No
      ii. What is the patient's weight? _____ kg **OR** _____ lbs
   b. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to conventional systemic therapy? ❑Yes* ***(*If YES, please select answer below)*** ❑No, patient has not tried conventional systemic therapy
      ❑Inadequate response **OR** ❑Intolerance or contraindication
   c. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to phototherapy?
      ❑Yes* ***(*If YES, please select answer below)*** ❑No, patient has not tried phototherapy
      ❑Inadequate response **OR** ❑Intolerance or contraindication
   d. **Standard/Basic Patient Option**: Is this medication being requested as a change from one of the following to allow the member access to their copay benefit: Bimzelx, Cimzia, Cosentyx, Ilumya, Siliq, or Sotyktu? ❑Yes* ❑No
      If YES, please select medication: ❑Bimzelx ❑Cimzia ❑Cosentyx ❑Ilumya ❑Siliq ❑Sotyktu

PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL DIAGNOSES

The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification. **Prescriber Certification:** I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer. Otezla – FEP MD Fax Form Revised 11/1/2024

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PAGE 2 - PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R _____

❑ Psoriatic Arthritis (PsA)

a. Is the patient's psoriatic arthritis active? ❑Yes ❑No

b. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to a 3-month trial of at least one conventional DMARD? ❑Yes ❑No

c. **Standard/Basic Patient Option**: Is this medication being requested as a change from one of the following to allow the member access to their copay benefit: Bimzelx, Cimzia, Cosentyx, Orencia SC, or Simponi? ❑Yes***** ❑No

****If YES***, please select medication: ❑Bimzelx ❑Cimzia ❑Cosentyx ❑Orencia SC ❑Simponi

❑ Other ***(please specify):*** _____

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Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

CONTINUATION OF THERAPY (PA RENEWAL)

Otezla (apremilast)

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its **entirety** for processing

1. Has the patient been on this medication continuously for the last **6 months** excluding samples? ***Please select answer below:***
   ❑**NO** – this is **INITIATION** of therapy, please answer the questions on **PAGE 1**
   ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the questions below:

2. Is this request for brand or generic? ❑Brand ❑Generic

3. Will the patient need more than 180 tablets every 90 days? ❑Yes* ❑No
   If YES, please specify the requested quantity: _____ tablets every 90 days

4. What is the patient's diagnosis?
   ❑Oral ulcers associated with Behcet's Disease (BD)
   ❑Plaque Psoriasis (PsO)
   a. **Age 6-17**: What is the patient's weight? _____ kg **OR** _____ lbs
   ❑Psoriatic Arthritis (PsA)
   ❑Other ***(please specify):*** _____

5. Has the patient's condition improved or stabilized with therapy? ❑Yes ❑No

6. Will Otezla be used in combination with another biologic DMARD or targeted synthetic DMARD? ❑Yes* ❑No
   If YES, please specify medication: _____
   DMARDs: Actemra, Avsola, Cimzia, Cosentyx, Enbrel, Entyvio, Humira, Ilumya, Inflectra, Kevzara, Kineret, Olumiant, Orencia, Remicade, Renflexis, Riabni, Rinvoq, Rituxan, Ruxience, Siliq, Simponi/Simponi Aria, Skyrizi, Sotyktu, Spevigo, Stelara, Taltz, Tremfya, Truxima, Xeljanz/Xeljanz XR

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