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Please note: All information below is required to process this request.

Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

## Otezla® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

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

Clinical Information (required)
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**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), Orenzia (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 swollen/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), Orenzia (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), Orenzia (abatacept)]?  **Yes**  **No**

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

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Please note: This request may be denied unless all required information is received.  
 For urgent or expedited requests please call 1-800-711-4555.  
 This form may be used for non-urgent requests and faxed to 1-800-527-0531.

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