Texas Standard Prior Authorization Form Addendum

Molina Healthcare of Texas

Cytokine and CAM Antagonists - Otezla (Apremilast) (Medicaid)

This fax machine is located in a secure location as required by HIPAA Regulations. Complete / Review information, sign, and date. Fax signed forms to Molina Pharmacy Prior Authorization Department at **1-888-487-9251**. Please contact Molina Pharmacy Prior Authorization Department at **1-855-322-4080** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Otezla (Medicaid).

Drug Name (select from list of drugs shown / provide drug information)	
OTEZLA 30 MG TABLET	OTEZLA 28 DAY STARTER PACK

Patient Information	
Patient Name:	
Patient ID:	
Patient DOB:	

Prescribing Physician	
Physician Name:	
Physician Phone:	
Physician Fax:	
Physician Address:	
City, State, Zip:	

Diagnosis:	ICD Code:
Directions for administration:	

*****Please include all relevant clinical notes, lab work, medication history and any other applicable documentation.**

Please circle the appropriate answer for each question.

1. Is the requested drug required per court order? (court order required) Y N
   If the answer to this question is yes, approved for 365 days.
   If the answer to this question is no, go to question 2.

2. Is the patient greater than or equal to 18 years of age? Y N
   If the answer to this question is yes, go to question 3.
   If the answer to this question is no, denied

3. Does the patient have a diagnosis of oral ulcers associated with Behcet's Disease, moderate to severe plaque psoriasis (PS) or psoriatic arthritis (PsA) in the last 730 days? Y N
   If the answer to this question is yes, go to question 4.
   If the answer to this question is no, denied.

4. Does the patient have a claim for a strong CYP3A4 inducer in the last 90 days? Y N

Strong CYP3A4 Inducer

ACTOPLUS MED	PHENYTOIN
ACTOPLUS MET	PHENYTOIN SOD EXT
ACTOPLUS MET XR	PIOGLITAZONE
ACTOS	PIOGLITAZONE-GLIMEPIRIDE
APTIOM	PIOGLITAZONE-METFORMIN
ATRIPLA	PRIFTIN
BEXAROTENE	PRIMIDONE
CARBAMAZEPINE	PROVIGIL
CARBAMAZEPINE ER	RIFABUTIN
CARBATROL ER	RIFADIN
DILANTIN	RIFADIN IV
DUETACT	RIFAMATE
EPITOL	RIFAMPIN
EQUETRO	RIFAMPIN IV
INTELENCE	RIFATER
LYSODREN	SUSTIVA
MODAFINIL	TAFINLAR
MYCOBUTIN	TARGRETIN
MYSOLINE	TEGRETOL
NEVIRAPINE	TEGRETOL XR
NEVIRAPINE ER	TRACLEER
ORKAMBI	VIRAMUNE
OSENI	VIRAMUNE XR
PHENOBARBITAL	XTANDI
PHENYTEK	

If the answer to this question is yes, denied.
If the answer to this question is no, go to question 5.

5. Does the patient have a claim for a tumor necrosis factor (TNF) blocker or an interleukin-1 (IL-1) inhibitor in the last 30 days? Y N

TNF Blocker
CIMZIA
ENBREL
HUMIRA
SIMPONI
SIMPONI ARIA

IL-1 Inhibitor
ARCALYST
ILARIS

If the answer to this question is yes, denied.
If the answer to this question is no, go to question 6.

6. Does the patient have a diagnosis of chronic kidney disease (stage 4 or 5) in the last 365 days? Y N
If the answer to this question is yes, go to question 7.
If the answer to this question is no, go to question 8.

7. Is the requested dose less than or equal to 30 mg per day? Y N
   If the answer to this question is yes, go to question 8.
   If the answer to this question is no, denied.

8. Is the request for a non-preferred drug? Y N
   If the answer to this question is yes, go to question 9.
   If the answer to this question is no, approved for 365 days.

9. Has the patient failed a 30-day treatment trial with at least 1 preferred agent within the last 180 days? Y N
   If the answer to this question is yes, approved for 365 days.
   If the answer to this question is no, go to question 10.

10. Is there a documented allergy or contraindication to preferred agents in this class? Y N
    If the answer to this question is yes, approved 365 days.
    If the answer to this question is no, go to question 11.

11. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions? Y N
    If the answer to this question is yes, approved for 365 days.
    If the answer to this question is no, denied.

Comments:

I affirm that the information given on this form is true and accurate as of this date.

_____ _____

Prescriber (or Authorized) Signature Date