



**Instructions:**

This form is used by Kaiser Permanente and/or participating providers for coverage of **Otezla (Apremilast)**. Please complete and fax this form back to Kaiser Permanente within 24 hours [fax: [1-866-331-2104](tel:1-866-331-2104)]. If you have any questions or concerns, please call [1-866-331-2103](tel:1-866-331-2103). **Requests will not be considered unless this form is complete. The KP-MAS Formulary can be found at: <http://pithelp.appl.kp.org/MAS/formulary.html>**

**1 – Patient Information**

Patient Name: \_\_\_\_\_ Kaiser Medical ID#: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**2 – Provider Information**

Provider Name: \_\_\_\_\_ Specialty: \_\_\_\_\_ Provider NPI: \_\_\_\_\_

Provider Address: \_\_\_\_\_

Provider Phone #: \_\_\_\_\_ Provider Fax #: \_\_\_\_\_

Please check the boxes that apply:

- Initial Request    Continuation of Therapy Request

**3 – Pharmacy Information**

Pharmacy Name: \_\_\_\_\_ Pharmacy NPI: \_\_\_\_\_

Pharmacy Phone # \_\_\_\_\_ Pharmacy Fax #: \_\_\_\_\_

**4 – Drug Therapy Requested**

Drug 1: Name/Strength/Formulation: \_\_\_\_\_  
Sig: \_\_\_\_\_

Drug 2: Name/Strength/Formulation: \_\_\_\_\_  
Sig: \_\_\_\_\_

### 5– Diagnosis/Clinical Criteria

1. Does the member have diagnosis of one of the following? **AND**
  - Psoriatic arthritis (PsA)
  - Plaque Psoriasis (PsO)
  - Other: \_\_\_\_\_
  
2. Was there therapeutic failure on oral methotrexate? **AND**
  - No  Yes
  
3. Was there therapeutic failure to one of the preferred agents? (e.g. Enbrel, Humira) **AND**
  - No  Yes
  
4. If this is being used for Plaque Psoriasis:
  - a. Was there therapeutic failure on a topical psoriasis agent? **AND**
    - No  Yes
  
  - b. Is the patient a candidate for phototherapy or systemic therapy?
    - No  Yes

### 6 – Provider Sign-Off

**Additional Information – Please provide any additional information that should be taken into consideration.**

**I certify that the information provided is accurate. Supporting documentation is available for State audits.**

**Provider Signature:**

**Date:**

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