TEXAS MEDICAID
Clinical Edit Prior Authorization
apremilast (OTEZLA)

STEP 1: CLEARLY PRINT AND COMPLETE TO EXPEDITE PROCESSING	
Date:	Prescriber First & Last Name:
Patient First & Last Name:	Prescriber NPI:
Patient Address:	Prescriber Address:
Patient ID:	Prescriber Phone:
Patient Date of Birth:	Prescriber Fax:

STEP 2: CLINICAL PRIOR AUTHORIZATION CRITERIA

☐ Indicate Primary Diagnosis: _____ ICD 10 Code: _____

1. Is the client greater than or equal to (≥) 18 years of age?

   ☐ Yes (Go to #2) ☐ No (Deny)

2. Does the client have a diagnosis of Psoriatic Arthritis (PsA), moderate to severe Plaque Psoriasis (Ps) or oral ulcers associated with Behcet's Disease in the last 730 days?

   ☐ Yes (Go to #3) ☐ No (Deny)

3. Does the client have a claim for a strong CYP3A4 inducer in the last 90 days?

   Examples include ATRIPLA, carbamazepine (CARBATROL, EQUETRO, TEGRETOL), modafinil (PROVIGIL), nevirapine (VIRAMUNE), phenobarbital, phenytoin (DILANTIN), pioglitazone (ACTOS), rifabutin, rifampin, SUSTIVA, XTANDI, and others.

   ☐ Yes (Deny) ☐ No (Go to #4)

4. Does the client have a claim for a tumor necrosis factor (TNF)-blocker or interleukin-17 (IL-17) inhibitor in the last 30 days?

   Examples include CIMZIA, COSENTYX, ENBREL, HUMIRA, and SIMPONI.

   ☐ Yes (Deny) ☐ No (Go to #5)

5. Does the client have a diagnosis of chronic kidney disease (stage 4 or 5) in the last 365 days?

☐ Yes (Go to #6) ☐ No (Approve – 365 days)

6. Is the requested dose less than or equal to (≤) 30 mg per day?

☐ Yes (Approve – 365 days) ☐ No (Deny)

STEP 3: SIGN AND FAX TO: NAVITUS PRIOR AUTHORIZATION AT: **855-668-8553**

Prescriber Signature: _____ **Date:** _____

If criteria not met, submit chart documentation with form citing complex medical circumstances.
For questions, please call Navitus Customer Care at 1-877-908-6023.