

**NC Medicaid  
Pharmacy Prior Approval Request  
Immunomodulators: Otezla**

**Beneficiary Information**

1. Beneficiary Last Name: \_\_\_\_\_ 2. First Name: \_\_\_\_\_  
3. Beneficiary ID #: \_\_\_\_\_ 4. Beneficiary Date of Birth: \_\_\_\_\_ 5. Beneficiary Gender: \_\_\_\_\_

**Prescriber Information**

6. Prescribing Provider NPI #: \_\_\_\_\_  
7. Requester Contact Information - Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Ext. \_\_\_\_\_

**Drug Information**

8. Drug Name: \_\_\_\_\_ 9. Strength: \_\_\_\_\_ 10. Quantity Per 30 Days: \_\_\_\_\_  
11. Length of Therapy (in days):  up to 30 Days  60 Days  90 Days  120 Days  180 Days  365 Days   
Other \_\_\_\_\_

**Clinical Information**

**Request for Plaque psoriasis (Adult)**

1. Does the beneficiary have a documented definitive diagnosis of moderate-to-severe Chronic Plaque Psoriasis?  
 Yes  No
2. Is the beneficiary 18 years of age or older?  Yes  No
3. Is the beneficiary not on another injectable biologic immunomodulator?  Yes  No
4. Does the beneficiary have body surface area (BSA) involvement of at least 3%?  Yes  No
5. Has the beneficiary had involvement of the palms, soles, head and neck, or genitalia, causing disruption in normal daily activities and/or employment?  Yes  No
6. Has the beneficiary failed to respond to, or has been unable to tolerate phototherapy and **ONE** of the following medications or beneficiary has contraindications to these treatments: Soriatane (acitretin), Methotrexate, or Cyclosporine?  Yes  No
7. Has the beneficiary had a trial and failure of Cosentyx, Enbrel or Humira or a clinical reason beneficiary cannot try Cosentyx, Enbrel or Humira?  Yes  No

**Request for Psoriatic Arthritis**

1. Does the beneficiary have a documented definitive diagnosis of Psoriatic Arthritis?  Yes  No
2. Is the beneficiary 18 years of age or older (OR 2 years or older for Simponi Aria)?  Yes  No
3. Is the beneficiary not on another injectable biologic immunomodulator?  Yes  No
4. Does the beneficiary have a documented inadequate response or inability to take methotrexate?  Yes  No
5. Has the beneficiary had a trial and failure of Cosentyx, Enbrel or Humira or a clinical reason beneficiary cannot try Cosentyx, Enbrel or Humira?  Yes  No

**Request for Oral Ulcers associated with Behcet's Disease**

1. Does the beneficiary have a documented diagnosis of Behcet's disease?  Yes  No
2. Is the beneficiary 18 years of age or older?  Yes  No
3. Is the beneficiary not on another injectable biologic immunomodulator?  Yes  No

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Signature of Prescriber: \_\_\_\_\_ Date: \_\_\_\_\_

**(Prescriber Signature Mandatory)**

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.