Health Partners Medicare

PRIOR AUTHORIZATION REQUEST FORM

Otezla - Medicare

Phone: 215-991-4300 **Fax back to: 866-371-3239**

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Medicare	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. Is the drug prescribed by or in consultation with a dermatologist or rheumatologist?

☐ Yes ☐ No

Q2. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q3. Does the patient have a confirmed diagnosis of plaque psoriasis? Please attach clinical documentation.

☐ Yes ☐ No

Q4. Does the patient have a confirmed diagnosis of active psoriatic arthritis? Please attach clinical documentation.

☐ Yes ☐ No

Q5. Does the patient have a confirmed diagnosis of oral ulcers associated with Behçet's Disease? Please attach clinical documentation.

☐ Yes ☐ No

Q6. Is there a documented history of inadequate response, intolerance or contraindication to at least one DMARD indicated for the diagnosis?

☐ Yes ☐ No

Q7. Is there a documented history of inadequate response, intolerance or contraindication to colchicine?

☐ Yes ☐ No

Health Partners Medicare

PRIOR AUTHORIZATION REQUEST FORM

Otezla - Medicare

Phone: 215-991-4300 **Fax back to: 866-371-3239**

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**

Q8. Requested Duration:

☐ 12 Months

Q9. Additional Information:

Prescriber Signature

Date

2023 Medicare Prior Authorization Request