

POLICY NAME

Otezla (apremilast)

POLICY #

2258P

Criteria

Exclusion Criteria – Any of the following prevents coverage

- ☐ 5.1 Inadequate response to initial or previous apremilast therapy
- ☐ 5.2 Health Alliance does not cover more than one biologic immunomodulator at a time because of the possible increased risk for infections and potential drug interactions CPT Codes HCPCS Codes

Coverage Criteria for Psoriatic Arthritis

- ☐ 1.1 See Psoriatic Arthritis Immunomodulator Therapies policy

Coverage Criteria for Plaque Psoriasis

- ☐ 2.1 See Plaque Psoriasis Immunomodulator Therapies policy

Coverage Criteria for Behcet Disease

- ☐ 3.1 Documented diagnosis of Behcet Disease/Syndrome with oral ulcers
- ☐ 3.2 Documented failure, intolerance, or contraindication to colchicine

Approval Time

- ☐ 4.1 Initial Authorization will be placed for 12 months
- ☐ 4.2 All subsequent authorizations will be placed for 12 months, based upon clinical response to therapy