UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2025 P 1129-17
Program	Prior Authorization/Notification
Medication	Otezla® (apremilast) / Otezla XR™ (apremilast)
P&T Approval Date	5/2014, 10/2014, 2/2015, 3/2016, 3/2017, 3/2018, 3/2019, 3/2020, 3/2021, 2/2022, 2/2023, 7/2023, 6/2024, 6/2025, 9/2025, 11/2025
Effective Date	2/1/2026

1. Background:

Otezla/Otezla XR (apremilast) is a phosphodiesterase 4 (PDE4) inhibitor indicated for the treatment of adult patients with active psoriatic arthritis, plaque psoriasis who are candidates for phototherapy or systemic therapy, and oral ulcers associated with Behçet's disease. Otezla is also indicated for the treatment of pediatric patients 6 years of age and older and weighing at least 20 kg with moderate to severe plaque psoriasis who are candidates for phototherapy or systemic therapy and active psoriatic arthritis.

2. Coverage Criteria[a]:

A. Psoriatic Arthritis (PsA)

1. **Initial Authorization**

   a. **Otezla or Otezla XR** will be approved based on **both** of the following criteria:

      (1) Diagnosis of active psoriatic arthritis

      -AND-

      (2) Patient is not receiving Otezla or Otezla XR in combination with another systemic targeted immunomodulator [e.g., adalimumab, Bimzelx (bimekizumab-bkzx), Cimzia (certolizumab), Cosentyx (secukinumab), Enbrel (etanercept), Orencia (abatacept), Rinvoq (upadacitinib), Simponi (golimumab), Skyrizi (risankizumab), Taltz (ixekizumab), Tremfya (guselkumab), Xeljanz/Xeljanz XR (tofacitinib), ustekinumab] for treatment of the same indication.

      Authorization will be issued for 12 months.

2. **Reauthorization**

   a. **Otezla or Otezla XR** will be approved based on **both** of the following criteria:

      (1) Documentation of positive clinical response to Otezla or Otezla XR therapy

      -AND-

      (2) Patient is not receiving Otezla or Otezla XR in combination with another

systemic targeted immunomodulator [e.g., adalimumab, Bimzelx (bimekizumab-bkzx), Cimzia (certolizumab), Cosentyx (secukinumab), Enbrel (etanercept), Orencia (abatacept), Rinvoq (upadacitinib), Simponi (golimumab), Skyrizi (risankizumab), Taltz (ixekizumab), Tremfya (guselkumab), Xeljanz/Xeljanz XR (tofacitinib), ustekinumab] for treatment of the same indication.

Authorization will be issued for 12 months.

B. Plaque Psoriasis

1. **Initial Authorization**

a. **Otezla or Otezla XR** will be approved based on **both** of the following criteria:

(1) Diagnosis of plaque psoriasis

-AND-

(2) Patient is not receiving Otezla or Otezla XR in combination with another systemic targeted immunomodulator [e.g., adalimumab, Bimzelx (bimekizumab-bkzx), Cimzia (certolizumab), Cosentyx (secukinumab), Enbrel (etanercept), Ilumya (tildrakizumab), Skyrizi (risankizumab), Siliq (brodalumab), Sotyktu (deucravacitinib), Taltz (ixekizumab), Tremfya (guselkumab), ustekinumab] for treatment of the same indication.

Authorization will be issued for 12 months.

2. **Reauthorization**

a. **Otezla or Otezla XR** will be approved based on **both** of the following criteria:

(1) Documentation of positive clinical response to Otezla or Otezla XR therapy

-AND-

(2) Patient is not receiving Otezla or Otezla XR in combination with another systemic targeted immunomodulator [e.g., adalimumab, Bimzelx (bimekizumab-bkzx), Cimzia (certolizumab), Cosentyx (secukinumab), Enbrel (etanercept), Ilumya (tildrakizumab), Skyrizi (risankizumab), Siliq (brodalumab), Sotyktu (deucravacitinib), Taltz (ixekizumab), Tremfya (guselkumab), ustekinumab] for treatment of the same indication.

Authorization will be issued for 12 months.

C. Behçet's disease

1. **Initial Authorization**

a. **Otezla or Otezla XR** will be approved based on **all** of the following criteria:

(1) Diagnosis of Behçet's disease

-AND-

(2) Patient has oral ulcers attributed to Behçet's disease

-AND-

(3) Patient is not receiving Otezla or Otezla XR in combination with another systemic targeted immunomodulator [e.g., adalimumab, Cimzia (certolizumab), Enbrel (etanercept), Olumiant (baricitinib), Orencia (abatacept), Simponi (golimumab), tocilizumab] for treatment of the same indication.

Authorization will be issued for 12 months.

2. **Reauthorization**

a. **Otezla or Otezla XR** will be approved based on **both** of the following criteria:

(1) Documentation of positive clinical response to Otezla or Otezla XR therapy

-AND-

(2) Patient is not receiving Otezla or Otezla XR in combination with another systemic targeted immunomodulator [e.g., adalimumab, Cimzia (certolizumab), Enbrel (etanercept), Olumiant (baricitinib), Orencia (abatacept), Simponi (golimumab), tocilizumab] for treatment of the same indication.

Authorization will be issued for 12 months.

[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3. Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4. References:

1. Otezla/Otezla XR [package insert]. Thousand Oaks, CA: Amgen Inc.; August 2025.

Program	Prior Authorization/Notification - Otezla (apremilast) / Otezla XR™ (apremilast)
Change Control	
5/2014	New program.
10/2014	Added new indication for plaque psoriasis.
2/2015	No change to coverage criteria. Minor reformatting. Updated clinical rules and background.
3/2016	No change to coverage criteria. Updated reference.
3/2017	Annual review with no changes to criteria.
3/2018	Annual review with no changes to criteria. Updated reference.
7/2018	Administrative change to include Oxford effective date.
3/2019	Annual review with no change to coverage criteria.
3/2020	Annual review. Updated background and criteria to include coverage for new indication for oral ulcers associated with Behçet's disease.
3/2021	Annual review with no change to clinical criteria. Updated reauthorization from 24 months to 12 months to align with other programs. Reference updated.
2/2022	Updated background and coverage criteria with expanded plaque psoriasis indication. Updated reference.
2/2023	Annual review. Updated listed examples from Humira to adalimumab and added Rinvoq. Added state mandate footnote.
7/2023	Updated not receiving in combination language to targeted immunomodulator and updated examples.
6/2024	Updated background to reflect new indication for pediatrics with plaque psoriasis. Updated reference.
6/2025	Annual review with no change to clinical criteria. Updated not used in combination examples with no change to clinical intent.
9/2025	Updated background to reflect new indication for pediatrics with active psoriatic arthritis. Updated reference.
11/2025	Added Otezla XR to the program with same clinical criteria as Otezla. Removed candidates for phototherapy or systemic therapy from PsO criteria. Updated background and reference.