START Form for Specialty Pharmacy

Otezla SUPPORTPLUS™

Step 1. Please complete **all** fields on this form (to prevent delays in processing).
Step 2. Fax this form, along with the signed HIPAA Authorization and copies of both sides of insurance and pharmacy benefit cards, to the specialty pharmacy (SP) of your choice. **FAX #**_____ **SP NAME** _____

For assistance or more information, please visit **otezlapro.com** or call **1-844-4OTEZLA** (1-844-468-3952).

Section 1: Patient Information

Name (First, MI, Last) _____ Date of birth ____ / ____ / _____ ☐ Male ☐ Female

Address _____ City_____ State_____ ZIP _____

E-mail address _____ Last 4 digits of SS #_____

Home phone _____ ☐ OK to leave message Mobile phone _____ ☐ OK to leave message

Preferred contact number: ☐ Home ☐ Mobile Best time to reach me: ☐ Morning ☐ Afternoon ☐ Evening

Section 2: Insurance Information

Primary insurance name _____ Policy # _____ Group # _____

Insurance phone _____ Policyholder name (First, MI, Last) _____

☐ Patient has no insurance ☐ Patient has secondary insurance Name of specialty pharmacy _____

Pharmacy Benefit Manager (PBM) _____ PBM phone _____

Rx Member ID _____ Rx PCN (if applicable) _____

Rx Group ID _____ Rx BIN (if applicable) _____

I have read and agree to the attached HIPAA Authorization to Share Health Information.

Patient/patient representative signature _____ Date (MM/DD/YYYY) _____ / _____ /_____

*(if signed by patient representative, please explain authority to act on behalf of the patient)*_____

Section 3: Clinical Information (TO BE COMPLETED BY HEALTHCARE PROVIDER)

PRIMARY DIAGNOSIS/ ICD-10-CM Code:

☐ L40.50 (Arthropathic psoriasis, unspecified)
☐ L40.51 (Distal interphalangeal psoriatic arthropathy)
☐ L40.52 (Psoriatic arthritis mutilans)
☐ L40.53 (Psoriatic spondylitis)
☐ L40.59 (Other psoriatic arthropathy)
☐ L40.0 (Psoriasis vulgaris) %BSA Affected _____
☐ L40.8 (Other psoriasis) %BSA Affected _____
☐ L40.9 (Psoriasis, unspecified) %BSA Affected _____

AFFECTED AREA(S) (For PsO ONLY): ☐ Hands ☐ Arms ☐ Nails ☐ Trunk ☐ Feet ☐ Legs ☐ Scalp ☐ Groin ☐ Other _____

PREVIOUS/CURRENT TREATMENT:

Medication	Duration/Reason for D/C	Medication	Duration/Reason for D/C
☐ Methotrexate		☐ Biologics	
☐ Cyclosporine		☐ Topicals	
☐ Sulfasalazine		☐ Other	
☐ Acitretin			
☐ PUVA or UV		ADDITIONAL MEDICAL JUSTIFICATION	

Section 4: Prescription Information (TO BE COMPLETED BY HEALTHCARE PROVIDER)

PRESCRIPTION FOR OTEZLA (apremilast) FOR ORAL USE: SELECT ALL THAT APPLY

Starter Pack (Titration) Rx for Otezla*

☐ **4-WEEK STARTER PACK** x28 days 55 tablets 0 refills

OR

☐ **PRESCRIBER PROVIDED PATIENT WITH 2-WEEK STARTER PACK SAMPLE** x14 days 27 tablets 0 refills Date provided ____ / ____ / ____

Additional information _____

*Titration Starter Pack Rx is only for patients who did not receive a titration sample during their office visit. Specialty Pharmacy will notify the patient via telephone prior to each shipment.

Maintenance Rx — 30 mg of Otezla ☐ x30 days ☐ x90 days | ☐ **TWICE DAILY** (Recommended daily dose) OR ☐ **ONCE DAILY** (For patients with severe renal impairment)

Refills: ☐ **11** ☐ **Other amount** (enter #) _____ Special instructions _____

Bridge Rx — 30 mg of Otezla†

☐ **TWICE DAILY** (Recommended daily dose) x14 days 28 tablets 12 refills

OR

☐ **ONCE DAILY** (For patients with severe renal impairment) x28 days 28 tablets 6 refills

†Bridge Rx is at no cost, for eligible commercially insured, on-label diagnosed patients only, and not contingent on purchase requirements of any kind. Bridge Rx is not available to enrollees in Medicare, Medicaid, and other federal and state programs, as well as Massachusetts residents. Intended to support continuation of prescribed therapy if there is a delay in determining whether commercial prescription coverage is available.

Section 5: Prescriber Information (TO BE COMPLETED BY HEALTHCARE PROVIDER)

Name (First, Last) _____ Facility name _____

Address _____ City_____

State _____ ZIP _____ Phone _____ Fax_____ NPI #_____ DEA # _____

Office contact _____ Best time to contact: ☐ Morning ☐ Afternoon

PRESCRIBER AUTHORIZATION*

By signing this START Form I certify that I have prescribed Otezla (apremilast) based on my professional judgment of medical necessity and that I will supervise the patient's medical treatment. I authorize the release of medical and/or other patient information relating to Otezla therapy to agents, and service providers of Celgene (including but not limited to Covance Specialty Pharmacy and Otezla-dispensing pharmacies) to use and disclose as necessary for fulfillment of the prescription and furnish any information on this form to the insurer of the above-named patient.

Prescriber signature (dispense as written) _____ Date _____ / _____ / _____

Supervising physician signature and date (where required) _____ Date _____ / _____ / _____

Signature stamps not acceptable. *If required by applicable law, please attach copies of all prescriptions on official state prescription forms.

HIPAA Authorization to Share Health Information

Fax this signed Authorization, the completed START Form, and copies of both sides of insurance and pharmacy benefit cards, to the specialty pharmacy (SP) of your choice. **FAX #**_____ **SP NAME**_____
For more information, or to get answers to your questions, please visit **otezlapro.com** or call **1-844-4OTEZLA** (1-844-468-3952).

Otezla SUPPORTPLUS™

By signing this Authorization, I authorize my healthcare providers, my health insurance company, and my pharmacy providers to disclose to Celgene and companies working with Celgene (collectively, "Celgene") health information relating to my medical condition, treatment, and insurance coverage to (1) provide me with Celgene-sponsored treatment support services, including online support, financial assistance services, co-pay assistance, reimbursement services, nurse services, and compliance and persistency services, as well as any information or materials related to such services or Celgene products, including promotional or educational communications, (2) provide me with information about, or ask me about my experience with or thoughts about, products, services, and programs that Celgene offers or sponsors, including treatment support services, and (3) allow Celgene to analyze the usage patterns and the effectiveness of Celgene products, services, and programs and help develop new products, services, and programs, and for other Celgene general business and administrative purposes.

I further authorize my healthcare providers, including my pharmacy providers, to use my health information to communicate with me by mail, e-mail, phone, fax or otherwise, about drugs that are currently being prescribed for me, including to remind me about refills of such drugs and adherence to my prescribed drug therapy. I understand that my healthcare providers, including my pharmacy providers, may receive remuneration from Celgene for disclosing my health information to Celgene, and for using my health information to contact me with communications about Celgene products which have been prescribed to me and Celgene-sponsored services.

Once my health information has been disclosed to Celgene and/or such other individuals, I understand that federal privacy laws may no longer protect the information. However, I understand that Celgene and other companies authorized to receive my health information pursuant to this Authorization agree to protect my health information by using and disclosing it only for purposes authorized in this Authorization or as required by law or regulations.

I understand that I may refuse to sign this Authorization, but that if I do, Otezla SupportPlus™ may not have full access to my prescription status.

I further understand that my treatment (including with a Celgene product), insurance enrollment, and eligibility for insurance benefits are not conditioned upon my signing this Authorization.

I may cancel this Authorization at any time by mailing a letter to Otezla SupportPlus™ at PO BOX 13185, La Jolla, California 92039 or by sending an e-mail to otezlaprivacy@celgene.com. I understand that if I revoke this authorization, it will not have any effect on the use of my information by the parties referenced herein before Celgene received the revocation. I also understand that if I revoke this authorization, it will not affect my ability to receive Otezla. This Authorization expires ten [10] years from the day I sign it as indicated by the date next to my signature unless otherwise earlier canceled as set forth above. I understand that I may receive a copy of this Authorization.

I have read and understand the HIPAA Authorization to Share Health Information and agree to the terms.

Signature of patient or patient representative _____ Date____ / ____ / ____

(if signed by patient representative, please explain authority to act on behalf of the patient) _____

Filling an Otezla prescription

PRESCRIBE

Prescribe Otezla® (apremilast) 30-mg tablets for an appropriate patient

PREPARE

1. Collect patient information, including prescription benefit information
2. Select a Specialty Pharmacy (SP) to process the Rx or choose Otezla SupportPlus™ (OSP) to initiate the prescription process
3. Provide Starter Pack, if appropriate

No Starter Pack?

Request Starter Pack in section 4 of the START Form or from your Otezla Sales Representative

SUBMIT

1. Complete the Otezla START Form or the SP enrollment form. Send with copies of the medical and prescription benefit card to the SP or OSP
2. SP or OSP conducts the benefit verification and determines if Prior Authorization (PA) is required

PA is not required

PA is required

Submit PA form along with other required documentation to the insurer

PA is approved

PA is denied

APPEAL

Appeal the denial by submitting the Letter of Medical Necessity and other required documentation to the insurer. Request this document in the Professional Resources tab at **otezlapro.com**, or contact OSP, **1-844-4OTEZLA** (1-844-468-3952) 8 AM - 8 PM ET, Monday - Friday

Appeal is approved

Benefit verification is complete.

SP coordinates co-pay collection and direct mail shipment of medication to the patient

Should appeal(s) be denied

Refer patient to OSP to determine eligibility for the Patient Assistant Program

Otezla® (apremilast) 30mg tablets

Otezla SupportPlus™ can help with access

This support network includes resources for you and your patients.

REIMBURSEMENT SUPPORT

- Benefits investigation and prior authorization (PA) assistance
- Assessment of patient eligibility for Medicare coverage
- Appeals support for coverage denials
- Specialty pharmacy triage and coordination
- Status updates on prescription fulfillment

PATIENT SUPPORT

- 24/7 access to specially trained nurses
- $0 co-pay* enrollment and follow-up
- Live insurance support
- Updates on prescription status
- Shipment of free bridge to maintenance supply during potential reimbursement delays for commercially insured patients

Financial assistance options

COMMERCIALLY INSURED

Otezla Savings Program

Eligibility requirements:

- Commercially insured (no Medicare or Medicaid)
- Patient must be a US resident

Be sure to remind your patients that they may be eligible for a $0 co-pay,* and to ask their specialty pharmacy about financial offers that may be available to them.

MEDICARE & MEDICAID

Independent Co-pay Foundations & State Programs

Eligibility requirements

(may vary by foundation):

- Each fund has its own enrollment process
- Patients can receive funding as needed

UNINSURED OR UNDERINSURED

Patient Assistance Program

Eligibility requirements:

- On-label diagnosis
- For uninsured or underinsured patients
- Patient must be a US resident
- Patient must meet financial requirements

*Certain restrictions apply. This offer is not valid for persons eligible for reimbursement of this product, in whole or in part, under Medicaid, Medicare, or similar state or federal programs. Offer void where prohibited by law.

Questions? Need more information?

Call **Otezla SupportPlus™** at **1-844-4OTEZLA** (1-844-468-3952)
8 AM – 8 PM ET, Monday – Friday

Or visit **OtezlaSupportPlus.com**

Otezla® (apremilast) 30mg tablets

The right information speeds the process

Any incorrect or missing information on the START Form can delay the approval process.

Did you remember to

- Obtain patient and HCP signatures. Patient signature on file may be acceptable for some specialty pharmacies and should be noted
- Note the patient's titration start date if you provided the Starter Pack directly to your patient
- Check "Bridge Rx – 30 mg of Otezla® (apremilast)" in section 4 of the START Form
- Indicate permission to leave a message with patient
- Include copies of both sides of the patient's (1) prescription benefit card and (2) medical benefit card
- Fax any clinical notes helpful in establishing diagnosis to the SP or OSP

Additional helpful tips

- Need a Prior Authorization form? One can be provided by the patient's insurance company
- If you have questions about filling out the START Form, **Otezla SupportPlus™** is here to help you every step of the way. Just call us at **1-844-4OTEZLA** (1-844-468-3952) 8 AM – 8 PM ET, Monday – Friday

Starting on Otezla® (apremilast)

OTEZLA BRIDGE PROGRAM

Commercial patients denied or waiting for coverage can receive a free supply of Otezla for up to 3 years*

If a Starter Pack is not provided in office as shown, please check the appropriate box in section 4 of the START Form and the specialty pharmacy will provide titration as part of first month's supply.

*Ensure your patient has received a Starter Pack prior to enrolling.

Otezla® (apremilast) 30mg tablets

Indications and Important Safety Information

INDICATIONS

Otezla® (apremilast) is indicated for the treatment of patients with moderate to severe plaque psoriasis who are candidates for phototherapy or systemic therapy.

Otezla is indicated for the treatment of adult patients with active psoriatic arthritis.

IMPORTANT SAFETY INFORMATION

Contraindications

- Otezla® (apremilast) is contraindicated in patients with a known hypersensitivity to apremilast or to any of the excipients in the formulation

Warnings and Precautions

- Diarrhea, Nausea and Vomiting: Cases of severe diarrhea, nausea, and vomiting were associated with the use of Otezla. Most events occurred within the first few weeks of treatment. In some cases patients were hospitalized. Patients 65 years of age or older and patients taking medications that can lead to volume depletion or hypotension may be at a higher risk of complications from severe diarrhea, nausea, or vomiting. Monitor patients who are more susceptible to complications of diarrhea or vomiting; advise patients to contact their healthcare provider. Consider Otezla dose reduction or suspension if patients develop severe diarrhea, nausea, or vomiting
- Depression: Carefully weigh the risks and benefits of treatment with Otezla for patients with a history of depression and/or suicidal thoughts/behavior, or in patients who develop such symptoms while on Otezla. Patients, caregivers, and families should be advised of the need to be alert for the emergence or worsening of depression, suicidal thoughts or other mood changes, and they should contact their healthcare provider if such changes occur
  - Psoriasis: Treatment with Otezla is associated with an increase in depression. During clinical trials, 1.3% (12/920) of patients reported depression compared to 0.4% (2/506) on placebo; Depression was reported as serious in 0.1% (1/1308) of patients exposed to Otezla, compared to none in placebo-treated patients (0/506). Suicidal behavior was observed in 0.1% (1/1308) of patients on Otezla, compared to 0.2% (1/506) on placebo. One patient treated with Otezla attempted suicide; one patient on placebo committed suicide
  - Psoriatic Arthritis: Treatment with Otezla is associated with an increase in depression. During clinical trials, 1.0% (10/998) reported depression or depressed mood compared to 0.8% (4/495) treated with placebo. Suicidal ideation and behavior was observed in 0.2% (3/1441) of patients on Otezla, compared to none in placebo treated patients. Depression was reported as serious in 0.2% (3/1441) of patients exposed to Otezla, compared to none in placebo treated patients (0/495). Two patients who received placebo committed suicide compared to none on Otezla
- Weight Decrease: Monitor body weight regularly; evaluate unexplained or clinically significant weight loss, and consider discontinuation of Otezla
  - Psoriasis: Body weight loss of 5-10% occurred in 12% (96/784) of patients treated with Otezla and in 5% (19/382) of patients treated with placebo. Body weight loss of ≥10% occurred in 2% (16/784) of patients treated with Otezla compared to 1% (3/382) of patients treated with placebo
  - Psoriatic Arthritis: Body weight loss of 5-10% was reported in 10% of patients taking Otezla and in 3.3% of patients taking placebo
- Drug Interactions: Apremilast exposure was decreased when Otezla was co-administered with rifampin, a strong CYP450 enzyme inducer; loss of Otezla efficacy may occur. Concomitant use of Otezla with

Please see additional Important Safety Information on the next page.

Indications and Important Safety Information

CYP450 enzyme inducers (e.g., rifampin, phenobarbital, carbamazepine, phenytoin) is not recommended

Adverse Reactions

- Psoriasis: Adverse reactions reported in ≥5% of patients were (Otezla%, placebo%): diarrhea (17, 6), nausea (17, 7), upper respiratory tract infection (9, 6), tension headache (8, 4), and headache (6, 4)
- Psoriatic Arthritis: Adverse reactions reported in at least 2% of patients taking Otezla, that occurred at a frequency at least 1% higher than that observed in patients taking placebo, for up to 16 weeks (after the initial 5-day titration), were (Otezla%, placebo%): diarrhea (7.7, 1.6); nausea (8.9, 3.1); headache (5.9, 2.2); upper respiratory tract infection (3.9, 1.8); vomiting (3.2, 0.4); nasopharyngitis (2.6, 1.6); upper abdominal pain (2.0, 0.2)

Use in Specific Populations

- Pregnancy and Nursing Mothers: Otezla is Pregnancy Category C; it has not been studied in pregnant women. Use during pregnancy only if the potential benefit justifies the potential risk to the fetus. It is not known whether apremilast or its metabolites are present in human milk. Caution should be exercised when Otezla is administered to a nursing woman
- Renal Impairment: Otezla dosage should be reduced in patients with severe renal impairment (creatinine clearance less than 30 mL/min); for details, see Dosage and Administration, Section 2, in the Full Prescribing Information

Please click here for Full Prescribing Information.