

# START Form for Specialty Pharmacy



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](http://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)  L40.0 (Psoriasis vulgaris) %BSA Affected \_\_\_\_\_  
 L40.51 (Distal interphalangeal psoriatic arthropathy)  L40.8 (Other psoriasis) %BSA Affected \_\_\_\_\_  
 L40.52 (Psoriatic arthritis mutilans)  L40.9 (Psoriasis, unspecified) %BSA Affected \_\_\_\_\_  
 L40.53 (Psoriatic spondylitis)  
 L40.59 (Other psoriatic arthropathy)

**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
<input type="checkbox"/> Methotrexate	_____	<input type="checkbox"/> Biologics	_____
<input type="checkbox"/> Cyclosporine	_____	<input type="checkbox"/> Topicals	_____
<input type="checkbox"/> Sulfasalazine	_____	<input type="checkbox"/> Other	_____
<input type="checkbox"/> Acitretin	_____		
<input type="checkbox"/> 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)   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)   ONCE DAILY (For patients with severe renal impairment)  
Refills:  11  Other amount (enter #) \_\_\_\_\_ Special instructions \_\_\_\_\_

**Bridge Rx — 30 mg of Otezla<sup>1</sup>**  TWICE DAILY (Recommended daily dose) (x14 days 28 tablets 12 refills)   ONCE DAILY (For patients with severe renal impairment) (x28 days 28 tablets 6 refills)

<sup>1</sup>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](http://otezlapro.com) or call **1-844-4OTEZLA** (1-844-468-3952).

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](mailto: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](http://otezlapro.com), or contact OSP, **1-844-4OTEZLA** (1-844-468-3952) 8 AM - 8 PM ET, Monday - Friday

Appeal is approved

Should appeal(s) be denied

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

**Benefit verification is complete.**

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



# Otezla SupportPlus™ can help with access

This comprehensive support network includes resources for your patients and your practice.

## COMPREHENSIVE 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, comprehensive 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](http://OtezlaSupportPlus.com)



# 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)



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.



# Indications and Important Safety Information

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## 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

**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.

Treatment with Otezla is associated with an increase in adverse reactions of depression. During clinical trials, 1.3% (12/920) of patients treated with Otezla reported depression compared to 0.4% (2/506) on placebo; 0.1% (1/1308) of Otezla patients discontinued treatment due to depression compared with none on placebo (0/506). 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.

**Weight Decrease:** Monitor body weight regularly; evaluate unexplained or clinically significant weight loss, and consider discontinuation of Otezla. 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  $\geq 10\%$  occurred in 2% (16/784) of patients treated with Otezla compared to 1% (3/382) of patients treated with 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 CYP450 enzyme inducers (eg, rifampin, phenobarbital, carbamazepine, phenytoin) is not recommended.

### Adverse Reactions

Adverse reactions reported in  $\geq 5\%$  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).

### 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.

