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) _____

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** or call **1-844-4OTEZLA (1-844-468-3952)**.

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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-9 CM 696.0 (Psoriatic Arthritis) ☐ ICD-9 CM 696.1 (Psoriasis) %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 2-WEEK STARTER PACK SAMPLE TO PATIENT 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 ☐ **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.