START Form

Step 1. Please complete all fields on this form (to prevent delays in processing).

Step 2. Fax this form and copies of both sides of insurance and pharmacy benefit cards to the specialty pharmacy (SP) of your choice or to Otezla SupportPlus™. FAX#_____Preferred SP NAME_____

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

Otezla® SUPPORTPLUS™

Section 1: Patient Information

Name (First, MI, Last) _____ Last 4 digits of SS #_____ Date of birth ____ / ____ / _____ ☐ Male ☐ Female

Address _____ (No P.O. Box) City_____ State _____ ZIP _____

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

Email address _____ Preferred number: ☐ Home ☐ Mobile Preferred time: ☐ Morning ☐ Afternoon ☐ Evening ☐ Telemed Visit

*By providing my phone number, I consent to Amgen calling and texting me at the phone number(s) I have provided with promotional communications relating to Amgen products and services and/or my condition or treatment. Amgen may use automatic dialing machines or artificial or prerecorded messages to contact me and may leave a voicemail or SMS/text message (standard text messaging rates may apply). I understand that I am not required to provide this consent as a condition of purchasing any goods or services. Reply STOP to cancel SMS messages.

Section 2: Insurance Information

☐ Insurance card attached ☐ Pharmacy benefit card attached ☐ Patient has no insurance ☐ Patient has secondary insurance

Primary insurance name _____ Policy # _____ Group # _____ Insurance phone _____

Policyholder name (First, MI, Last) _____ Pharmacy Benefit Manager (PBM) _____ PBM phone _____

Rx Member ID _____ Rx PCN (if applicable) _____ Rx Group ID _____ Rx BIN (if applicable) _____

☐ If eligible, I would like to enroll in the Otezla Co-pay program.

I understand that co-pay assistance is only available for commercially insured patients and does not apply if I have prescription drug coverage through a federal, state, VA or similar program.

I have read and agreed to the attached HIPAA Authorization to Share Health Information accompanying this form.

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 _____
☐ M35.2 (Behçet's Disease)

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	_____		
☐ Colchicine	_____		

ADDITIONAL MEDICAL JUSTIFICATION _____

Section 4: Prescription for OTEZLA® (apremilast) FOR ORAL USE (TO BE COMPLETED BY HEALTHCARE PROVIDER)

① STEP 1: SELECT TITRATION

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. The specialty pharmacy will notify the patient via telephone prior to each shipment.

② STEP 2: SELECT MAINTENANCE DOSE

Maintenance Rx—30 mg of Otezla

☐ x30 days ☐ x90 days

☐ **TWICE DAILY**

☐ **ONCE DAILY renal dose 30 mg**
(For patients with severe renal impairment)

Refills: ☐ **11** ☐ **Other amount** (enter #) ____

Special instructions
_____
_____
_____
_____

③ STEP 3: SELECT BRIDGE (IF APPLICABLE)†

Bridge Rx—30 mg of Otezla

☐ **TWICE DAILY**
x14 days, 28 tablets, 12 refills

☐ **ONCE DAILY renal dose 30 mg**
x28 days, 28 tablets, 6 refills

†Bridge Rx is at no cost for eligible commercially insured, on-label diagnosed patients only, and is not contingent on purchase requirements of any kind. Bridge Rx is not available to enrollees in Medicare, Medicaid, and other federal and state programs intended to support continuation of prescribed therapy if there is a delay in determining whether commercial prescription coverage is available. In Step 1, please indicate if you provided the patient with the 2-week Starter Pack sample, or if the 4-week Starter Pack needs to be dispensed.

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 Amgen (including but not limited to Covance Specialty Pharmacy and Otezla-dispensing pharmacies) to use and disclose as necessary for fulfillment of the prescription and to 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.

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PLEASE DO NOT WRITE IN THE MARGINS – INFORMATION CAN BE MISSED OR CUT OFF

PLEASE DO NOT WRITE IN THE MARGINS – INFORMATION CAN BE MISSED OR CUT OFF

Patient Authorization to Share Health Information

Otezla® SUPPORTPLUS™

Please present this Authorization to the patient/patient representative and obtain the required signature.

Uses and Disclosure of Personal Information
I authorize Amgen and its contractors and business partners ("Amgen") to use and/or disclose my personal information, *including my personal health information*, only for the following purposes:

- To operate, administer, enroll me in, and/or continue my participation in Amgen's Otezla SupportPlus™ program or any other Amgen-affiliated patient support services and activities related to my condition or treatment (for example, co-pay card programs, reimbursement assistance programs, drug coverage verification, nurse educator services, adherence program and disease management support);
- To contact, with my permission, my doctor and the rest of my health care team and share with them my health information that may be useful for my care;
- **To provide me with informational and promotional materials relating to Amgen products and services, and/or my condition or treatment**; and/or
- To improve, develop, and evaluate products, services, materials and programs related to my condition or treatment.

In order for Amgen to provide me with the services and/or programs described above, Amgen needs to collect and use my personal information, including *my personal health information*. I understand that *my personal health information* may include any information, in electronic or physical form, in the possession of or derived from a health care provider, health care plan, pharmacy, pharmaceutical company, laboratory and/or their contractor ("Health Care Provider"). This may include select information from or about my medical history and general health, my health care plan benefits, payment limits or restrictions covered by my health care plan policy, and/or my adherence to my treatment.

I authorize my Health Care Providers to disclose *my personal health information* to Amgen, and between themselves, as necessary, but only for the purposes stated above in this Authorization. I understand that certain of my Health Care Providers (such as pharmacies and specialty pharmacies) may receive remuneration from Amgen in exchange for disclosing *my personal health information* and/or for using my information to contact me with communications about Amgen products which have been prescribed to me (for example medication reminder programs) and other patient support services.

Expiration, Right to Obtain a Copy and Right to Cancel
I understand that by signing this form, I authorize my Health Care Providers or others who might hold my health information to only release it to Amgen employees, as well as to its contractors and business partners, who are performing the services set forth in this Authorization. I also understand I am authorizing my personal information, including *my personal health information*, to be used for the purposes described above. I understand and agree that by signing below, I am authorizing those who rely on this Authorization to release my personal health information for the earlier of five (5) years or until my participation in the program ends through my cancellation, unless a shorter time period is required by state law.

I understand that I can obtain a copy of this Authorization or cancel this Authorization at any time by calling Amgen at 1-844-468-3952 or by writing to PO BOX 13185, La Jolla, California, 92039. If I cancel my consent, I will no longer qualify for the services described. I also understand that if a Health Care Provider is disclosing my personal health information to Amgen on an authorized on-going basis, my cancellation with Amgen will be effective with respect to any such Health Care Providers as soon as they receive notice of my cancellation.

No Effect on Treatment
I understand I do not have to sign this Authorization and that my enrollment in any of the services and/or programs described above is entirely voluntary. I understand that Amgen, as well as Health Care Providers, cannot require me, as a condition of having access to medications, prescription drugs, treatment or other care, to sign this Authorization. Federal Law (including HIPAA) requires a signed authorization in order for Amgen to collect this information from my Health Care Providers. I understand I cannot participate in the listed services and/or programs without signing this Authorization or an equivalent authorization with my Health Care Providers.

Information Received from Health Care Providers
I understand that once my personal health information has been disclosed to Amgen, federal privacy laws may no longer apply and protect it from further disclosure. Amgen agrees, however, to protect my personal health information by only using and disclosing it as stated in the Authorization or as otherwise allowed or required by law.

Authorization to Contact
I understand and consent to Amgen contacting me using the contact information provided in this form to enroll me in, operate, and administer Amgen patient support services and/or programs as described above other than promotional communications by telephone or SMS/text (which I can separately opt-in below). I understand that the operation and administration of certain of these services and/or programs may require that Amgen contact me by telephone or SMS/text.

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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 → **Benefit verification is complete.** SP coordinates co-pay collection and direct mail shipment of medication to the patient

PA is required

Submit PA form along with other required documentation to the insurer

PA is approved → **Benefit verification is complete.** SP coordinates co-pay collection and direct mail shipment of medication to the patient

PA is denied

APPEAL

Appeal the denial by submitting the Letter of Medical Necessity and other required documentation to the insurer. Find this document on 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 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

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

- Fax completed and signed Otezla START Form to Otezla SupportPlus™ (Patient signature is not required during a telemedicine visit.)
- 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 PA 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

Otezla®
(apremilast) 30mg tablets

How to start on Otezla

Starting with in-office sample:

Otezla® (apremilast) 30 mg Starter Pack

- 2 weeks of medication, including 5 days of titration doses

Starting with the specialty pharmacy:

Otezla 30 mg 28-Day Pack

- Includes 5 days of titration doses and additional maintenance doses if Starter Pack is not provided in office

Otezla®
BRIDGE PROGRAM

Denied or awaiting coverage?

Get Your Patients *3 for Free**

Offers your commercially insured patients up to 3 years of Otezla for $0

- Check the "Bridge Rx" option on the Otezla START Form when prescribing

Otezla 30 mg 30-Day Supply

- Maintenance doses for patients who have received benefit verification

Check the "Bridge Rx" option on the Otezla START Form when prescribing

*To receive a free Bridge supply of Otezla, commercially insured patients must have an on-label diagnosis and be denied or waiting for coverage. If an in-office Starter Pack (Titration) is not available, please check both the 4-week Starter Pack and Bridge Rx boxes.

Indications and Important Safety Information

INDICATIONS

Otezla® (apremilast) is indicated for the treatment of adult 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.

Otezla is indicated for the treatment of adult patients with oral ulcers associated with Behçet's Disease.

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
  - Behçet's Disease: Treatment with Otezla is associated with an increase in depression. During the clinical trial, 1% (1/104) reported depression or depressed mood compared to 1% (1/103) treated with placebo. No instances of suicidal ideation or behavior were reported in patients treated with Otezla or treated with placebo

Please see additional Important Safety Information on the next page.

Otezla® (apremilast) 30mg tablets

Indications and Important Safety Information (cont'd)

- 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% (49/497) of patients taking Otezla and in 3.3% (16/495) of patients taking placebo
  - Behçet's Disease: Body weight loss of >5% was reported in 4.9% (5/103) of patients taking Otezla and in 3.9% (4/102) 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 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)
- Behçet's Disease: Adverse reactions reported in ≥5% of patients taking Otezla, that occurred at a frequency at least 1% higher than that observed in patients taking placebo, for up to 12 weeks, were (Otezla%, placebo%): diarrhea (41.3, 20.4); nausea (19.2, 10.7); headache (14.4, 10.7); upper respiratory tract infection (11.5, 4.9); upper abdominal pain (8.7, 1.9); vomiting (8.7, 1.9); back pain (7.7, 5.8); viral upper respiratory tract infection (6.7, 4.9); arthralgia (5.8, 2.9)

Use in Specific Populations

- Pregnancy: Otezla has not been studied in pregnant women. Advise pregnant women of the potential risk of fetal loss. Consider pregnancy planning and prevention for females of reproductive potential. There is a pregnancy exposure registry that monitors pregnancy outcomes in women exposed to Otezla during pregnancy. Information about the registry can be obtained by calling 1-877-311-8972 or visiting https://mothertobaby.org/ongoing-study/otezla/
- Lactation: There are no data on the presence of apremilast or its metabolites in human milk, the effects of apremilast on the breastfed infant, or the effects of the drug on milk production. The developmental and health benefits of breastfeeding should be considered along with the mother's clinical need for Otezla and any potential adverse effects on the breastfed child from Otezla or from the underlying maternal condition
- 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.

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Otezla® (apremilast) 30mg tablets