Otezla SUPPORTPLUS™

FAX COMPLETED FORM TO 1-844-269-3053

Thank you for your interest in the Celgene Patient Assistance Program for Otezla® (apremilast).

The Celgene Patient Assistance Program for Otezla provides no-cost medication to patients who meet specific program eligibility requirements. Please complete, sign, and submit this application form in order to begin the evaluation process for enrollment.

To prevent processing delays, all fields of this application must be completed and submitted with copies of all required financial documents. Do not send original documents as they will not be returned.

No Prescription Coverage for Otezla	Medicare Part D Coverage
If you do not have prescription drug coverage, or Otezla is not covered by your plan, you may be eligible for the Celgene Patient Assistance Program for Otezla. If eligible, your enrollment will expire after twelve (12) months.	If you have Medicare Part D you may be eligible for the Celgene Patient Assistance Program for Otezla. If eligible, your enrollment will expire on December 31st.

Program eligibility criteria

To be eligible, uninsured or underinsured patients must meet the following criteria:

- FDA-approved diagnosis
- Be a permanent resident of the United States
- Medicare-eligible beneficiaries must have enrolled in a Medicare Part D plan or other creditable coverage
- Annual family gross income is equal to or less than the Annual Income Guidelines (adjusted gross income is not accepted)

Annual Income Guidelines*			
Household Size	**All States and DC**	**Hawaii**	**Alaska**
1	$49,960	$57,520	$62,400
2	$67,640	$77,840	$84,520
3	$85,320	$98,160	$106,640
4	$103,000	$118,480	$128,760
5	$120,680	$138,800	$150,880
6	$138,360	$159,120	$173,000

*Please note: The income limits are 400 percent of the 2019 Federal Poverty Level (FPL). You may visit https://aspe.hhs.gov/poverty-guidelines for information on Federal Poverty Level guidelines. Federal Poverty Guidelines may change yearly.

In order to begin the application process, please complete the following steps:

Provider:

- Complete Section B of this application, including the required signature

Patient:

- Complete and sign Section A of this application
- Provide a copy of the front and back of your insurance card(s), if applicable
- Proof of household income is required to determine eligibility for assistance. Proof of income should include a copy of your most recent federal tax return documents (1040, 1040A, 1040EZ, or 1099s), W-2 form(s), Social Security Disability Income (SSDI), and Social Security Income (SSI) for all household members who contribute to your family's income
- If you have $0 income, you must provide a written letter of explanation on how you are being supported
- Fax the completed application and required financial documents to Celgene Patient Assistance Program for Otezla at **1-844-269-3053**. If you do not have access to a fax machine, please mail documents to the Celgene Patient Assistance Program for Otezla at P.O. box 13185, La Jolla, CA 92039

If you have any questions regarding this application, please call us at **1-855-554-9168**, Monday–Friday, 8:00AM–8:00PM ET.

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☐ New ☐ Renewal

Section A: Patient Information ▶TO BE COMPLETED BY PATIENT OR PATIENT REPRESENTATIVE

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

Address (P.O. box not accepted)_____ City_____ State_____ ZIP _____

Phone number_____ Email_____

Marital Status: ☐ Single ☐ Married ☐ Widowed Do you permanently reside in the U.S. or a U.S territory? ☐ Yes ☐ No

Do you give Celgene Patient Assistance Program for Otezla consent to leave you detailed voice messages? ☐ Yes ☐ No

Patient Insurance Information

If the patient has insurance, please check all that apply (include copies of front & back of insurance cards): ☐ Part D ☐ Medicare Advantage ☐ Private Insurance ☐ Patient has **no** insurance ☐ Patient has secondary insurance

Medicaid: ☐ **Denied/Not Eligible (Please provide copy of denial letter)** ☐ **Not applied** ☐ **Pending Coverage**

Primary insurance name_____ Policy # _____

Group # _____

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

Pharmacy Benefit Manager (PBM) _____ PBM phone _____

Rx Member ID _____ Rx Group ID _____

Patient Household Income

Total Annual Gross Household Income*_____ Household Size†_____

*Remember to include proof of household income (1040, 1040A, 1040EZ, 1099, W-2 form(s) SSI/SSDI, etc). If you have $0 income, you must provide a written letter of explanation on how you are being supported.

†Number of people who contribute to or are dependent on your household income (household size must be reflected on your tax forms).

Patient Consent and Attestation

To the extent necessary to process and administer my Celgene Patient Assistance Program for Otezla® (apremilast) application, in connection with all Celgene Patient Assistance Program for Otezla services, I hereby agree:

By completing this application you are providing authorization to Celgene and its agents* engaged in providing services under the Celgene Patient Assistance Program for Otezla (collectively, "Celgene") for the collection of certain information that is necessary in order to evaluate your enrollment into the Celgene Patient Assistance Program for Otezla, and if enrolled, to provide you with Otezla at no cost to you. This personal information may be shared with physicians and health insurers in order to provide you with program services. By completing this application you are agreeing that the information you provide is accurate and you have made no misrepresentations regarding your residency, insurance status, or income. You are required to notify the program of insurance changes or financial changes that may impact your eligibility for the program. You will promptly provide to the Celgene Patient Assistance Program for Otezla all documentation and information requested by the program to verify the accuracy of your eligibility, including any and all documentation requested by the Celgene Patient Assistance Program for Otezla pertaining to your income level, financial situation, insurance status and medical condition. The Celgene Patient Assistance Program for Otezla may terminate your enrollment in the program if you fail to comply with our request for any documentation.

I understand that the Celgene Patient Assistance Program for Otezla and its agents will request only that information needed to process and administer this application, and that they will not disclose the information they obtain, except as needed for this purpose or as required by applicable law.

*Agents may include third-party reimbursement service providers.

I hereby represent, covenant and certify as follows: (a) the medical and insurance information in this form is provided with my consent; (b) the information contained in this application is complete and accurate to the best of my knowledge; (c) I understand that if my prescription drug plan coverage changes or if my financial status changes, I may no longer be eligible under this program, and I will promptly notify Celgene Patient Assistance Program for Otezla of any such changes; (d) in the event that I become eligible for a benefit through a federal, state or private program which may reimburse for the medication requested I will notify Celgene Patient Assistance Program for Otezla and understand that I may no longer be eligible for assistance; (e) upon the request of Celgene Patient Assistance Program for Otezla and/or its agents/representatives, I will provide documentation—including but not limited to personal financial records—to verify the information contained in this application; (f) I understand that if there is a determination at any time that I am no longer eligible for this program, Celgene may immediately stop any assistance provided under this program; and (g) I will notify Celgene Patient Assistance Program for Otezla of any errors regarding the foregoing and will make every effort to correct those errors.

Patient signature _____ Date (MM/DD/YYYY) ____/____/____

Patient Representative (PLEASE PRINT)_____ Date (MM/DD/YYYY) ____/____/____

(If signed by Patient Representative, please fax documentation of Power of Attorney)

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Section B: Patient Diagnosis and Prescriber Information ▶ TO BE COMPLETED BY HEALTHCARE PROVIDER

Patient name (First, Last) _____ Date of birth ____/____/____

Primary insurance _____ Policy number _____

Primary Diagnosis/ICD-10-CM:

- ☐ 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)

Physician Name (First, Last) _____ NPI # _____ Tax ID # _____

Address _____ City _____ State _____ ZIP _____

Office Contact Name _____ Email _____

Phone & Ext. # _____ Fax # _____

Best time to contact: ☐ Morning ☐ Afternoon ☐ Evening

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.

Maintenance Rx – 30 mg of Otezla Covance Specialty Pharmacy will notify the patient via telephone prior to each shipment.

☐ **x90 DAYS TWICE DAILY** (Recommended daily dose) OR ☐ **x90 DAYS ONCE DAILY** (For patients with severe renal impairment)

REFILLS: ☐ **3** ☐ **Other amount** (enter #) _____ Special instructions _____

PRESCRIBER AUTHORIZATION*

By signing this START Form I certify that I have prescribed Otezla 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 Celgene and its agents† engaged in providing services under the Celgene Patient Assistance Program for Otezla (collectively, "Celgene"), 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.

I hereby represent, covenant, and certify as follows: (a) I have obtained from my patient all required authorization to release to Celgene Patient Assistance Program for Otezla and its representatives/agents all patient information needed for this application, including, without limitation, my patient's financial and medical information; (b) I understand that this information is for the sole use of Celgene to assess the patient's eligibility for participation in Celgene Patient Assistance Program for Otezla; (c) I have not received, nor will I seek or accept, reimbursement for any drug provided for my patient in Celgene Patient Assistance Program for Otezla; (d) I understand that if my patient's insurance or financial status changes, the patient may no longer be eligible under this program, and I will notify Celgene Patient Assistance Program for Otezla if I become aware of any such changes; (e) I understand that I am under no obligation to prescribe any Celgene drug and I have not received and will not receive any benefit from Celgene for prescribing a Celgene drug; (f) the information contained in this form is complete and accurate to the best of my knowledge; and (g) I will notify Celgene Patient Assistance Program for Otezla of any errors regarding the foregoing and will make every effort to correct those errors.

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.
†Agents may include third-party reimbursement service providers.

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