Thank you for your referral for **OTEZLA**

REQUIRED DOCUMENTATION

Please send the following items to initiate the new prescription process:

- ☑ Manufacturer form (attached), complete with FlexCare Specialty Services identified as the preferred specialty pharmacy
- ☑ Patient Demographics
- ☑ Insurance Card
- ☑ Recent Clinicals & Labs
- ☑ Medication List
- ☑ Tried/Failed Therapies
- ☑ BSA

INSTRUCTIONS

1. Please send the completed forms to us for processing.
2. You may also send the completed forms to the manufacturer, if enrollment into the manufacturer's monitoring program is desired.

Notice: This message and any attached documents may contain confidential and privileged information and/or protected health information ("PHI") from the sender for the use of the recipient listed above. If you are not the intended recipient, you may not read, copy, distribute, disclose or use this communication or the information contained within it. If you have received this communication in error, please notify the sender immediately and destroy the material in its entirety, whether in electronic or hard copy format. All PHI is confidential and subject to HIPAA laws and regulations.

PHONE: 866-205-4239 | FAX: 855-222-2514
Email: referrals@flexcarespecialty.com | visit: flexcareinfusion.com/referrals

Otezla® Specialty Pharmacy (SP) START Form

Step 1: Please complete this form if you'd like an SP to provide prior authorization support or to process a prescription.

Step 2: Fax this form, along with copies of the ***front and back*** of both your patient's insurance and prescription benefit cards, to your preferred SP.

Preferred SP name FlexCare Specialty Services **Fax #** (855) 222-2514

Please note that if the patient's insurance mandates the use of a different SP than what is preferred, your preferred SP may need to transfer the prescription to the mandated SP.

Patient and Prescriber Information

Section 1: Patient Information

Name (First, Middle, Last) ______ Date of birth ___/___/___ ☐ Male ☐ Female

Address (No P.O. Box) ______ City ______ State ______ ZIP ______

Home phone ______ Mobile phone ______

Email address ______

Section 2: Insurance Information *Include both sides of your patient's insurance and prescription benefit card.

☐ Insurance card attached ☐ Prescription benefit card attached ☐ Patient has no insurance

Primary insurance provider ______ Policy # ______ Group # ______ Insurance phone ______

Policyholder name (First, Middle, Last) ______ Pharmacy insurance ______

Pharmacy insurance phone ______ Rx member ID ______ Rx PCN *(if applicable)* ______

Rx group ID ______ Rx BIN *(if applicable)* ______

Section 3: Prescriber Information

Name (First, Last) ______ Facility name ______

Address ______ City ______ State ______ ZIP ______

Phone ______ Fax ______ NPI # *Required ______ Office contact ______

Prior Authorization (PA) Information

☐ I do not require PA support *(please skip this section)* ☐ I would like PA support *(please complete required clinical information in this section)*

CLINICAL INFORMATION Primary diagnosis/ICD-10-CM Code:

☐ L40.0 (Psoriasis vulgaris) %BSA Affected ______
☐ L40.51 (Distal interphalangeal psoriatic arthropathy)
☐ L40.52 (Psoriatic arthritis mutilans)
☐ L40.53 (Psoriatic spondylitis)
☐ L40.59 (Other psoriatic arthropathy)
☐ 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 discontinuation	Medication	Duration/Reason for discontinuation
☐ Methotrexate	______	☐ Orals ______	______
☐ Cyclosporine	______	☐ Topicals ______	______
☐ Sulfasalazine	______	☐ Biologics ______	______
☐ Acitretin	______	☐ Other ______	______
☐ PUVA or UV	______		
☐ Colchicine	______		

ADDITIONAL MEDICAL JUSTIFICATION: ______
*Include any clinical notes helpful in establishing diagnosis.

Prescription Information for Otezla® (apremilast) FOR ORAL USE

Starting with in-office sample

Date titration sample was provided to patient: ___ / ___ / ___ In-office 2-WEEK TITRATION SAMPLE **x14 days, 27 tablets, 0 refills**

***Note the patient's start date if you directly provided the in-office sample to your patient.**

Starting with the Specialty Pharmacy

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

☐ **Titration Dose: 4-WEEK STARTER PACK x28 days, 55 tablets, 0 refills**

Maintenance Dose: 30 mg of Otezla®
☐ **Twice daily** ☐ **Once-daily renal dose 30 mg** (For patients with severe renal impairment)
☐ **x30 days** ☐ **x90 days Refills:** ☐ **11 or** ☐ **Other** (enter #) ______
Special instructions ______

***Prescriber signature (dispense as written)** ______ Date ___/___/___

***Supervising physician signature and date (where required)** ______ Date ___/___/___

All items marked with an * are required.

Encourage commercially insured patients to enroll in the combined Co-Pay & Bridge Program by scanning the QR code, visiting otezla.com, or calling 1-844-4OTEZLA (1-844-468-3952).

Please see the back page for Indications and Important Safety Information.
Please click here for the full Prescribing Information for Otezla.

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

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