Otezla® Referral Form

Phone (888) 763.5517 Fax (402) 896.4862
10004 S. 152nd St, Suite A, Omaha NE 68138

Patient Information

Last Name	First Name	Home Phone	Work/Mobile Phone	
Home Address		City	State	ZIP
Shipping Address (if different from above)		City	State	ZIP

Social Security Number	Gender (M/F)	Weight	Date of Birth	Allergies

Emergency Contact	Phone	Primary Caregiver	Phone

Primary Diagnosis

❑ ICD-9 CM 696.0 (psoriatic arthritis) ❑ ICD-9 CM 696.1 (psoriasis) ❑ Other:

Current or most recent therapy (include dates/duration)

❑ No prior disease modifying therapies

Insurance Information *Fill out entirely OR fax a copy of patient's insurance card - both sides*

Primary Insurance	Phone	Name/SSN of Insured	ID Number	Group Number
Secondary Insurance	Phone	Name/SSN of Insured	ID Number	Group Number
Other Insurance				

Healthcare Provider Information: **Indicates Required Field*

Practice/Facility Name	**Physician First and Last Name***	**Phone***	Fax

Address*	**City***	**State***	**ZIP***

Physician NPI #*	Physician UPIN #	Physician DEA #	Physician State License #

Nurse/Key Contact	Phone or Pager Number	Email

Otezla®

❑ **Otezla® Rx**

30mg ❑ TWICE Daily ❑ ONCE Daily x30 days _____ Refills Date titration sample provided to patient: ____ /____ /____

Special instructions: _____

❑ **Bridge Rx – 14 days***

❑ 30mg TWICE Daily x14 days 28 tablets 4 Refills

❑ 30mg ONCE Daily x28 days 28 tablets 2 Refills

*Bridge Rx is at no cost, for commercially insured patients only, and not contingent on purchase requirements of any kind. Enrollees in Medicare, Medicaid, and other federal and state programs, as well as Minnesota and Massachusetts residents are not eligible. Intended to promote patient access to prescribed therapy if there is a delay in determining whether commercial prescription coverage is available.

❑ **Titration Starter Pack - 28 days**

Take as Directed x28 days 55 tablets 0 Refills

*****When sending a referral please include all clinical information relevant to performing a prior authorization and copies of patient's insurance cards*****

Physician Signature:_____ (Dispense as Written) **Date** ____/____/____

I authorize Amber Pharmacy and its representatives to act as my agent in order to initiate and execute the insurance prior authorization process and, in doing so, to release clinical information via phone to the appropriate third party payer.

Otezla®
apremilast tablets

PATIENT CONSENT INFORMATION

I. HIPAA Authorization to Share Health Information

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 health care 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 health care providers, including my pharmacy providers, may receive remuneration from Celgene 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 I will be unable to participate in Celgene support services, such as the Patient Assistance programs (see Otezla.com for eligibility guidelines) and Free Trial Offers.

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 Celgene at 9801 Washingtonian Blvd, Gaithersburg, Maryland 20878 or by sending an e-mail to privacy@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. 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 patient.