145 The West Mall, P.O. Box 110 U
Toronto, ON M8Z 5M4

PRIOR AUTHORIZATION PROGRAM FORM

Otezla® (Apremilast)

Instructions:

1. Section 1 to be completed by Plan Member / Patient
2. Section 2 to be completed by Physician (expenses incurred by the completion of this form is at plan member's expense)
3. Section 3 to be completed by Pharmacist

Please fax completed form to NexgenRx Formulary Management to 1-877-639-4369 or mail to 145 The West Mall P.O. Box 110 U, Toronto, Ontario,M8Z-5M4

Section 1a: To be completed by Patient

Member's Name: (Last , First)	Card ID Number:		
Patient's Name: (Last, First)	Patient's Date of Birth (dd/mm/yy)	Relationship to Member (please circle) Employee Spouse Dependent	PATIENT CODE

Results of this request to be communicated to:

☐ Pharmacy	☐ Patient / Legal Guardian Named Below	☐ email:

I authorize NexgenRx Inc. (a) to use the personal information disclosed on this form, and any other personal information known to NexgenRx Inc. regarding the above-named patient, for the purpose of assessing this prior authorization request and any related claim and administering the benefit plan under which any such claim is made, and (b) to contact, and to obtain any such personal information from and to disclose any such personal information to, any physician, pharmacist or other health care professional having knowledge of such patient's health relevant to this request and any related claim.

Patient / Legal Guardian Name: ______________________ Telephone Number: ______________________

Signature of Patient/ Legal Guardian: ______________________ Date (dd/mm/yy):______________________

Section 1b: To be completed by Patient

Other Group Benefit Coverage ☐ Yes ☐ No	If Yes please complete the following and attach documentation with decision to accept or decline: Name of family member covered:______________________ Name of Insurance Company:______________________ Plan Number: ______________ Plan Member ID Number:______________________
Provincial Coverage ☐ Yes ☐ No	If Yes please complete the following and attach documentation with decision to accept or decline: If No explain reason that application has not been made:______________________
Patient Assistance Program ☐ Yes ☐ No	Name of program:______________________ Patient Assistance ID Number:______________________ Patient Assistance Contact Person: Name:______________________ Phone Number:______________________
Disability Benefits related to condition. ☐ Yes ☐ No	

145 The West Mall, P.O. Box 110 U
Toronto, ON M8Z 5M4

PRIOR AUTHORIZATION PROGRAM FORM

Otezla® (Apremilast)

Section 2: To be completed by Physician

Drug Name & Strength:	DIN: 02434318 02434334	Dosage Instructions:

Eligibility for drug coverage is dependent upon the patient meeting at least one of the qualifying criteria listed below. If the patient has another drug plan, prior authorization may cover some or all of the excess not paid by the primary plan.

Please indicate if the patient meets the following qualifying criteria for drug coverage:

☐ Otezla is indicated for the treatment of adult patients with moderate tosevere plaque psoriasis who are candidates for phototherapy or systemic therapy. Limitations of Use:Otezla has not been studied and is therefore not indicated in combination with other systemic (conventional or biologic) therapies or phototherapy for psoriasis.

□Otezla alone or in combination with methotrexate, is indicated for the treatment of active psoriatic arthritis in adult patients who have had an inadequate response, intolerance, or contraindication to a prior disease-modifying anti-rheumatic drug (DMARD).

Date of Initial Diagnosis (dd/mm/yyyy)_______________ Anticipated Duration of Therapy_____________

Medical Rationale to Treat

% BSA Areas of body involved

PASI______________ Date(dd/mm/yyyy)___________ Thickness of plaques__________________

All Relevant Drugs /Treatment	Dose and schedule	Start date (dd/mm/yyyy)	End Date (dd/mm/yyyy)	Response

Other Relevant Information____

Physician Name: (Last, First)	License Number:
Address: (Street, City, Province, Postal Code)	Telephone Number : ( ) - Fax Number: ( ) -
Signature of Physician:	Date (dd/mm/yy)

Section 3: To be completed by Pharmacist

Pharmacy Name:	Provider Number:
Pharmacy Address: (Street, City, Province, Postal Code)	Telephone Number : ( ) - Fax Number: ( ) -
Signature of Pharmacist: ____________________ Pharmacist's Name: (Print Last, First) ____________________	

Internal Office Use Only:

Date Received:			Date Approved & By: