



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

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

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Otezla® (Apremilast)

Section 2: To be completed by Physician

Drug Name & Strength: OTEZLA	DIN: 02434318 02434334	Dosage Instructions:
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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 to severe 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).

Otezla should not be taken during pregnancy or in women attempting to conceive.

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: _____
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