OTEZLA ez Start
Psoriatic Arthritis Enrolment Form

Please complete and fax to: 1-844-397-5635

For questions, please call 1-844-ez-Start (1-844-397-8278) *Fields denoted by an asterisk (*) are mandatory*

PATIENT INFORMATION

Name*	
Gender ❑ Male ❑ Female	**Date of birth (mm/dd/yy)**
Address	
City	
Province	**Postal code**
Home phone* ❑ Preferred number ❑ OK to leave message	**Cellular/alternate phone** ❑ Preferred number ❑ OK to leave message
Email **Preferred method of contact** ❑ Phone ❑ Email	

I consent to the receipt of electronic communications from Celgene, the Administrator, and Program Personnel, for the purposes of determining my eligibility for the Program, conducting Program-related activities and in the delivery of Program services to me. Email communications may be sent to the address I have provided. I understand I can withdraw my consent at any time.

❑ YES ❑ NO

PATIENT CONSENT*

I confirm I have reviewed the full agreement and consent terms on the reverse side of this enrolment form; and do hereby agree to its terms and do hereby grant my consent to disclose health information in accordance with the terms in this enrolment form.

Signature of Patient or Legal Representative/Substitute Decision Maker/Guardian:

_____

Printed Name of Patient or Legal Representative/Substitute Decision Maker/Guardian:

_____

Relationship to Patient if a Legal Representative/Substitute Decision Maker/Guardian:

_____

Date: _____

IMPORTANT. If Health Care Provider is unable to obtain written consent from patient, please document when patient verbal consent was obtained. This will allow the Program to continue with processing this enrolment. Written consent will be obtained by the Program.

Verbal Consent Obtained by Health Care Provider:

Name: _____

Date: _____

Pr Otezla® apremilast tablets

ez Start

PRESCRIBER INFORMATION*

Name		
Address		
City	Province	Postal code
Phone	Fax	

Please stamp or write the physician information here

Clinic/hospital affiliation	**Physician licence (registration) no.**

STATEMENT OF MEDICAL NECESSITY

Diagnosis
❑ Psoriatic Arthritis (PsA) ❑ Other: _____

SJC: _____

Presence of:
Dactylitis: ❑ Yes ❑ No Tenosynovitis: ❑ Yes ❑ No Enthesitis: ❑ Yes ❑ No
Radiographic evidence of PsA or joint erosion on imaging study: ❑ Yes ❑ No
Inflammatory back pain: ❑ Yes ❑ No

HAQ: _____ CRP value: _____ ESR: _____

Other: _____

CRP = C-Reactive Protein; ESR = Erythrocyte Sedimentation Rate; HAQ=Health Assessment Questionnaire; SJC = Swollen Joint Count

Treatment history *(i.e., dosage, start of therapy, end of therapy, reason for discontinuation, etc.)*

❑ Sulfasalazine: _____ ❑ Leflunomide: _____

❑ Methotrexate: _____

❑ Biologics (specify): _____

❑ Other: _____

PRESCRIPTION FOR OTEZLA® (APREMILAST)*

Starter Pack (Titration) Rx for OTEZLA ❑ Take as directed x 14 days 27 tablets
❑ **OTEZLA (apremilast) tablets 30 mg PO BID x 28 days _____ Refills**
Patient received Starter Pack in office ❑ Yes ❑ No
Please assess patient for ez Start Bridging Program ❑ Yes ❑ No
Special instructions

PRESCRIBER AUTHORIZATION*

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 OTEZLA ez Start Program/Celgene and/or the contracted third party program administrator as my designated agents and on behalf of my patient to (1) forward the above statement of medical necessity and furnish any information on this form to the insurer of the above-named patient and (2) forward the above prescription, by fax or other mode of delivery, to the pharmacy chosen by the above-named patient.

Prescriber Signature (Dispense as Written): _____

Date: _____

AGREEMENT AND CONSENT TO DISCLOSE HEALTH INFORMATION

Fax this form to 1-844-397-5635

I agree and consent to the following collection, use and disclosure of my Health Information for OTEZLA ez Start ("Program"):

- The collection, retention, use and disclosure of my Health Information or the Health Information of the individual named above for whom I am the legal representative/substitute decision maker/guardian by Celgene Inc. and its Administrator and my Health Care Providers. Health Information is provided in this Enrolment Form and in subsequent records and communications. I hereby authorize Health Care Providers participating in the Program to provide Celgene with Health Information on my behalf (or on behalf of the individual for whom I am a legal representative/substitute decision maker/guardian). I understand and agree that this information will be used and disclosed to determine my possible eligibility for and participation in the services offered through the Program and by Program Personnel, and in carrying out Program activities; and treatment and for the ongoing registration, administration, reporting, monitoring and evaluation requirements of the Program. I understand that the information is being collected in accordance with Celgene's Privacy Policy, available at: http://www.celgenecanada.net/en/utility/privacy.aspx.
- Program representatives may contact me and leave messages for me regarding my Health Information or any other information required for the administration of the Program.

I understand:

- No Program Personnel will (i) collect, use, disclose or store my Health Information for any activity other than the activities contemplated above, or (ii) disclose my Health Information to anyone other than my Health Care Providers, unless the Health Information that identifies me is removed (for example, my name and address);
- I may withdraw my consent at any time by mailing or faxing a signed request to the Administrator at the fax number set out above or to the Administrator at the address below, but if I do so, I understand that to the extent that such consent is necessary to provide the services under the Program, my participation in the Program may be terminated and, among other things, I may not be able to get help with reimbursement for OTEZLA;
- Except where prohibited by law, I may obtain a copy of my Health Information and can correct any errors and/or direct any questions regarding the collection, use, disclosure and storage of my Health Information to the Administrator;
- Any calls to or from the Administrator in the course of its administration of the Program may be monitored or recorded for control of quality and for training purposes;
- My Health Information may be collected, used, disclosed and/or stored outside of my province or territory or country, and that the laws of those countries regarding privacy may be less stringent than the laws of Canada and its provinces, and the terms and conditions of this enrolment form and that I am entitled to a copy of this document.

Administrator: The Administrator is Celgene Inc.'s service provider, Innomar Strategies Inc. and its affiliates, located at 3470 Superior Court, Oakville, Ontario, Canada, L6L 0C4. If at any time and for any reason Celgene Inc. appoints a new contractor to replace Innomar as the administrator of the Program, I hereby give permission for Innomar to transfer my personal and medical records to a new administrator designated by Celgene Inc., for the purpose of continuing my participation in the Program, in the same manner as required of Innomar as described above. I further consent to be contacted by an additional third party provider for the purpose of quality, training and auditing the Program's services.

Health Information: The term Health Information includes, without limitation, my personal information (name, address, phone number, date of birth, etc.) and personal health information (medical history, medical condition(s), information relating to my treatment).

Health Care Providers: The term Health Care Providers includes, without limitation, my doctors, nurses, pharmacists and health insurer(s).

Program or OTEZLA ez Start: The term "Program" or "OTEZLA ez Start" is Celgene Inc.'s OTEZLA ez Start and is provided by Celgene Inc. for the purpose of assisting patients in obtaining access to OTEZLA for patients with psoriatic arthritis (PsA).

Program Personnel or OTEZLA ez Start Personnel: The term "Program Personnel" or "OTEZLA ez Start Personnel" include the employees and consultants of the Administrator.

OTZ-PSA-15-019E

Otezla® apremilast tablets

ez Start

OTEZLA ez Start
3470 Superior Court
Oakville, Ontario L6L 0C4
Tel: 1-844-ez-Start (1-844-397-8278)
Fax: 1-844-397-5635