AMGEN Safety Net Foundation

R_x PRESCRIPTION

2P2

This page must be completed and faxed by your prescribing physician. Prescribing physician signature attesting to consent is required on this application (bottom of page). An original prescription is also accepted in place of the prescription section on this form.

Patient name ______________________ ______________________
Last name First name

Sex: **MALE** **FEMALE** Date of birth (MM/DD/YYYY) ______ / ______ / ______ Phone # ______________

Prior Authorization completed: **YES** **NO** » Required to be completed to avoid unnecessary delays in application processing

Prior Authorization status: **APPROVED** **DENIED** **APPEALED** » To expedite process, please submit PA determination from patients insurance. (Do not submit screen shots or CoverMyMeds notification).

Medication **Otezla® (apremilast)**

Dose	Frequency	Dispense Amount	Refills	Patient Diagnosis Code ICD-10 required if patient has insurance
Otezla 4-week titration starter pack	**STANDARD:** as directed per package instructions (for CrCl ≥30 mL/min): 55 tablets 10 mg daily on days 1–3, 20 mg daily on days 4–5, 30 mg once daily thereafter **(for CrCl<30 ml/min)**	28 days	0	ICD-10 ______________
Otezla 30 mg tablet	**STANDARD:** Twice daily Once daily **(for CrCl<30 ml/min)**	90 days ________	1 year or x ________	ICD-10 ______________

Electronic Prescription (eRX) Submitted Pharmacy NPI: **1336325265** NCPDP number: **3989603**
NY State Prescribers must also submit an ePrescription or phone in the prescription.

Facility/Practice name ______________________________

Address ______________________ ______________ ______ ______
Street (PO Box not accepted) City State Zip

Phone ______________________ Fax ______________________

Prescribing physician name ______________________ ______________________
Last name First name

National Provider ID (NPI) ______________ Tax ID ______________ Both IDs required

Prescribing physician state license number ______________________________

I have prescribed the Amgen medicine indicated above for the referenced patient. My patient gave consent for me to provide this information. I understand that no third party or patient may be billed or charged for the Amgen medicine provided by this program. I understand that no medication received from Amgen Safety Net Foundation may be sold, traded, or distributed for sale.

Prescribing physician's signature Stamps not accepted ______________________ **Date signed** MM/DD/YYYY ______________

This form must be completed and submitted with the patient application but does not guarantee enrollment in or fulfillment of this prescription by the Amgen Safety Net Foundation. Amgen Safety Net Foundation must review the complete application including this prescription or an original script to determine the patient's eligibility.

Fax this prescription to 1-833-959-1409