FLEXCARE SPECIALTY SERVICES

Thank you for your referral for **HUMIRA**

(for Gastroenterology indications).

REQUIRED DOCUMENTATION

Please send the following items to initiate the new prescription process:

- ☑ Manufacturer form (attached), complete with FlexCare Specialty Services identified as the preferred specialty pharmacy
- ☑ Patient Demographics
- ☑ Insurance Card
- ☑ Recent Clinicals & Labs
- ☑ Medication List
- ☑ Tried/Failed Therapies
- ☑ Negative TB Results

INSTRUCTIONS

1. Please send the completed forms to us for processing.
2. You may also send the completed forms to the manufacturer, if enrollment into the manufacturer's monitoring program is desired.

PHONE: 866-205-4239 | FAX: 855-222-2514
Email: referrals@flexcarespecialty.com | visit: flexcareinfusion.com/referrals

Getting Started

HUMIRA COMPLETE

HUMIRA Complete offers information, support, and resources designed around you.

Use this checklist to start and stay on track with your prescribed treatment plan.

1 NAVIGATE INSURANCE AND SAVINGS

Get 1-to-1 support from a Nurse Ambassador.*

- ☐ Connect with your Ambassador. They will call you within a few days, but if you need help sooner, reach out at **1.800.4HUMIRA** (1.800.448.6472).†
- ☐ Write down your Ambassador's name and phone number so you can find it easily.
- ☐ Ask your Ambassador about your savings options. They can also connect you with an Insurance Specialist to help navigate the insurance process.

Ambassador Name: _____

Ambassador Phone: _____

2 GETTING YOUR PRESCRIPTION

A specialty pharmacy will help fill your HUMIRA prescription and arrange delivery.

- ☐ Ask your health care professional for the name and phone number of your specialty pharmacy.
- ☐ Write down the information so you can find it easily.
- ☐ Write down the date of your first injection: _____ /_____ /_____
- ☐ Call your Specialty Pharmacy to confirm your delivery address at least 2 weeks before your first injection.

Specialty Pharmacy Name: FlexCare Specialty Services

Specialty Pharmacy Phone: (866) 205-4239

3 PREPARING TO INJECT AT HOME

Get step-by-step instructions for injecting HUMIRA. Don't try to inject HUMIRA yourself until your doctor has decided you can and you've been shown the right way to give injections. Read the entire Patient Instructions for Use found in your HUMIRA package for full directions on how to inject yourself.

- ☐ Watch self-injection training videos at **HUMIRA.com/training** or use your phone's camera to scan the QR code at the right.
- ☐ Ask your Ambassador any additional questions you have about injection training or taking HUMIRA.

Not enrolled?

Go to **HUMIRA.com/start** to sign up, or chat with us live 24/7.

*Nurse Ambassadors are provided by AbbVie and do not work under the direction of your health care professional (HCP) or give medical advice. They are trained to direct patients to their HCP for treatment-related advice, including further referrals.

†Help is available Monday through Friday from 8:00 AM to 8:00 PM ET, except for holidays.

Please see Uses and Important Safety Information on page 2.

Please see full Prescribing Information, including Medication Guide, and discuss with your doctor.

HUMIRA® adalimumab

HUMIRA COMPLETE

Enrollment and Prescription Form

HG-120123-A12

Faxing Instructions:
Fax to HUMIRA Complete **1.678.727.0690**

The health care professional (HCP) and the patient or legally authorized person should fill out this form completely before leaving the office.
Sections in **PLUM** (1, 2, 3, 4) are necessary for enrollment into HUMIRA Complete. Required fields are marked with an asterisk (*).

1 PATIENT'S INFORMATION - To be completed by patient or legally authorized person. Please print clearly.

First Name*: Last Name*: Date of Birth: / / Gender (check one): ☐ M ☐ F

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

Home Phone*: Mobile Phone: Email Address*: ☐ Spanish interpreter needed

- Best Time to Call (Monday-Friday): ☐ Anytime ☐ Morning ☐ Afternoon ☐ Evening
- When did you start on treatment?* ☐ Not Yet Started ☐ 0-3 Months Ago ☐ 4-6 Months Ago ☐ 7-12 Months Ago ☐ Over 12 Months Ago
- ☐ I consent to receive HUMIRA Complete automated and recurring text messages from "Complete Treatment Support," including services updates and marketing messages, refill reminders, and prescription notifications to the above mobile number. Message and data rates may apply. I am not required to consent as a condition of receiving goods or services. I can reply HELP for help. I can reply STOP to opt out at any time. View privacy notice at **https://privacy.abbvie/privacy-policies/us-privacy-policy.html** and mobile T&Cs at **https://abbv.ie/USMobileTerms**.

By enrolling, you may receive your own Nurse Ambassador provided by AbbVie. Ambassadors do not work under the direction of your health care professional (HCP) or give medical advice. They are trained to direct patients to their HCP for treatment-related advice, including further referrals.

- ☐ I consent to the collection, use, and disclosure of my health-related personal data to receive communications from AbbVie regarding its products, programs, services, clinical trials, research opportunities, and for online targeted advertising, as further described in the "**How we may use Personal Data**," "**How we disclose Personal Data**," and "**Cookies and similar tracking and data collection technologies**" sections of our **Privacy Notice**. My consent is required to process sensitive personal data under certain privacy laws, and I have the right to withdraw my consent by visiting "**Your Privacy Choices**" on AbbVie's website.

For information on how we collect and process your personal data, including the categories we collect, purposes for their collection, and disclosures to third parties, visit **https://abbv.ie/PrivacyPatient**.

Through my submission of the HUMIRA Complete Enrollment and Prescription Form, I consent to the collection, use, and disclosure of my personal health data, as described in the Privacy Notice above and in AbbVie's Privacy Notice in the "**How We May Disclose Personal Data**" section. My consent is required to process sensitive personal data under certain privacy laws, and I have the right to withdraw my consent by visiting "**Your Privacy Choices**" on AbbVie's website.

2 INSURANCE INFORMATION - Please attach insurance cards, if available.

What kind of health insurance do you have? ☐ Private/Commercial† ☐ Medicare ☐ Government-funded plan, Medicaid, or VA insurance‡ ☐ Not insured

Beneficiary/Cardholder Name: _____

Medical Insurance: _____

Medical Insurance ID #: _____

Group #: _____

Prescription Insurance: _____

Rx Group #: _____

Rx ID #: _____

Rx Bin #: _____

Rx PCN #: _____

†Health insurance for you or a family member purchased privately or through an employer.

‡For example, Medicaid, TRICARE, Department of Defense, or Veterans Affairs programs.

▼ TO BE COMPLETED BY A HEALTH CARE PROFESSIONAL ▼

3 DIAGNOSIS* ☐ Crohn's disease ☐ Ulcerative colitis ICD-10: _____ Date of Diagnosis: _____/_____/_____

4 PRESCRIBER INFORMATION I would like to receive a copy: ☐ **Benefits Verification summary** ☐ Prior Authorization form

Prescriber's Name (First, Last)*: _____

NPI #*: _____

Office Phone*: _____

Office Contact Name: _____

Office Fax*: _____

Address*: _____

City*: _____

State*: _____ ZIP*: _____

5 CLINICAL INFORMATION

Prior Therapies: _____

Concomitant Medications: _____

Drug Allergies: _____

TB Test (Date): ____/____/_____ ☐ Pos ☐ Neg

Fax any necessary clinical/office notes to the preferred Specialty Pharmacy only.

6 INJECTION TRAINING

☐ I request supplemental injection training and/or administration, if needed, for this patient. Order valid for up to one year.
Fill out and sign pharmacy prescription below.

7 PHARMACY PRESCRIPTION - Select medication, fill out and sign corresponding prescription below.

Patient's preferred Specialty Pharmacy: FlexCare Specialty Services ☐ Check if faxed to Specialty Pharmacy

Starting Therapy:
Adult Crohn's disease or Ulcerative colitis

Choose 1 SIG
- ☐ PEN HUMIRA Starter Pack (CF) **80 mg/0.8 mL**
- ☐ 160 mg SC inj on Day 1, 80 mg SC inj on Day 15
- ☐ 80 mg SC inj on Day 1, Day 2, and Day 15

#QS No Refills

Ongoing Therapy:
Adult Crohn's disease or Ulcerative colitis

Key: ■ HUMIRA Citrate Free (CF) ■ HUMIRA with citrate buffers

Choose 1 Presentation
- ☐ PEN HUMIRA (CF) **40 mg/0.4 mL**
- ☐ SYRINGE HUMIRA (CF) **40 mg/0.4 mL**
- ☐ PEN HUMIRA **40 mg/0.8 mL**
- ☐ SYRINGE HUMIRA **40 mg/0.8 mL**

SIG: 40 mg SC inj every other week

Choose 1 Quantity
- ☐ #2 (1 month)
- ☐ #6 (3 months)

Refills: _____

PRESCRIBER CERTIFICATION: I certify that the above therapy is medically necessary and that the information provided is accurate to the best of my knowledge. I certify that I am the prescriber who has prescribed HUMIRA to the previously identified patient and that I provided the patient with a description of the HUMIRA Complete patient support program. I authorize HUMIRA Complete to act on my behalf for the purposes of transmitting this prescription to the appropriate pharmacy designated by the patient utilizing their benefit plan (if applicable).

Prescriber's signature required (sign below) (Physician attests this is his/her legal signature. NO STAMPS)

SIGN HERE _____ **Dispense as written** _____ **Date** _____ **Substitution allowed** _____ **Date**

The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.

IMPORTANT INFORMATION: The categories of personal information collected on this form include prescriber name, address, NPRI, etc. **The personal information collected will be used for program management and to perform research and analytics. For more information about the categories of personal information collected by AbbVie and the purposes for which AbbVie uses personal information, visit https://privacy.abbvie.**

Please share this information with your patient.

Please see Important Safety Information, including BOXED WARNING on Serious Infections and Malignancy, on page 4.

Please see full Prescribing Information.

US-HUMG-230026

HUMIRA® adalimumab