FLEXCARE SPECIALTY SERVICES

Thank you for your referral for **HUMIRA**

(for pediatric 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 and your child.

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

1 NAVIGATE INSURANCE AND SAVINGS

Get support from your child's Nurse Ambassador.*

- ☐ Connect with your child's 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 the name and phone number of your child's Ambassador so you can find it easily.
- ☐ Ask your child's 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 CHILD'S PRESCRIPTION

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

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

Specialty Pharmacy Name: FlexCare Specialty Services

Specialty Pharmacy Phone: (866) 205-4239

3 PREPARING YOUR CHILD 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 to your child. Read the entire Patient Instructions for Use found in your HUMIRA package for full directions on how to inject your child.

- ☐ Watch injection training videos at **HUMIRA.com/training** or use your phone's camera to scan the QR code at the right.
- ☐ Ask your child's 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 child's doctor.

HUMIRA® adalimumab

HUMIRA COMPLETE

HG-120123-P12

Two-Page Form Faxing Instructions:
Fax to HUMIRA Complete **1.678.727.0690**

Enrollment and Prescription Form

The health care professional (HCP) and the parent or legal guardian 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 child's parent or legal guardian. Please print clearly.

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

Name of Patient's Parent or Guardian*: Relationship to Patient:

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

Home Phone*: Parent/Guardian Mobile Phone:

Parent/Guardian Email*: ☐ 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.

Beneficiary/Cardholder Name:

Medical Insurance:

Medical Insurance ID #:

Group #:

Prescription Insurance:

Rx Group #:

Rx ID #:

Rx Bin #:

Rx PCN #:

▼ TO BE COMPLETED BY A HEALTH CARE PROFESSIONAL ▼

3 DIAGNOSIS* ☐ Pediatric Crohn's Disease ☐ Pediatric 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*:

Email:

5 CLINICAL INFORMATION

Prior Therapies:

Weight:

Concomitant Medications:

Drug Allergies:

TB Test (Date): ___/___/___ ☐ Pos ☐ Neg

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

CONTINUE FILLING OUT FORM ON PG.5

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.

Enrollment and Prescription Form (Second Page)

6 PATIENT'S INFORMATION - To be completed by child's parent or legal guardian. Please print clearly.

First Name*: Last Name*: Date of Birth: / /

7 PRESCRIBER INFORMATION

Prescriber's Name (First, Last)*: _____ NPI #*: _____ Office Phone: _____

8 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.

9 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

Key: ■ HUMIRA Citrate-free (CF) ■ HUMIRA with citrate-buffers

Starting Therapy:

Pediatric Crohn's Disease *(17 kg [37 lbs] to <40 kg [88 lbs]):*

☐ SYRINGE HUMIRA Starter Pack (CF) **80 mg/0.8 mL, 40 mg/0.4 mL**
SIG: 80 mg SC inj on Day 1, 40 mg SC inj on Day 15
#2 syringes No Refills

Pediatric Crohn's Disease *(≥40 kg [88 lbs]):*

Choose 1 Presentation
☐ PEN HUMIRA Starter Pack (CF) **80 mg/0.8 mL**
☐ SYRINGE HUMIRA Starter Pack (CF) **80 mg/0.8 mL**

Choose 1 SIG
☐ 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

Pediatric Ulcerative Colitis *(20 kg [44 lbs] to <40 kg [88 lbs]):*

Choose 1 Presentation
☐ PEN HUMIRA (CF) **40 mg/0.4 mL**
☐ SYRINGE HUMIRA (CF) **40 mg/0.4 mL**
SIG: 80 mg SC inj on Day 1, 40 mg SC inj on Day 8 and Day 15
#4 No Refills

Pediatric Ulcerative Colitis *(≥40 kg [88 lbs]):*

☐ PEN HUMIRA Starter Pack (CF) **80 mg/0.8 mL**

Choose 1 SIG
☐ 160 mg SC inj on Day 1, 80 mg SC inj on Day 8 and Day 15
☐ 80 mg SC inj on Day 1, Day 2, Day 8, and Day 15
#4 pens No Refills

Ongoing Therapy:

Pediatric Crohn's Disease *(17 kg [37 lbs] to <40 kg [88 lbs]):*

☐ SYRINGE HUMIRA (CF) **20 mg/0.2 mL**
SIG: 20 mg SC inj every other week

Choose 1 Quantity
☐ #2 (1 month)
☐ #6 (3 months) Refills: _____

Pediatric Crohn's Disease *(≥40 kg [88 lbs]):*

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: _____

Pediatric Ulcerative Colitis *(20 kg [44 lbs] to <40 kg [88 lbs]):*

Choose 1 Presentation
☐ PEN HUMIRA (CF) **40 mg/0.4 mL** ☐ SYRINGE HUMIRA (CF) **40 mg/0.4 mL**
☐ SYRINGE HUMIRA (CF) **20 mg/0.2 mL**

Choose 1 SIG ☐ 40 mg SC inj every other week ☐ 20 mg SC inj every week

Choose 1 Quantity
☐ 1-month supply
☐ 3-month supply Refills: _____

Pediatric Ulcerative Colitis *(≥40 kg [88 lbs]):*

Choose 1 Presentation
☐ PEN HUMIRA (CF) **80 mg/0.8 mL** ☐ PEN HUMIRA (CF) **40 mg/0.4 mL**
☐ SYRINGE HUMIRA (CF) **40 mg/0.4 mL**

Choose 1 SIG ☐ 80 mg SC inj every other week ☐ 40 mg SC inj every week

Choose 1 Quantity
☐ 1-month supply
☐ 3-month supply 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.

10 HUMIRA COMPLETE PRESCRIPTION - For Pediatric Ulcerative Colitis Only - required in the event a patient experiences an insurance delay or denial

Eligible patients must have (1) commercial insurance, (2) a valid Rx for HUMIRA, and (3) experienced a delay or denial in insurance determination. See program Terms and Conditions on page 6. Please complete the full form as well as this section and sign below. **Prescription to be filled through an AbbVie-authorized pharmacy.** I understand that faxing this form to HUMIRA Complete will result in an original copy being simultaneously transmitted to the AbbVie-authorized pharmacy under this section.

Key: ■ HUMIRA Citrate-free (CF)

Starting Therapy:

Pediatric Ulcerative Colitis *(20 kg [44 lbs] to <40 kg [88lbs]):*

Choose 1 Presentation
☐ PEN HUMIRA (CF) **40 mg/0.4 mL**
☐ SYRINGE HUMIRA (CF) **40 mg/0.4 mL**
SIG: 80 mg SC inj on Day 1, 40 mg SC inj on Day 8 and Day 15
#4 No Refills

Pediatric Ulcerative Colitis *(≥40 kg [88lbs]):*

PEN HUMIRA Starter Pack (CF) **80 mg/0.8 mL**

Choose 1 SIG
☐ 160 mg SC inj on Day 1, 80 mg SC inj on Day 8 and Day 15
☐ 80 mg SC inj on Day 1, Day 2, Day 8, and Day 15
#4 pens No Refills

Ongoing Therapy:

Pediatric Ulcerative Colitis *(20 kg [44 lbs] to <40 kg [88 lbs]):*

Choose 1 Presentation
☐ PEN HUMIRA (CF) **40 mg/0.4 mL** ☐ SYRINGE HUMIRA (CF) **40 mg/0.4 mL**
☐ SYRINGE HUMIRA (CF) **20 mg/0.2 mL**

Choose 1 SIG ☐ 40 mg SC inj every other week ☐ 20 mg SC inj every week

Choose 1 Quantity
☐ 1-month supply
☐ 3-month supply Refills: _____

Pediatric Ulcerative Colitis *(≥40 kg [88 lbs]):*

Choose 1 Presentation
☐ PEN HUMIRA (CF) **80 mg/0.8 mL** ☐ PEN HUMIRA (CF) **40 mg/0.4 mL**
☐ SYRINGE HUMIRA (CF) **40 mg/0.4 mL**

Choose 1 SIG ☐ 80 mg SC inj every other week ☐ 40 mg SC inj every week

Choose 1 Quantity
☐ 1-month supply
☐ 3-month supply 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. I understand that the no charge resource through HUMIRA Complete may support patients who are experiencing a delay in insurance coverage for HUMIRA until coverage is obtained, and I confirm that I will support the above-identified patient in seeking to secure such coverage as I deem appropriate. I certify that I will not seek reimbursement from any third party payor for any no charge product dispensed by an AbbVie authorized pharmacy.

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.

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Please share this information with your patient.

Please see Important Safety Information, including BOXED WARNING on Serious Infections and Malignancy, on page 6.

Please see full Prescribing Information.