Thank you for your referral for **HUMIRA**

(for Rheumatology 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
- ☑ History & Physical
- ☑ 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.

Notice: This message and any attached documents may contain confidential and privileged information and/or protected health information ("PHI") from the sender for the use of the recipient listed above. If you are not the intended recipient, you may not read, copy, distribute, disclose or use this communication or the information contained within it. If you have received this communication in error, please notify the sender immediately and destroy the material in its entirety, whether in electronic or hard copy format. All PHI is confidential and subject to HIPAA laws and regulations.

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

Welcome to HUMIRA Complete.

Resources designed around you.

You may have questions about HUMIRA. That's why HUMIRA Complete is here to help you:

- Make sense of your insurance coverage and confirm savings options
- Schedule one-to-one supplemental injection training
- Get resources to stay on track with your prescribed treatment plan
- Dispose of your used Pens or syringes

Your HUMIRA Complete Nurse Ambassador* is committed to helping you understand your treatment, answering your questions, and supporting you in achieving your personal goals while on HUMIRA. Your Nurse Ambassador will be there every step of the way, for as long as you need.

You've signed up for HUMIRA Complete. Here's what to do next:

1. **Before you leave the doctor's office, ask your health care professional** which Specialty Pharmacy your prescription is being sent to and write down its number below. This pharmacy will help you fill your HUMIRA prescription and arrange delivery.

   SPECIALTY PHARMACY: FlexCare Specialty Services PHONE: (866) 205-4239

2. **Expect a call from your Ambassador within one business day** (call may come from any area code). They'll help you navigate the prescription process, and help you start and stay on track with your prescribed treatment plan.

For questions, or if you have not yet connected with your HUMIRA Complete Nurse Ambassador, please call **1.800.4HUMIRA** (1.800.448.6472).

*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.

The categories of personal information collected in this Enrollment and Prescription Form include contact, insurance, prescription, and medical history information. The personal information collected will be used to provide and manage the HUMIRA Complete program and to perform research and analytics on a de-identified basis. For more information about the categories of personal information collected by AbbVie and the purposes for which AbbVie uses personal information, visit www.abbvie.com/privacy.html.

Please see Uses and Important Safety Information on page 2.

Please see full Prescribing Information, including Medication Guide, or visit www.rxabbvie.com/pdf/humira.pdf and discuss with your doctor.

HUMIRA COMPLETE

HUMIRA® adalimumab

HUMIRA COMPLETE

Enrollment and Prescription Form

Faxing Instructions:
1. Fax to HUMIRA Complete **(1.678.727.0690)**
2. Fax to the patient's preferred Specialty Pharmacy

Questions? Call 1.800.448.6472

Sections in **PLUM** (1, 2, 3, 4) are necessary for enrollment into HUMIRA Complete. Required fields are marked with an asterisk (*).

The health care professional (HCP) and the patient or legally authorized person should fill out this form completely before leaving the office.

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

☐ **I consent to receive recurring text messages from AbbVie, Including service updates, medication reminders and marketing messages, to the above mobile number. Message and data rates may apply. My consent is not a condition of receiving goods or services. I can reply HELP for help. I can text STOP to unsubscribe any time.**

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

By enrolling, you may receive your own Nurse Ambassador provided by AbbVie. Ambassadors do not work under the direction of your HCP or give medical advice. They are trained to direct patients to their HCP for treatment-related advice, including further referrals. To learn about AbbVie's privacy practices and your privacy choices, visit www.abbvie.com/privacy.html.

☐ I would like to receive news and updates about AbbVie's products, clinical trials, research opportunities, programs, and other information that may be of interest to me.

2 Insurance Information ☐ Check box if your doctor's office will copy and attach insurance cards.

Beneficiary/Cardholder Name: ______ Prescription Insurance: ______

Medical Insurance: ______ Rx Group #: ______

Medical Insurance ID #: ______ Rx ID #: ______

Group #: ______ Rx Bin #: ______ Rx PCN #: ______

▼ FOR HEALTH CARE PROVIDER USE ONLY ▼

3 Diagnosis*

☐ Rheumatoid Arthritis (RA) ☐ Psoriatic Arthritis (PsA) ☐ Ankylosing Spondylitis (AS) ☐ Uveitis (UVI) ICD-10: ______

4 Prescriber Information

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

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

NPI #*: ______

Address: ______

City: ______ State: ______ ZIP*: ______

Email: ______

Office Phone: ______

Office Contact Name: ______

Office Fax*: ______

5 Clinical Information

Date of Diagnosis: ____/____/____

Prior Therapies: ______

Concomitant Medications: ______

Weight: ______ Height: ______

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

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

Starting therapy:

NI Uveitis

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

SIG: 80 mg SC inj. on Day 1, 40 mg SC inj. on Day 8 and on Day 22

QTY: #QS No Refills

Ongoing therapy:

Rheumatoid Arthritis (RA), Psoriatic Arthritis, Ankylosing Spondylitis, NI Uveitis

Choose 1 Presentation
- ☐ PEN HUMIRA (CF) **40mg/0.4ml**
- ☐ SYRINGE HUMIRA (CF) **40mg/0.4ml**
- ☐ PEN HUMIRA **40mg/0.8ml**
- ☐ SYRINGE HUMIRA **40mg/0.8ml**
- ☐ PEN HUMIRA (CF) **80mg/0.8ml (For RA only)**

SIG
- ☐ 40mg SC inj. every other week
- ☐ 40mg SC inj. every week*
- ☐ 80mg SC inj. every other week*

QTY: ☐ 1 month ☐ 3 months Refills: ______

*Dosage frequency is recommended only for patients not receiving MTX.

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)* ______ **Date*:** ____/____/____

IMPORTANT INFORMATION: By submitting this form you are referring the above patient to AbbVie's patient support program to determine eligibility and receive support related to an AbbVie product. AbbVie, its affiliates, collaborators and agents will use the information collected about you and your patient to provide the patient support and perform research and analytics, on a de-identified basis, for management of the program. For more information about the categories of personal information collected by AbbVie and the purposes for which AbbVie uses personal information, visit www.abbvie.com/privacy.html. 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-HUM-200590

HUMIRA® adalimumab