FLEXCARE SPECIALTY SERVICES

Thank you for your referral for SKYRIZI

(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

SKYRIZI GETTING STARTED CHECKLIST

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

1 NAVIGATE INSURANCE AND SAVINGS

Skyrizi Complete can help you understand your insurance and find possible ways to save.

- ☐ **If you have not talked with your Skyrizi Complete Nurse Ambassador* yet,** reach out by calling **1.866.SKYRIZI** (1.866.759.7494)
- ☐ **Ask your Nurse Ambassador about your savings options**
  Find out if your SKYRIZI could be as little as $5† per treatment

Your Nurse Ambassador is: _____

Your Nurse Ambassador's phone number: _____

2 PREPARE FOR YOUR INFUSIONS

You'll have 3 infusions; 1 every 4 weeks. Help understanding the infusion phase of your treatment is just a click away.

- ☐ **Watch the SKYRIZI Infusion Video**
- ☐ **Review the Infusion Checklist** with your Nurse Ambassador
- ☐ **Talk to your doctor about lab tests before, during, and up to 12 weeks of treatment with SKYRIZI**
- ☐ **Write down any questions** you may have for your next doctor appointment:

_____

_____

Infusion location: _____

_____

Phone number: _____

Infusion dates: *Completed!*

1. ___/___/___ ☐
2. ___/___/___ ☐
3. ___/___/___ ☐

3 GET READY TO INJECT AT HOME

You can ask for supplemental injection training to be delivered in person or during a virtual visit with your Nurse Ambassador.

- ☐ **Watch the SKYRIZI On-Body Injection Training Video**
- ☐ **Talk to your Nurse Ambassador about injection resources, or get additional information at SkyriziComplete.com**
- ☐ **Date of first injection at home:** ___/___/___
  - Call the specialty pharmacy to arrange delivery 2 weeks before this date

Specialty Pharmacy: FlexCare Specialty Services

Phone number: (866) 205-4239

Skyrizi® COMPLETE

Not enrolled? Call 1.866.SKYRIZI (1.866.759.7494) to join today.
Once enrolled, you can expect a call from your Nurse Ambassador within 1 business day. The call may come from any area code.

*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.

†For eligible, commercially insured patients only. See Terms and Conditions on back.
If eligible, you'll receive your Savings Card in the mail. Call your Ambassador if you do not receive your card.

Please see Use and Important Safety Information on page 2.

Please see full Prescribing Information, including Medication Guide, at https://www.rxabbvie.com/pdf/skyrizi_pi.pdf and discuss with your doctor.

Skyrizi® risankizumab-rzaa

Skyrizi® COMPLETE

SCD-100122-A10

Fax to Skyrizi Complete (1.678.727.0690)
Questions? Call 1.866.759.7494

Enrollment and Prescription Form

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

1 PATIENT'S INFORMATION - The healthcare professional (HCP) and the patient should fill out this form completely before leaving the office.

Please print clearly.

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

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

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

☐I consent to receive automated and 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. **View full Terms and Conditions**.

What was patient's last completed treatment? ☐Not started ☐Infusion 1 ☐Infusion 2 ☐Infusion 3 ☐SKYRIZI On-Body Injector Date of Last Treatment: ____/____/____

By enrolling, you may receive your own Support Specialist/Nurse provided by AbbVie. Nurse Ambassadors/Support Specialists do not work under the direction of your healthcare 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 form include name, date of birth, address, Rx, and insurance information. The personal information collected will be used for program enrollment 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 https://privacy.abbvie. **If you are an HCP please show this to your patient.**

☐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 Please attach insurance cards and provide supplemental insurance information, if available.

Beneficiary/Cardholder Name: _____
Medical Insurance: _____
Medical Insurance ID #: _____
Group #: _____

Prescription Insurance: _____
Rx Group #: _____
Rx ID #: _____
Rx Bin #: _____ Rx PCN #: _____

▼ FOR HEALTH CARE PROVIDER USE ONLY ▼

3 DIAGNOSIS* ☐Crohn's disease (CD) ICD-10: _____ Date of Diagnosis: ____/____/____

4 PRESCRIBER INFORMATION I would like to receive a copy: ☐Pharmacy Benefits ☐Medical Benefits

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

Office Phone*: _____
Office Contact Name: _____
Office Fax*: _____

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

5 CLINICAL INFORMATION

Prior Therapies: _____

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

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

6 SITE OF INFUSION INFORMATION

☐Prescriber's office (if checked, enter the Tax ID; then skip to section 7) ☐Non-prescribing MD's office ☐Hospital outpatient ☐Infusion center ☐Other: _____

Practice/Facility Name: _____
Site of Infusion NPI #: _____ Tax ID: _____

Address: _____
City: _____ State: _____ ZIP: _____
Phone: _____ Fax: _____

7 INJECTION TRAINING ☐I request supplemental injection training and/or administration for On-Body Injector, if needed, for this patient. Order valid for up to one year.

Fill out and sign pharmacy prescription 8a below.

8 PRESCRIPTION INFORMATION - Fill out and sign corresponding prescription(s) below

Check appropriate boxes to indicate quantity to dispense and directions:

Induction Therapy†—SKYRIZI 600 mg/10 mL single use vial

☐Week 0: 600 mg to be administered via IV Infusion
1 vial; no refills

☐Week 4: 600 mg to be administered via IV Infusion
1 vial; no refills

☐Week 8: 600 mg to be administered via IV Infusion
1 vial; no refills

†For the treatment of Crohn's disease, evaluate liver enzymes and bilirubin at baseline, and during induction at least up to 12 weeks of treatment. Monitor thereafter according to routine patient management.

Select ONE Ongoing Therapy‡—SKYRIZI prefilled cartridge with SKYRIZI On-Body Injector—Week 12:

☐Inject **180 mg/1.2 mL** SC and every 8 weeks
1 device with prefilled cartridge; Refills: ____

☐Inject **360 mg/2.4 mL** SC and every 8 weeks
1 device with prefilled cartridge; Refills: ____

‡The recommended maintenance dosage is dependent on therapeutic response. Use the lowest effective dosage needed to maintain response.

8a. PHARMACY PRESCRIPTION (OPTIONAL) – Rx will be forwarded to pharmacy listed below or appropriate pharmacy, if blank

Patient's preferred Specialty Pharmacy: IV: _____ **OBI:** FlexCare Specialty Services

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 SKYRIZI to the previously identified patient and that I provided the patient with a description of the Skyrizi Complete patient support program. I authorize Skyrizi 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) X _____ **Date:** ____/____/____

8b. SKYRIZI COMPLETE PRESCRIPTION - required in the event a commercially insured patient with a valid Rx for SKYRIZI experiences an insurance delay or denial

See Program Terms and Conditions on reverse side. 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 Skyrizi Complete will result in an original copy being simultaneously transmitted to the AbbVie-authorized pharmacy under this section.

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 SKYRIZI to the previously identified patient and that I provided the patient with a description of the Skyrizi Complete patient support program. I authorize Skyrizi 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 Skyrizi Complete may support patients who are experiencing a delay in insurance coverage for SKYRIZI 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. I confirm my patient has or will complete IV initiation therapy as recommended in the FDA-approved prescribing information.

Prescriber's Signature: (REQUIRED) X _____ **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. The categories of personal information collected in this form include prescriber name, address, and NPI. The personal information collected will be used for program enrollment 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 see Indication and Important Safety Information on page 4. Please see full Prescribing Information.

US-SKZG-220507

Skyrizi® risankizumab-rzaa