myAbbVie Assist | Patient Assistance

APPLICATION FOR SKYRIZI® (risankizumab-rzaa)

myAbbVie Assist provides free medicine to qualifying patients. We review all applications on a case-by-case basis. Participation in our program is free; we do not collect any fees from people seeking our assistance.

CHECKLIST FOR SUBMITTING AN APPLICATION

☐ **IF YOU ARE THE PRESCRIBER, COMPLETE PAGE 2**

- **SECTION 1:** Prescriber Information and Shipping Preference
- **SECTION 2:** Patient History, Diagnosis
- **SECTION 3:** Infusion Site Information (if applicable)
- **SECTION 4:** Prescription
- **SECTION 5:** Prescriber Certification and Signature

☐ **IF YOU ARE A PATIENT, COMPLETE PAGE 3. PLEASE READ PAGE 4**

- **SECTION 6:** Patient Information
- **SECTION 7:** Financial and Medical Information
  - **REQUIRED**: Please include proof of income for all in household. A copy of your current federal tax return is preferred. If you do not file taxes, alternate documents are acceptable such as W-2 form, Social Security Statement or Pay Stubs.
- **SECTION 8:** Insurance Information
  - **REQUIRED**: If you have Insurance, include front and back copies of all prescription insurance cards.
  - To help us determine your eligibility please also include a detailed list of prescription and medical out of pocket expenses for the household. If you have multiple prescriptions, your pharmacy can print you a list.
- **SECTION 9:** Additional Permission for Program Purposes (Optional)
- **SECTION 10:** Patient Consent and Signature
  - Carefully read the HIPAA authorization, patient terms of participation and privacy notice in Section 11 on Page 4.
  - Provide your consent for eligibility determination by checking the boxes in Section 10
  - Confirm your understanding of our privacy policy by providing your signature and date in Section 10.

☐ **Please keep a copy for your records.**

☐ **Please do not staple documents together when mailing.**

FAX OR MAIL THE COMPLETED APPLICATION AND DOCUMENTATION TO THE FOLLOWING:

myAbbVie Assist
D-617927, AP5 NE
1 N. Waukegan Rd.
North Chicago, IL 60064

Phone: 1-800-222-6885
Fax: 1-866-250-2803

Upon review of a completed application, we will notify the prescriber and patient about eligibility. If approved, we will ship the medication to the patient's home unless otherwise indicated on the application. Prior to each subsequent shipment, we will call the patient or prescriber to schedule the next delivery.

Please contact us at 1-800-222-6885 Monday through Friday for additional assistance.

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PRESCRIBER PRESCRIPTION AND CERTIFICATION
TO BE COMPLETED AND FAXED BY PRESCRIBER

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NORTH CHICAGO, IL 60064
PHONE: 1-800-222-6885 FAX: 1-866-250-2803

1 PRESCRIBER INFORMATION ● SHIPPING PREFERENCE

Prescriber Name: ☐ MD ☐ DO ☐ Other:_____ ☐ Derm ☐ Gastro ☐ Other:_____

Office Name: Office Contact Name:

Office Address: Office City/State/Zip:

NPI or SLN: Phone: Fax:

Collaborating MD Name and NPI *(if applicable)* Name: NPI:

Ship Preference for Self-Injection Dose(s): Check ONLY if you prefer shipping to Prescriber's office: ☐

For additional information on how AbbVie processes your personal information, please visit www.abbvie.com/privacy.html.

2 PATIENT MEDICAL HISTORY

Patient's Name: _____ **DOB:** _____ **Patient Phone:** _____ ☐ Cellphone ☐ Work ☐ Home

☐ No known allergies ☐ Allergies (Please list): _____

☐ No other medications ☐ Other Medications (Please list): _____

☐ **PLAQUE PSORIASIS** ☐ **PSORIATIC ARTHRITIS** ☐ **CROHN'S DISEASE** **Choose one or both:** ☐ Initiation Therapy ☐ Ongoing Therapy ☐ **OTHER:** _____

3 SITE OF INFUSION: INTRAVENOUS INITIATION DOSE FOR CROHN'S DISEASE

Complete ONLY if different from Prescriber's office

Facility Name:

Contact Person Name: **Contact Person Title:**

Address: City/State/Zip:

Phone: Fax:

4 RX: MUST BE COMPLETED BY A LICENSED PRESCRIBER AND FAXED DIRECTLY FROM PRESCRIBER'S OFFICE

CHOOSE DOSAGE FORM(S) NEEDED	CHOOSE DIRECTIONS FOR USE	QUANTITY	REFILLS
PLAQUE PSORIASIS / PSORIATIC ARTHRITIS			
☐ **SKYRIZI 150 mg/mL (1 Pen kit)** **-OR-** ☐ **SKYRIZI 150 mg/mL (1 Syringe kit)**	☐ **WEEK 0 and WEEK 4 -** Inject 150 mg SQ (Next Dose is due on Week 16)	2 kits – 112 days	No Refills
	☐ **EVERY 12 WEEKS -** Inject 150 mg SQ (Starting on Week 16)	1 kit – 84 days	1 year supply Other: _____
CROHN'S DISEASE **INITIATION THERAPY** ☐ **SKYRIZI 600 mg/10 mL single use vial**	☐ Intravenous infusion of 600 mg/10 mL on Week 0, Week 4, and Week 8 Other: _____	1 vial with 2 refills - 84 days Other: _____	NA Other: _____
ONGOING THERAPY **SKYRIZI On-Body Injector (Choose One)** ☐ **Pre-Filled Cartridge 180 mg/1.2 mL** ☐ **Pre-Filled Cartridge 360 mg/2.4 mL**	**Starting Week 12, every 8 weeks thereafter:** Inject 180 mg/1.2 mL SC via on-body injector Inject 360 mg/2.4 mL SC via on-body injector	1 device with pre-filled cartridge – 56 days	1 year supply Other: _____

SKYRIZI: _____ **Directions:** _____ **Qty:** _____ **Refills:** _____

PLEASE SUBMIT PRESCRIPTIONS ACCORDING TO YOUR SPECIFIC STATE LAWS, RULES AND REGULATIONS

5 PRESCRIBER PLEASE SIGN AND DATE ● PRESCRIBER MUST MANUALLY SIGN BELOW

RUBBER STAMPS, SIGNATURE BY OTHER OFFICE PERSONNEL OR COMPUTER-GENERATED IMAGES ARE NOT ALLOWED

PRESCRIBER SIGNATURE AND DATE: **X** _____ **X** _____ **DATE:** _____

☐ **Substitution Permitted** ☐ **Dispense as Written**

I verify that the information provided is current, complete and accurate to the best of my knowledge. myAbbVie Assist reserves the right to request additional information if needed and to change or discontinue the program at any time, without notice. I shall not seek reimbursement for any medication dispensed hereunder from any government program or third party, including patient, nor will I sell, trade or distribute any such medication. I also understand that the applicant's acceptance into the program should not influence treatment decisions. By signing this form, I authorize the program and its representatives to transmit this prescription form electronically, by facsimile, or by mail to a pharmacy designated by the program for the dispensing of the medication called for herein. I understand that I may not delegate signature authority. I certify that treatment with this medication is medically necessary.

For full Prescribing Information please visit www.rxabbvie.com

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PATIENT INFORMATION TO BE COMPLETED BY PATIENT

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6 PATIENT INFORMATION

Patient Name: | DOB: | Sex: ☐ M ☐ F

SSN (last four digits ONLY): ___ | ___ | ___ If you do not have an SSN, check here: ☐

Mailing Address: | City/State/Zip:

Shipping Address (No P.O. Box): | City/State/Zip:

Preferred Phone: ☐ Cellphone ☐ Work ☐ Home | Alternate Phone: ☐ Cellphone ☐ Work ☐ Home

Check the Box for Text ☐ Mobile Phone: _____ | Email address: _____

* I consent to receive automated and recurring text messages from [myAbbVie Assist], including service updates and medication and refill reminders to the above number. Message and data rates may apply. I am not required to consent or provide my consent as a condition of receiving any goods or services. I can reply HELP for help. I can text STOP to unsubscribe any time.

7 FINANCIAL AND MEDICAL INFORMATION

Please include financial documentation for everyone in the household. A copy of your current federal tax return is preferred. If you do not file taxes, alternate documents are acceptable such as W-2 forms, Social Security Statements and Pay Stubs.

Monthly Household Income $_____ | Number in Household (including yourself) : _____ | Number in household over 18 yrs old with income : _____

☐ **Plaque Psoriasis** ☐ **Psoriatic Arthritis** ☐ **Crohn's Disease** ☐ **Other:** _____

Treating Physician Name: _____ **Phone:** _____ **Fax:** _____

If you have any changes to your medical information please call us at 1-800-222-6885*

8 INSURANCE

☐ **I have no insurance coverage – go to Section 9**

INSURANCE TYPE: ☐ **Medicare** ☐ **Insurance through an Employer (Employer Name):** _____
☐ **Medicaid** ☐ **Other Commercial:** _____ ☐ **Other:** _____

Please provide insurance details below and attach a front and back copy of all insurance cards. Also include a detailed list of prescriptions such as a Pharmacy print-out and medical expenses for the household to help us determine eligibility for our program.

MEDICAL INSURANCE		PRESCRIPTION INSURANCE	
Insurance Company:		Insurance Company:	
Insurance Co. Phone:		Insurance Co. Phone:	
Policy ID #:	Group #:	Policy ID #:	Group #:
Policyholder Name:	Relationship:	BIN #:	PCN #:

Do you have secondary insurance? ☐ Yes ☐ No ☐ Unsure

Please provide your Medicare Part A Identification #: _____ **Do you have a Medicare supplement?** ☐ Yes (please include a copy) ☐ No ☐ Unsure

Has your employer, insurance company, or another third party directed you to apply to myAbbVie Assist? ☐ **Yes** ☐ **No**

9 ADDITIONAL PERMISSION FOR PURPOSES OF THE PROGRAM (optional)

I permit myAbbVie Assist to speak with the following person about this application: (myAbbVie Assist reserves the right to limit some program-related communications to the patient and/or their legal representative only.)

Name: _____ **Relationship:** _____ **Phone Number:** _____

10 PATIENT CONSENT

PLEASE REVIEW HIPAA AUTHORIZATION, PATIENT TERMS OF PARTICIPATION AND PRIVACY NOTICE IN SECTION 11 TO UNDERSTAND HOW WE USE YOUR PERSONAL INFORMATION

CHECK THE BOXES:

☐ ***I understand that I am providing written instructions to the Program under the Fair Credit Reporting Act authorizing the Program to obtain information about my credit profile from credit reporting agencies or other sources. I authorize the Program to obtain such information solely to determine PAP eligibility.***

☐ ***I acknowledge that I have provided accurate and complete information and that I have read, understood, and agree to the Patient Terms of Participation in Section 11.***

PLEASE SIGN AND DATE:

My signature below certifies that I have read, understood and agree to the release of my protected health information pursuant to the HIPAA Authorization in Section 11.

X _____ X _____

PATIENT SIGNATURE / LEGAL REPRESENTATIVE * (indicate relationship) DATE

* Only representatives with legal authority for health care decision-making may apply to myAbbVie Assist on a patient's behalf.

For full Prescribing Information please visit www.rxabbvie.com

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11 HIPAA AUTHORIZATION, PATIENT TERMS OF PARTICIPATION AND PRIVACY NOTICE

HIPAA AUTHORIZATION Please provide signature in Section 10 of Enrollment Form

I authorize my healthcare providers, pharmacies, insurers, and laboratory testing facilities (my "Healthcare Companies") to disclose information about me, my medical condition, treatment, insurance coverage, and payment information in relation to my use of AbbVie products, to AbbVie to enroll me in and provide me with patient assistance and support for AbbVie products. I understand that information released under this Authorization will no longer be protected by HIPAA. I also understand that if my Healthcare Companies use or disclose my Personal Information for marketing purposes, they may receive financial remuneration.

I understand that I am not required to sign this Authorization and that my Healthcare Companies will not condition my treatment, payment, enrollment, or eligibility for benefits on whether I sign this Authorization. However, I understand that if I do not sign this Authorization, I cannot take part in myAbbVie Assist (should I qualify). This Authorization will expire in 10 years or a shorter period if required by state law, unless I cancel it sooner by calling 1-800-222-6885 or by writing to myAbbVie Assist, D-617927, AP5 NE; 1 N. Waukegan Rd, North Chicago, IL 60064. I understand that cancelling my Authorization will not affect any use of my information that occurred before my request was processed.

PATIENT TERMS OF PARTICIPATION

myAbbVie Assist provides free medicine to qualifying patients. Participation in our program is free; we do not collect any fees from people seeking our assistance. Medication assistance is dependent on your ability to meet the eligibility criteria for our program as determined by myAbbVie Assist. myAbbVie Assist does not have any obligation to provide the program services to you and is not liable in the provision of these services. Patients with insurance plans or employers participating in an alternate funding program (also sometimes referred to as patient advocacy programs, specialty networks, SHARx, Paydhealth, or Payer Matrix, among other names) requiring them to apply to a manufacturer's patient assistance program or otherwise pursue specialty drug prescription coverage through an alternate funding vendor as a condition of, requirement for, or prerequisite to coverage of relevant AbbVie products, or that otherwise denies, restricts, eliminates, delays, alters, or withholds any insurance benefits or coverage contingent upon application to, or denial of eligibility for, specialty drug prescription coverage through the alternate funding program are not eligible for the myAbbVie Assist program. You agree to inform myAbbVie Assist if you are a member of such an insurance plan or if you are applying to myAbbVie Assist on behalf of a patient who is a member of such an insurance plan. The program may be changed or discontinued without notice. You will not seek reimbursement for any products dispensed under the program. You will notify the program if your insurance or financial situation changes. If this application has been completed by a personal representative, the personal representative will provide a copy of this completed application to you.

If you are a member of a Medicare plan including a Medicare Prescription Drug Plan and are qualified for program assistance, you will: (i) be eligible to obtain the medication from the program for a calendar year term (ii) not purchase this medication under your Medicare plan while enrolled in the program; (iii) not submit claims nor seek true out-of-pocket (TrOOP) credit for the medication provided during your enrollment; (iv) myAbbVie Assist will inform your Medicare Prescription Drug Plan, if applicable that you are receiving your medication at no cost outside of the Medicare Part D benefit..

If you have questions, want to update your information, or terminate your enrollment, please call 1-800-222-6885 or write to us at D-617927, AP5 NE; 1 N. Waukegan Rd, North Chicago, IL 60064.

PATIENT PRIVACY NOTICE

myAbbVie Assist will use and disclose with authorized third parties your personal information including your financial and health information collected on this enrollment form and through participation in the program for the following purposes:

(1) To determine your eligibility for the program and to provide you with related services, including transfer to a separate private or public payer program, reimbursement services, services to ship your medication, and other support services.
(2) To obtain information from your credit profile about your income for the sole purpose of determining eligibility for the program. This notice serves as written instruction under the Fair Credit Reporting Act authorizing myAbbVie Assist to obtain this information.
(3) To perform research and data analytics to develop and evaluate products, services, materials, and treatments.
(4) To administer and maintain the quality of the program, including but not limited to case review, compliance checks, audit review and accounting purposes.

For additional information on how AbbVie processes your personal information, please visit www.abbvie.com/privacy.html.

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