myAbbVie Assist | Patient Assistance

APPLICATION FOR SKYRIZI™ (rizankizumab-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:** Prescription
- **SECTION 4:** Prescriber Certification and Signature

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

- **SECTION 5:** Patient Information
- **SECTION 6:** Financial and Medical Information
  - Also include proof of income for all in household. A copy of your current federal tax return is preferred.
- **SECTION 7:** Insurance Information
  - 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 8:** Patient Consent and Signature
  - Carefully read the privacy notice and terms of participation in Section 10 on Page 4.
  - Provide your consent for eligibility determination by checking the box in Section 8
  - Confirm your understanding of our privacy policy by providing your signature and date in Section 8.
- **SECTION 9:** Additional Permission for Program Purposes (Optional)

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

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 ☐ Other:_________________

Office Name: Office Contact Name:

Address: City/State/Zip:

NPI or SLN: Phone: Fax:

Collaborating/Supervising MD Name and NPI Name: NPI:

***Check ONLY if you prefer shipping to the Prescriber's office*:** ☐

2 PATIENT MEDICAL HISTORY

Patient's Name: ____ **DOB:** ________________

☐ No known allergies ☐ Allergies (Please list)**:** ____

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

☐ **PLAQUE PSORIASIS** ☐ **OTHER:** __________________

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

	CHOOSE DIRECTIONS FOR USE BELOW	QUANTITY	REFILLS
SKYRIZI 75 mg/0.83 mL (2 syringe kit)	☐ **On WEEK 0 and WEEK 4:** Inject 150 mg (two 75 mg injections) SQ (Next Dose is due on Week 16)	4 syringes (2 kits) – 112 days	No Refills
	☐ **EVERY 12 WEEKS:** Inject 150 mg (two 75 mg injections) SQ (Starting on Week 16)	☐ 2 syringes (1 kit) – 84 days	☐ 1 year supply
	☐ Other: ______________________________	☐ Other: ______________	☐ Other: ______

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

4 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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5 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

6 FINANCIAL AND MEDICAL INFORMATION

Monthly Total Income for everyone in the household: $ ________

Please include financial documentation for <u>everyone in the household.</u> A copy of your current federal tax return is preferred.

Number of people in your household (including yourself): ________ Number in household over 18 yrs old with income: ________

Treating Physician Name: ________________________ Treating Physician Phone:______________ Fax: _______________

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

7 INSURANCE INFORMATION ☐ I have no insurance coverage – go to Section 8

If you have insurance please provide insurance details below and attach a front and back copy of all prescription insurance cards. Include detailed list of medical expenses for household, including medications, office visit copays, insurance premiums, medical bills, etc. If you have multiple prescriptions, your pharmacy can print you a list. This information will help us determine eligibility for our program.

PRIMARY INSURANCE		SECONDARY INSURANCE	
Insurance Company:		Insurance Company:	
Insurance Co. Phone:		Insurance Co. Phone:	
Policy #:	Group #:	Policy #:	Group #:
Policyholder Name:	DOB:	Policyholder Name:	DOB:
Relationship to Policyholder:		Relationship to Policyholder:	

MEDICARE INFORMATION

Are you enrolled in a Medicare Prescription Drug Plan (Medicare Part D)? ☐ Yes ☐ No ☐ Unsure

If Yes, please provide your Medicare Part A Identification #: ______________________ Value of your assets: $ ___________

Assets include checking and savings accounts, CD's, stocks and bonds, savings bonds, mutual funds, IRAs and other investments, cash at home or anywhere else, and the value of your life insurance policies if turned in for cash right now. Do not include your home, vehicles, burial plots, or personal possessions.

8 PATIENT CONSENT

PLEASE REVIEW PRIVACY NOTICE AND PROGRAM TERMS IN SECTION 10 TO UNDERSTAND HOW WE USE YOUR PERSONAL DATA

I acknowledge that I have provided accurate and complete information and understand the Patient Terms of Participation in Section 10.

CHECK THE BOX: ☐ ***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 program eligibility.***

PLEASE SIGN AND DATE: ***My signature below certifies that I have read, understood and agreed to the HIPAA Authorization on Page 4.***

→ X____

PATIENT SIGNATURE / LEGAL REPRESENTATIVE (indicate relationship) DATE

9 ADDITIONAL PERMISSION FOR PURPOSES OF THE PROGRAM (optional)

I permit myAbbVie Assist to speak with the following person about this application:

Name: ________________________________ **Relationship:**________________ **Phone Number:** ______________

Patient Signature: ________________________ **Date:**____________________

For full Prescribing Information please visit www.rxabbvie.com

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10 PATIENT PRIVACY NOTICE AND TERMS OF PARTICIPATION

HIPAA AUTHORIZATION Please provide signature in Section 8 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 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. 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) provide written notification to your Medicare Prescription Drug Plan, if applicable, that you are receiving your medication at no cost outside of the Medicare Part D benefit.

In order for you to participate, the program will use and disclose with authorized third parties your personal information, including your health information, collected on this enrollment form and through participation in the program for the following purposes:

(1) To determine your eligibility 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 ("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 the program 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.

We may combine the information it receives about you with information from other sources. However, we will not sell or rent any information that can identify you to third parties for their own purposes or otherwise use or disclose any information that can identify you for any purpose not authorized above. If you have questions about this Privacy Notice, 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.

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