Patient Access Support

SKYRIZI® (risankizumab-rzaa)

AbbVie Patient Access Support includes programs that provide access and financial support and treatment-related resources to patients. We can help identify financial assistance options to support patients in accessing prescribed AbbVie medications. We understand that there's a lot more to you than just your condition. Think of us as your partner on your AbbVie medication treatment journey.

Getting Started

Questions? Call 1-800-222-6885

If you are a patient:

1. Carefully read the terms of participation, privacy notice, financial information and HIPAA authorizations on pages 1–3.
2. Print and complete the enrollment form on page 4.
3. Provide your consent for eligibility determination by checking the boxes in Section 5 and confirm your understanding of the Terms of Participation by providing your signature and date. You must also provide a separate signature and date for HIPAA authorization.
4. If you have health insurance, please include front and back copies of all insurance cards.
5. **The following only applies to AbbVie medications that are reimbursed under a Medicare Part D prescription drug plan.**
   If you have Medicare and income below 150% of the Federal Poverty Limit (FPL), you may qualify for the "Medicare Part D Extra Help" Program, also known as "Extra Help", "Low-Income Subsidy" or "LIS". Patients with Medicare and income below 150% FPL will not be eligible for myAbbVie Assist unless you have applied and been denied for that Program. Please include a denial letter with your PAP enrollment. If your income is above 150% FPL, you do not need to include a denial letter from the "Medicare Part D Extra Help" Program.
   Extra Help is a Medicare program to help people with limited income and resources pay Medicare drug coverage (Part D) premiums, deductibles, coinsurance, and other costs. For more information visit https://medicare.gov/extrahelp.
6. Keep a copy of this application for your records.

If you are the prescriber:

1. Complete the enrollment & prescription form on page 5.
2. Confirm you will abide by the terms and conditions and that the prescription is accurate by checking the boxes in section 11 and providing your signature and date.

Submitting an Application

AbbVie can start assessing you for eligibility of Patient Access Support programs when pages 4 and 5 of this form and required documentation are submitted by you and your prescriber's office in one of the following ways:

FAX	ONLINE	MAIL
Fax to AbbVie: **1-866-250-2803**	**Patients may complete this form electronically. Please visit:** **www.AbbVie.com/PAS**	**AbbVie Patient Access Support** **D-617927, AP5 NE** **1 N. Waukegan Rd.** **North Chicago, IL 60064**

Upon review of a completed application, we will notify the prescriber and patient about eligibility. AbbVie may also request a detailed list of prescription and medical out-of-pocket expenses for the household to further determine eligibility for the Patient Assistance Program (PAP).

Financial Information

AbbVie offers a financial assistance program that provides access and financial support to those meeting program guidelines. By signing this application form, you provide written instructions to the Program under the Fair Credit Reporting Act authorizing the Program to obtain information about your credit profile from credit reporting agencies or other sources. You authorize AbbVie to obtain such information solely to determine Patient Assistance Program (PAP) eligibility, and to perform an electronic income verification. You understand that you may be required to provide additional financial documentation for Patient Assistance consideration.

Terms of Participation

AbbVie Patient Access Support offers various affordability and access programs:

PATIENT ASSISTANCE PROGRAM (PAP): 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.

SAVINGS CARD: Available to patients with commercial prescription insurance coverage who meet eligibility criteria. Copay assistance program is not available to patients receiving prescription reimbursement under any federal, state, or government-funded insurance programs (for example, Medicare [including Part D], Medicare Advantage, Medigap, Medicaid, TRICARE, Department of Defense, or Veterans Affairs programs) or where prohibited by law. Offer subject to change or discontinuance without notice. Restrictions, including monthly maximums, may apply. This is not health insurance. To learn about AbbVie's privacy practices and your privacy choices, visit https://abbv.ie/corpprivacy.

BRIDGE PROGRAM: Available to patients aged 63 or younger with commercial insurance coverage. Patients must have a valid prescription for an FDA approved indication of the applicable AbbVie Product and a denial of insurance coverage based on a prior authorization request on file along with a confirmation of appeal. Continued eligibility for the program requires the submission of an appeal of the coverage denial every 180 days. Program provides the applicable AbbVie Product at no charge to patients for up to two years or until they receive insurance coverage approval, whichever occurs earlier, and is not contingent on purchase requirements of any kind. Program is not available to patients whose medications are reimbursed in whole or in part by Medicare, Medicaid, TRICARE, or any other federal or state program. Offer subject to change or discontinuance without notice. This is not health insurance and program does not guarantee insurance coverage. No claims for payment may be submitted to any third party for product dispensed by program. Limitations may apply. 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.

Privacy Notice

AbbVie may collect your personal data through your online and offline interactions with us, including your contact, transaction, financial, demographic, insurance, geolocation, and health-related data. We may also collect your online usage data automatically through cookies and similar technologies. We use this information for several purposes, such as to provide you with, administer, and improve our programs, services and products, customize your experiences, and for research and analytics. We retain your personal data for as long as necessary to fulfill these purposes or to comply with our record retention obligations. We do not sell your personal data, but may use and disclose your personal data with marketing and advertising partners to deliver you ads based on your interests inferred from your activity across other unaffiliated sites and services ("online targeted advertising") and for website analytics. To opt out of the use or disclosure of your personal data for online targeted advertising or for website analytics, go to Your Privacy Choices, https://abbviemetadata.my.site.com/AbbvieDSRM on our website. For more information on the personal data categories we collect, the purposes for their collection, disclosures to third parties, and data retention, visit our Privacy Notice at https://abbv.ie/corpprivacy.

HIPAA Authorization

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION: I authorize my health care providers and staff, health plan, and pharmacies (collectively, my "Healthcare Providers") to disclose individually identifiable information about me, my health or condition(s), treatment and care that I have received, my insurance coverage, my payment information, and my medication history and prescriptions (collectively, "Protected Health Information") to AbbVie Inc. and/or its designated affiliates, agents, representatives, and service providers (collectively, "AbbVie") in order for AbbVie to (i) enroll me in, provide, operate and administer the AbbVie Financial Support Program ("Program"); (ii) provide me with information concerning the Program; and (iii) develop, evaluate, and improve products, services, materials, and programs related to my condition or treatment. I understand that Protected Health Information disclosed to AbbVie under this Authorization will no longer be protected by HIPAA and may be subject to redisclosure by AbbVie. I understand that I am not required to sign this Authorization and that my Healthcare Providers will not otherwise condition my treatment, payment, health insurance enrollment, or eligibility for health care benefits to which I am otherwise entitled on whether I sign this Authorization. However, I understand that if I do not sign this Authorization, I cannot take part in the Program. I understand that this Authorization will expire once I am no longer participating in the Program, unless I cancel it sooner.

I understand that I may cancel this Authorization at any time by making a data subject rights request at https://abbv.force.com/AbbvieDSRM/s/?language=en_US or by writing to privacydsr@abbvie.com. However, I understand that if I cancel this Authorization, it will end my enrollment in the Program. I understand that cancelling this Authorization will not affect any use or disclosure of my Protected Health Information that has already taken place in reliance on this Authorization.

SKYRIZI® (risankizumab-rzaa) Patient Access Support: Enrollment Form

PLEASE SUBMIT THIS PAGE.
Fax to AbbVie: 1-866-250-2803

Please print clearly.

⇩ **TO BE COMPLETED BY PATIENT** ⇩

1 PATIENT INFORMATION: See Privacy Notice on page 3 for information about how your personal data will be collected, used, and disclosed.

FIRST NAME: **LAST NAME:**

DATE OF BIRTH: **SEX:** ☐ **MALE** ☐ **FEMALE** **SSN (last four digits ONLY):**

MAILING ADDRESS: **CITY:** **STATE:** **ZIP:**

SHIPPING ADDRESS (no P.O. box): **CITY:** **STATE:** **ZIP:**

PHONE: ☐ HOME ☐ MOBILE* **EMAIL:**

**OPTIONAL: To consent to text messaging, see the consent language on page 3 of the Patient Privacy Notice and Consent Terms section of this form.*

When did you start on treatment? ☐ **Not yet started** ☐ **0-3 months** ☐ **3-6 months** ☐ **6-12 months** ☐ **more than 12 months**

2 INSURANCE INFORMATION: A copy of front and back sides of **ALL** Insurance Cards is **REQUIRED.**

INSURANCE TYPE: ☐ No insurance ☐ Medicare ☐ Medicaid ☐ Private/Commercial (*Is insurance through an employer?:* ☐ YES ☐ NO) ☐ Other: _____

EMPLOYER NAME (if applicable): PRESCRIPTION INSURANCE COMPANY:

MEDICAL INSURANCE COMPANY: Rx ID #:

MEDICAL ID #: GROUP #: Rx GROUP #:

CARDHOLDER NAME: Rx BIN #: Rx PCN #:

Please provide your Medicare Part A ID #: DO YOU HAVE A MEDICARE SUPPLEMENT?: ☐ **YES** ☐ **NO** ☐ **UNSURE**

Has your employer, insurance company, or another third party directed you to apply to the patient assistance program at AbbVie? ☐ **YES** ☐ **NO**

DO YOU HAVE SECONDARY INSURANCE?: ☐ **YES** ☐ **NO** ☐ **UNSURE**

3 PRESCRIBER INFORMATION:

TREATING PHYSICIAN'S NAME: **OFFICE PHONE:** **OFFICE FAX:**

4 ADDITIONAL PERMISSION FOR PURPOSES OF THE PROGRAM (optional):

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

NAME: **RELATIONSHIP:** **PHONE NUMBER:**

5 PATIENT CONSENT: Please review Terms of Participation, Privacy Notice, Financial Information and HIPAA Authorization on pages 1–3.

☐ **FAIR CREDIT REPORTING ACT CONSENT (REQUIRED):** 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.

☐ **SMS TEXT CONSENT (OPTIONAL):** I consent to receive automated and recurring text messages from "AbbVie", including services updates, marketing messages, refill reminders, and Rx 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, https://abbv.ie/corpprivacy and Mobile T&C, https://privacy.abbvie/us-mobile-terms-and-conditions.html.

☐ **MARKETING CONSENT (OPTIONAL):** I consent to the collection, use, and disclosure of my health-related personal data to receive communications from AbbVie regarding its products, programs, services, scientific research and other research opportunities, and for online targeted advertising, as further described in the "How we may use Personal Data", https://abbv.ie/PrivacyUseData, "How we may disclose Personal Data", https://abbv.ie/PrivacyDiscloseData and "Cookies and similar tracking and data collection technologies" sections, https://abbv.ie/PrivacyTrackingCollection of our Privacy Notice, https://abbv.ie/corpprivacy. 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" https://abbviemetadata.my.site.com/AbbvieDSRM on AbbVie's website.

CONSENT TO PROCESS MY SENSITIVE PERSONAL INFORMATION: Through my submission of the AbbVie Patient Access Support enrollment 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, https://abbv.ie/PrivacyDiscloseData. 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", https://abbviemetadata.my.site.com/AbbvieDSRM on AbbVie's website.

My signature below certifies that I have provided accurate and complete information and that I have read, understood, and agree to the Patient Terms of Participation on page 2.

REQUIRED—PATIENT SIGNATURE or LEGAL REPRESENTATIVE*: **DATE:**

LEGAL REPRESENTATIVE'S RELATIONSHIP TO PATIENT:

My signature certifies that I have read, understood, and agree to the release of my protected health information pursuant to the HIPAA Authorization.
Note: You have a right to receive a copy of this Authorization. You may print a copy of or save this Authorization and retain a copy for your records.

REQUIRED—PATIENT SIGNATURE or LEGAL REPRESENTATIVE*: **DATE:**

LEGAL REPRESENTATIVE'S RELATIONSHIP TO PATIENT:

Only representatives with legal authority for healthcare decisions may apply on a patient's behalf.* ***Indicate relationship* *below signature if signing on behalf of the patient.*

For full Prescribing Information please visit www.rxabbvie.com

SKYRIZI® (risankizumab-rzaa) Patient Access Support: Enrollment & Prescription Form

PLEASE SUBMIT THIS PAGE.
Fax to AbbVie: 1-866-250-2803

Please print clearly. ⇩ **FOR HEALTH CARE PROVIDER USE ONLY** ⇩

Must be completed by a licensed prescriber and faxed directly from a healthcare office.

6 PRESCRIBER INFORMATION:

PRESCRIBER'S NAME: ☐ MD ☐ DO ☐ OTHER: **NPI #:**

OFFICE CONTACT NAME: **OFFICE PHONE:** **OFFICE FAX:**

ADDRESS: **CITY:** **STATE:** **ZIP:**

(if applicable) **COLLABORATING MD NAME:** *(if applicable)* **NPI #:**

7 PATIENT INFORMATION:

PATIENT NAME: **DOB:** **PHONE:**

DRUG ALLERGIES: **PATIENT WEIGHT (IF UNDER 18)*:**
**add weight only if applicable*

CONCOMITANT MEDICATIONS:

HAS YOUR PATIENT'S INSURANCE DENIED COVERAGE FOR THE REQUESTED MEDICATION?*: *If yes, please include denial document* ☐ **YES** ☐ **NO**

8 INDICATION:

☐ **PLAQUE PSORIASIS** ☐ **PSORIATIC ARTHRITIS** **CROHN'S DISEASE (choose one or both):** ☐ **Initiation Therapy** ☐ **Ongoing Treatment**

☐ **Other:** **ULCERATIVE COLITIS (choose one or both):** ☐**Initiation Therapy** ☐**Ongoing Treatment**

9 SITE OF INFUSION INFORMATION: COMPLETE IF CRONH'S DISEASE OR ULCERATIVE COLITIS INITIATION THERAPY IS SELECTED ABOVE.

☐ **PRESCRIBER'S OFFICE (if checked, skip to next section)** ☐ **Other:**

PRACTICE/FACILITY NAME: **CONTACT PERSON NAME:**

CONTACT PERSON TITLE: **PHONE:** **FAX:**

ADDRESS: **CITY:** **STATE:** **ZIP:**

10 PRESCRIPTION INFORMATION: PLEASE SUBMIT PRESCRIPTIONS ACCORDING TO YOUR SPECIFIC STATE LAWS, RULES AND REGULATIONS.

SKYRIZI THERAPY OPTIONS	DOSAGE FORM(S) NEEDED	QUANTITY	DIRECTIONS FOR USE	REFILLS
PLAQUE PSORIASIS / PSORIATIC ARTHRITIS	☐ SKYRIZI 150 mg/mL (1 PEN KIT) -or- ☐ SKYRIZI 150 mg/mL (1 SYRINGE KIT)	☐ 2 KITS (112 DAYS)	WEEK 0 and 4 - INJECT 150 mg SQ (NEXT DOSE DUE WEEK 16)	NO REFILLS
		☐ 1 KIT (84 DAYS)	EVERY 12 WEEKS - INJECT 150 mg SQ (STARTING WEEK 16)	1 YEAR ☐ OTHER:____
CROHN'S DISEASE AND ULCERATIVE COLITIS	**CROHN'S DISEASE INITIATION THERAPY** ☐ SKYRIZI 600 mg/10 mL SINGLE USE VIAL **ULCERATIVE COLITIS INITIATION THERAPY** ☐ SKYRIZI 600 mg/10 mL (60 mg/mL) SINGLE USE VIAL	1 VIAL w/ 2 REF (84 DAYS) 2 VIALS w/ 2 REF (84 DAYS) ☐ OTHER:_____	INTRAVENOUS INFUSION OF 600 mg/10 mL ON WEEK 0, 4, 8 INTRAVENOUS INFUSION OF (2) 600 mg/10mL ON WEEK 0, 4, 8 ☐ OTHER: _____	N/A ☐ 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	1 DEVICE WITH PRE-FILLED CARTRIDGE – 56 DAYS	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 YEAR ☐ OTHER: ____
☐ **SKYRIZI:** _____		**QTY:** _____	**DIRECTIONS:** _____	**REF:** _____

11 PRESCRIBER CERTIFICATION: See Program Terms of Participation on page 2.

☐ **SUBSTITUTION PERMITTED** ☐ **DISPENSE AS WRITTEN**

I understand that this prescription may be transmitted to an AbbVie-authorized pharmacy for patient enrollment in an AbbVie sponsored program for free product. I certify that the above therapy is medically necessary and that the information provided is accurate to the best of my knowledge. 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.

myAbbVie Assist Program: myAbbVie Assist reserves the right to request additional information if needed and to change or discontinue the program at any time, without notice. I also understand that the applicant's acceptance into the program should not influence treatment decisions.

Bridge Program: 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 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.

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.

PRESCRIBER'S SIGNATURE (REQUIRED): **DATE:**

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

Privacy Notice for Prescriber: 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/PrivacyHCP.

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