Welcome to Skyrizi Complete.

Resources designed around you.

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

- Making sense of your insurance coverage
- Identifying ways you may be able to save on SKYRIZI
- Providing support to help you prepare for your appointments
- Providing supplemental self-injection training, if needed

Your Skyrizi Complete Nurse Ambassador* will be there to help you understand financial resources and provide information on SKYRIZI. They will be there for you every step of the way for as long as you need.

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

1 **Before you leave the doctor's office, ask your doctor** which Specialty Pharmacy your prescription is being sent to and write down their number below. This pharmacy will help you plan your SKYRIZI delivery and may follow up with you.

SPECIALTY PHARMACY: Amber Specialty Pharmacy **PHONE:** P: 1-855-896-9254; F: 1-402-896-3774

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, understand your insurance coverage, and help you identify ways you may be able to save on SKYRIZI.

For questions, please call **1.866.SKYRIZI (1.866.759.7494)**.

*Ambassadors do not give medical advice and will direct you to your health care professional for any treatment-related questions, including further referrals.

For more information about AbbVie's privacy practices and your privacy choices, visit www.abbvie.com/privacy.html

Please see Important Safety Information on page 2.

Please see accompanying full Prescribing Information or visit https://www.rxabbvie.com/pdf/skyrizi_pi.pdf

Skyrizi™ COMPLETE

Skyrizi™
risankizumab-rzaa
75mg/0.83mL Injection

USE AND IMPORTANT SAFETY INFORMATION ABOUT SKYRIZI™ (risankizumab-rzaa)[1]

SKYRIZI Use[1]

SKYRIZI™ (risankizumab-rzaa) is a prescription medicine used to treat adults with moderate to severe plaque psoriasis who may benefit from taking injections or pills (systemic therapy) or treatment using ultraviolet or UV light (phototherapy).

Important Safety Information[1]

What is the most important information I should know about SKYRIZI™ (risankizumab-rzaa)?

SKYRIZI may cause serious side effects, including infections. SKYRIZI is a prescription medicine that may lower the ability of your immune system to fight infections and may increase your risk of infections. Your healthcare provider should check you for infections and tuberculosis (TB) before starting treatment with SKYRIZI and may treat you for TB before you begin treatment with SKYRIZI if you have a history of TB or have active TB. Your healthcare provider should watch you closely for signs and symptoms of TB during and after treatment with SKYRIZI.

- Tell your healthcare provider right away if you have an infection or have symptoms of an infection, including:
  - fever, sweats, or chills
  - muscle aches
  - weight loss
  - cough
  - warm, red, or painful skin or sores on your body different from your psoriasis
  - diarrhea or stomach pain
  - shortness of breath
  - blood in your mucus (phlegm)
  - burning when you urinate or urinating more often than normal

Before using SKYRIZI, tell your healthcare provider about all of your medical conditions, including if you:

- have any of the conditions or symptoms listed in the section "What is the most important information I should know about SKYRIZI?"
- have an infection that does not go away or that keeps coming back.
- have TB or have been in close contact with someone with TB.
- have recently received or are scheduled to receive an immunization (vaccine). You should avoid receiving live vaccines during treatment with SKYRIZI.
- are pregnant or plan to become pregnant. It is not known if SKYRIZI can harm your unborn baby.
- are breastfeeding or plan to breastfeed. It is not known if SKYRIZI passes into your breast milk.

Tell your healthcare provider about all the medicines you take, including prescription and over-the-counter medicines, vitamins, and herbal supplements.

What are the possible side effects of SKYRIZI?

SKYRIZI may cause serious side effects. See "What is the most important information I should know about SKYRIZI?"

The most common side effects of SKYRIZI include upper respiratory infections, fungal skin infections, headache, feeling tired, and injection site reactions.

These are not all the possible side effects of SKYRIZI. Call your doctor for medical advice about side effects.

Use SKYRIZI exactly as your healthcare provider tells you to use it.

You are encouraged to report negative side effects of prescription drugs to the FDA.
Visit www.fda.gov/medwatch, or call 1-800-FDA-1088.

If you cannot afford your medication, visit www.pparx.org for assistance.

Reference: 1. SKYRIZI [package insert]. North Chicago, IL: AbbVie Inc.

Please see accompanying full Prescribing Information or visit
https://www.rxabbvie.com/pdf/skyrizi_pi.pdf

abbvie

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Skyrizi™ COMPLETE

Enrollment and Prescription Form

Faxing Instructions:
1. Fax to Skyrizi Complete **(1.678.727.0690)**
2. Fax to the patient's preferred Specialty Pharmacy
Questions? Call 1.866.759.7494

All fields marked with an asterisk (*) are required. The 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:

Phone: Email Address:

Best Time to Call: Monday-Friday ☐ Morning ☐ Afternoon ☐ Evening ☐ Check here only if it is *not* okay to leave a message

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. Ambassadors do not give medical advice and are trained to direct patients to their health care professionals 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: _____
Medical Insurance: _____
Medical Insurance ID #: _____
Group #: _____

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

▼ FOR HEALTHCARE PROVIDER USE ONLY ▼

3 Diagnosis* ☐ Plaque Psoriasis (Ps) (ICD-10 Code: L40.0) Date of Diagnosis: _____/_____/_____

4 Clinical Information

Prior Therapies: _____
_____
_____
_____

Concomitant Medications: _____
Weight: _____ Height: _____
Allergies: _____
Plaque Psoriasis: BSA % _____

TB Test (Date): _____/_____/_____ ☐ Pos ☐ Neg
_____
Fax any necessary clinical/office notes to the preferred Specialty Pharmacy only.

5 Prescriber Information I would like to receive a copy: ☐ Benefits Verification summary ☐ Prior Authorization form

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

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

Address*: _____
City*: _____ State*: ____ ZIP*: _____
Email: _____

6 Skyrizi Complete Prescription* - required in the event a patient experiences an insurance delay or denial

Eligible patients must have (1) commercial insurance, (2) a valid Rx for SKYRIZI, and (3) experienced a delay or denial in insurance determination. 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.

SKYRIZI 75mg/0.83mL Syringes
Inject 1 dose (2 syringes, 150mg total) subcutaneously at week 0, week 4, and every 12 weeks thereafter

Qty of doses: _____

Refills: _____

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.

Prescriber's Signature: (REQUIRED) _____ **Date:** ____/____/____

7 SKYRIZI Shipping Preferences* **Date needed:** ___/___/___ **First Dose Address:** ☐ Prescriber ☐ Patient **Follow-Up Doses Address:** ☐ Prescriber ☐ Patient

8 Injection Training ☐ I request supplemental injection training, if needed, for this patient. Order valid for up to one year.
Fill out and sign pharmacy prescription below.

9 Pharmacy Prescription - Fill out and sign corresponding prescription below.

The prescriber confirms that this prescription has been faxed to the patient's preferred Specialty Pharmacy of*: Amber Pharmacy Fax: 1-402-896-3774

SKYRIZI 75mg/0.83mL Syringes
Inject 1 dose (2 syringes, 150mg total) subcutaneously at week 0, week 4, and every 12 weeks thereafter

Qty of doses: _____

Refills: _____

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) _____ **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 this information to provide the patient support and perform research and analytics, on a de-identified basis, for management of the program. For more information, visit www.abbvie.com/privacy.html. Please share this information with your patient.

Please see Important Safety Information and full Indication on reverse side.
Please see accompanying full Prescribing Information

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INDICATION AND IMPORTANT SAFETY INFORMATION[1]

SKYRIZI Indication[1]

SKYRIZI™ (risankizumab-rzaa) is indicated for the treatment of moderate to severe plaque psoriasis in adults who are candidates for systemic therapy or phototherapy.

Important Safety Information[1]

Infection

SKYRIZI™ (risankizumab-rzaa) may increase the risk of infection. Do not initiate treatment with SKYRIZI in patients with a clinically important active infection until it resolves or is adequately treated.

In patients with a chronic infection or a history of recurrent infection, consider the risks and benefits prior to prescribing SKYRIZI. Instruct patients to seek medical advice if signs or symptoms of clinically important infection occur. If a patient develops such an infection or is not responding to standard therapy, closely monitor and discontinue SKYRIZI until the infection resolves.

Pre-Treatment Evaluation for Tuberculosis (TB)

Prior to initiating treatment with SKYRIZI, evaluate for TB infection and consider treatment in patients with latent or active TB for whom an adequate course of treatment cannot be confirmed. Monitor patients for signs and symptoms of active TB during and after SKYRIZI treatment. Do not administer SKYRIZI to patients with active TB.

Immunizations

Prior to initiating SKYRIZI, consider completion of all age appropriate immunizations according to current immunization guidelines. Avoid use of live vaccines in patients treated with SKYRIZI.

Adverse Reactions

Most common (≥1%) adverse reactions associated with SKYRIZI include upper respiratory infections, headache, fatigue, injection site reactions, and tinea infections.

SKYRIZI COMPLETE PRESCRIPTION TERMS & CONDITIONS

*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 or by the patient's health insurance provider. If at any time a patient begins receiving prescription drug coverage under any such federal, state, or government-funded healthcare program, patient will no longer be eligible to participate in program. Available to patients between the ages of 18-63 with commercial prescription insurance coverage who meet eligibility criteria. **Eligibility:** Patients must be diagnosed with moderate to severe plaque psoriasis, have a valid prescription for SKYRIZI and participate in a commercial insurance plan that has denied or not yet made a formulary decision for SKYRIZI. Once the patient's insurance plan has made a formulary decision and established a process for reviewing coverage requests for SKYRIZI, continued eligibility for the program requires the submission of a Prior Authorization prior to the next scheduled dose and appeal of the coverage denial within 180 days. Program provides SKYRIZI at no charge to patients for up to 2 years or until they receive insurance coverage approval, whichever occurs earlier. Offer subject to change or discontinuance without notice. This is not health insurance and program does not guarantee insurance coverage.

Reference: 1. SKYRIZI [package insert]. North Chicago, IL: AbbVie Inc.

Please see accompanying full Prescribing Information

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