HUMIRA® (adalimumab) CITRATE-FREE REFERRAL AND PRESCRIPTION FORM

Sign and fax this form to Pharmacy Solutions at 877-314-8427 or the pharmacy of your choice. For questions, please call 800-448-6472.

DERMATOLOGY

PATIENT AND PRESCRIBER INFORMATION

PATIENT INFORMATION SSN (Last 4 ONLY) ____ | ____ | ____ | ____

First Name: _____ MI: _____

Last Name: _____

DOB: _____ Weight (lbs): _____ Sex: ☐ M ☐ F

Address: _____

City/State/Zip: _____

Primary Phone: _____ ☐ H ☐ W ☐ M

Alternate Phone: _____ ☐ H ☐ W ☐ M

Drug Allergies: _____

PRESCRIBER INFORMATION ☐ MD ☐ DO ☐ Other: _____

Prescriber Name: _____

Specialty: ☐ Derm ☐ Other: _____

NPI/Provider #: _____ State License #: _____

Office Name: _____

Contact: _____

Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____

INSURANCE INFORMATION

Fax a copy of the front and back of prescription insurance card(s) or fill in the information below

Primary Insurance: _____

Phone: _____

Cardholder ID #: _____ Group #: _____

PCN: _____ BIN: _____

Policyholder Name: _____ DOB: _____

Secondary Insurance: _____

Phone: _____

Cardholder ID #: _____ Group #: _____

PCN: _____ BIN: _____

Policyholder Name: _____ DOB: _____

BV

BENEFIT VERIFICATION ONLY ☐ I do **not** want to prescribe HUMIRA at this time, but please verify drug coverage.

CLINICAL AND PRESCRIPTION INFORMATION

PATIENT'S DIAGNOSIS Date of Diagnosis: _____

☐ Plaque Psoriasis ICD-10: _____

☐ Psoriatic Arthritis ICD-10: _____

☐ Hidradenitis Suppurativa ICD-10: _____

☐ Other (include code): _____

Prior medications: _____

TB Test (Date) _____ ☐ Pos _____ ☐ Neg _____

Please attach any clinical or office notes relevant to therapy.

SHIPPING PREFERENCE Date needed: _____

☐ Deliver medication to the patient

☐ Deliver medication to the prescriber

PRESCRIPTION

☐ New ☐ Restart ☐ Continuing

Current filling pharmacy: _____

Starting Therapy – Plaque Psoriasis

☐ HUMIRA 40 mg/0.4 mL Syringe *NDC: 0074-0243-02*	☐ Two 40 mg SQ inj. Day 1, one 40 mg SQ inj. Day 8, one 40 mg SQ inj. Day 22	☐ #4 syringes	No Refills
Or				
☐ HUMIRA Starter Pkg 80 mg/0.8 mL, 40 mg/0.4 mL *NDC: 0074-1539-03*	☐ One 80 mg SQ inj. Day 1, one 40 mg SQ inj. Day 8, one 40 mg SQ inj. Day 22	☐ #3 pens	No Refills

Ongoing Therapy – Plaque Psoriasis or Psoriatic Arthritis Therapy

		1 month	3 month	
☐ HUMIRA 40 mg/0.4 mL Syringe *NDC: 0074-0243-02*	☐ One 40 mg SQ inj. QOW	☐ #2 syringes	☐ #6 syringes	Refills: _____
Or ☐ HUMIRA 40 mg/0.4 mL Pen *NDC: 0074-0554-02*		☐ #2 pens	☐ #6 pens	Refills: _____

Starting Therapy – Hidradenitis Suppurativa

☐ HUMIRA Starter Pkg 80 mg/0.8 mL Pen *NDC: 0074-0124-03*	☐ Two 80 mg SQ inj. Day 1, one 80 mg SQ inj. Day 15 ☐ One 80 mg SQ inj. Day 1, one 80 mg SQ inj. Day 2, one 80 mg SQ inj. Day 15	☐ #3 pens	No Refills

Ongoing Therapy – Hidradenitis Suppurativa

		1 month	3 month	
☐ HUMIRA 40 mg/0.4 mL Syringe *NDC: 0074-0243-02*	☐ One 40 mg SQ inj. Day 29 & every week thereafter	☐ #4 syringes	☐ #12 syringes	Refills: _____
Or ☐ HUMIRA 40 mg/0.4 mL Pen *NDC: 0074-0554-02*		☐ #4 pens	☐ #12 pens	Refills: _____

Other ☐ HUMIRA _____ SIG: _____ Qty: _____ Refills: _____

PRESCRIBER SIGNATURE: PRESCRIBER MUST MANUALLY SIGN (RUBBER STAMPS, SIGNATURE BY OTHER OFFICE PERSONNEL FOR THE PRESCRIBER, AND COMPUTER-GENERATED SIGNATURES WILL NOT BE ACCEPTED), OR SEND AN ELECTRONIC PRESCRIPTION TO THE PHARMACY.

☐ **Dispense as written/Do not substitute** **Date**

☐ **Substitution permitted/Brand exchange permitted** **Date**

I authorize the pharmacy and its employees to serve as my agent for the sole purpose of obtaining patient benefit information and the necessary prior authorization forms when dealing with Health Plans and Pharmacy Benefits Managers (PBMs), if the plan or PBM requires such authorization.

For states requiring handwritten expressions of Product Selection, use this area (e.g., medically necessary, may not substitute, dispense as written, etc.)

Please see accompanying full Prescribing Information, including BOXED WARNING, or visit www.rxabbvie.com/pdf/humira.pdf.