

# 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.

## OPHTHALMOLOGY

<b>PATIENT AND PRESCRIBER INFORMATION</b>	<b>PATIENT INFORMATION</b> SSN (Last 4 ONLY) ____   ____   ____   ____	<b>PRESCRIBER INFORMATION</b> <input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> Other: _____
	First Name: _____ MI: _____	Prescriber Name: _____
	Last Name: _____	Specialty: <input type="checkbox"/> Rheum <input type="checkbox"/> Other: _____
	DOB: _____ Weight (lbs): _____ Sex: <input type="checkbox"/> M <input type="checkbox"/> F	NPI/Provider #: _____ State License #: _____
	Address: _____	Office Name: _____
	City/State/Zip: _____	Contact: _____
	Primary Phone: _____ <input type="checkbox"/> H <input type="checkbox"/> W <input type="checkbox"/> M	Address: _____
	Alternate Phone: _____ <input type="checkbox"/> H <input type="checkbox"/> W <input type="checkbox"/> M	City/State/Zip: _____
Drug Allergies: _____	Phone: _____ Fax: _____	

<b>INSURANCE INFORMATION</b>	<b>Fax a copy of the front and back of prescription insurance card(s) or fill in the information below</b>	
	Primary Insurance: _____	Secondary Insurance: _____
	Phone: _____	Phone: _____
	Cardholder ID #: _____ Group #: _____	Cardholder ID #: _____ Group #: _____
	PCN: _____ BIN: _____	PCN: _____ BIN: _____
	Policyholder Name: _____ DOB: _____	Policyholder Name: _____ DOB: _____

<b>BV</b>	<b>BENEFIT VERIFICATION ONLY</b> <input type="checkbox"/> I do <b>not</b> want to prescribe HUMIRA at this time, but please verify drug coverage.
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<b>CLINICAL AND PRESCRIPTION INFORMATION</b>	<b>PATIENT'S DIAGNOSIS</b> Date of Diagnosis: _____	<b>SHIPPING PREFERENCE</b> Date needed: _____
	<input type="checkbox"/> Uveitis ICD-10: _____	<input type="checkbox"/> Deliver medication to the patient
	<input type="checkbox"/> Other (include code): _____	<input type="checkbox"/> Deliver medication to the prescriber
	Prior medications: _____	<b>PRESCRIPTION</b>
	TB Test (Date) _____ <input type="checkbox"/> Pos <input type="checkbox"/> Neg	<input type="checkbox"/> New <input type="checkbox"/> Restart <input type="checkbox"/> Continuing
	<b>Please attach any clinical or office notes relevant to therapy.</b>	Current filling pharmacy: _____
<b>Starting Therapy – NI Uveitis*</b>		
<input type="checkbox"/> HUMIRA 40 mg/0.4 mL Syringe    NDC: 0074-0243-02	<input type="checkbox"/> Two 40 mg SQ inj. Day 1, one 40 mg SQ inj. Day 8, one 40 mg SQ inj. Day 22	<input type="checkbox"/> #4 syringes    No Refills
<b>Or</b>	<input type="checkbox"/> HUMIRA Starter Pkg 80 mg/0.8 mL, 40 mg/0.4 mL    NDC: 0074-1539-03	<input type="checkbox"/> One 80 mg SQ inj. Day 1, one 40 mg SQ inj. Day 8, one 40 mg SQ inj. Day 22
<b>Ongoing Therapy – NI Uveitis*</b>		<b>1 month</b> <b>3 month</b>
<input type="checkbox"/> HUMIRA 40 mg/0.4 mL Syringe    NDC: 0074-0243-02	<input type="checkbox"/> One 40 mg SQ inj. QOW	<input type="checkbox"/> #2 syringes <input type="checkbox"/> #6 syringes   Refills: _____
<b>Or</b>	<input type="checkbox"/> HUMIRA 40 mg/0.4 mL Pen    NDC: 0074-0554-02	<input type="checkbox"/> #2 pens <input type="checkbox"/> #6 pens      Refills: _____
<b>Other</b> <input type="checkbox"/> HUMIRA _____    SIG: _____    Qty: _____    Refills: _____		

\*Non-infectious intermediate, posterior and panuveitis.

**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.)

The information contained in this communication is confidential and intended for the addressee. It may contain Protected Health Information (PHI) under HIPAA. PHI is personal and sensitive information related to a person's health. This information is sent to you under circumstances when a participant's authorization is not required. You, the recipient, are obligated to maintain it in a safe, secure, and confidential manner. Redisclosure, unless permitted by law, is prohibited. If you are not the intended recipient, you are hereby notified that dissemination, disclosure, copying, or distribution of this information is strictly prohibited and may be unlawful. Please notify sender immediately to arrange for return of this document.

Please see accompanying full Prescribing Information, including BOXED WARNING, or visit [www.rxabbvie.com/pdf/humira.pdf](http://www.rxabbvie.com/pdf/humira.pdf).