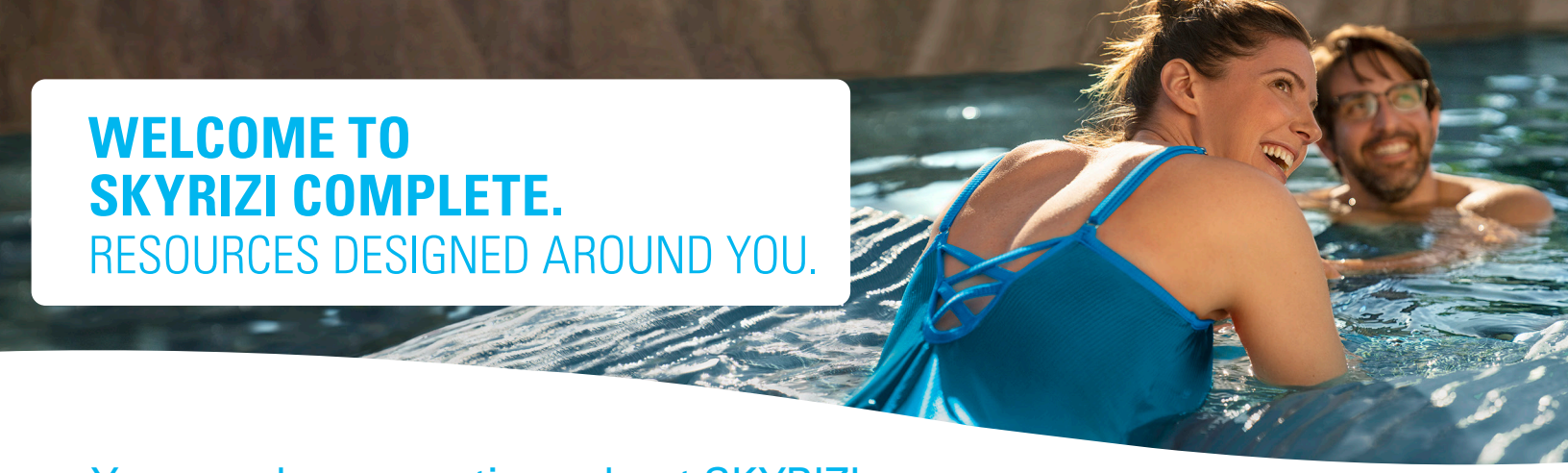

WELCOME TO SKYRIZI COMPLETE.
RESOURCES DESIGNED AROUND YOU.

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

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

Your Skyrizi Complete Nurse Ambassador* is committed to helping you understand your treatment, answering your questions, and supporting you to achieve your personal goals while on SKYRIZI. Your Ambassador will be there 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 office, ask your health care professional** which Specialty Pharmacy your prescription is being sent to and write down its number below. This pharmacy will help you plan your SKYRIZI delivery and may follow up with you.

SPECIALTY PHARMACY: _____ **PHONE:** _____

2. **Expect a call from your Ambassador within 1 business day** (the call may come from any area code). They'll help you navigate the prescription process and help you start and stay on track with your prescribed treatment plan.

For questions, or if you have not yet connected with your Nurse Ambassador, please call **1.866.SKYRIZI (1.866.759.7494).**

Skyrizi® COMPLETE

*Nurse Ambassadors are provided by AbbVie and do not work under the direction of your health care professional (HCP) or give medical advice. They are trained to direct patients to their HCP for treatment-related advice, including further referrals.

The categories of personal information collected in this Enrollment and Prescription Form include contact, insurance, prescription, and medical history information. The personal information collected will be used to provide and manage the Skyrizi Complete program and to perform research and analytics on a de-identified basis. For more information about the categories of personal information collected by AbbVie and the purposes for which AbbVie uses personal information, visit www.abbvie.com/privacy.html.

Please see Use and Important Safety Information on page 2.

Please see full Prescribing Information, including Medication Guide, and discuss with your doctor.

Skyrizi®
risankizumab-rzaa

Use and Important Safety Information About SKYRIZI® (risankizumab-rzaa)[1]

SKYRIZI Use[1]

SKYRIZI 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). Medications that interact with the immune system may increase your risk of getting an infection after receiving live vaccines. You should avoid receiving live vaccines right before, during, or right after treatment with SKYRIZI. Tell your healthcare provider that you are taking SKYRIZI before receiving a vaccine.
- 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, feeling tired, fungal skin infections, headache, 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.

SKYRIZI is available in a 150 mg/mL prefilled syringe and pen.

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 are having difficulty paying for your medicine, AbbVie may be able to help.
Visit AbbVie.com/myAbbVieAssist to learn more.

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

Please see full Prescribing Information, including Medication Guide, and discuss with your doctor.

abbvie

US-SKZ-210091

Skyrizi® risankizumab-rzaa

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**

Sections in **BLUE** (1, 2, 3, 4) are necessary for enrollment into Skyrizi Complete. Required fields are marked with an asterisk (*).

The health care professional (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*:

Home Phone*: Mobile Phone: Email Address*: ☐Spanish interpreter needed

Best Time to Call (Monday-Friday): ☐Anytime ☐Morning ☐Afternoon ☐Evening

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 provided by AbbVie. Ambassadors do not work under the direction of your health care professional (HCP) or give medical advice. They are trained to direct patients to their HCP 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 HEALTH CARE PROVIDER USE ONLY ▼

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

4 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: _____

5 CLINICAL INFORMATION

Prior Therapies: _____

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

TB Test (Date): ____/____/____ ☐Pos ☐Neg

Fax any necessary clinical/office notes to the preferred Specialty Pharmacy only.

6 INJECTION TRAINING ☐I request supplemental injection training and/or administration, if needed, for this patient. Order valid for up to one year.

Fill out and sign pharmacy prescription below.

7 PHARMACY PRESCRIPTION - OPTIONAL - Fill out and sign corresponding prescription below.

Patient's preferred Specialty Pharmacy: _____ ☐Check if faxed to Specialty Pharmacy

Choose One SKYRIZI Presentation:
☐PEN 150mg
☐SYRINGE 150mg

Check appropriate boxes to indicate quantity to dispense (one dose each) and directions:
☐Initiation at Week 0: Inject 150mg SC
☐Initiation at Week 4: Inject 150mg SC
☐Inject 150mg SC every 12 weeks thereafter
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) X _____ **Date:** ____/____/____

8 SKYRIZI SHIPPING PREFERENCES **Date needed:** ____/____/____ **First Dose Address:** ☐Prescriber ☐Patient **Follow-Up Doses Address:** ☐Prescriber ☐Patient

9 SKYRIZI COMPLETE PRESCRIPTION - required in the event a commercially insured patient with a valid RX for SKYRIZI experiences an insurance access challenge.

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.

Choose One SKYRIZI Presentation:
☐PEN 150mg
☐SYRINGE 150mg

Inject 150mg SC at Week 0, Week 4, and every 12 weeks thereafter
Quantity: 1 dose of 150mg
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 an insurance access challenge 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) X _____ **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 the information collected about you and your patient to provide the patient support and perform research and analytics, on a de-identified basis, for management of the program. For more information about the categories of personal information collected by AbbVie and the purposes for which AbbVie uses personal information, visit www.abbvie.com/privacy.html. Please share this information with your patient.

Please see Important Safety Information and full Indication on page 4. Please see full Prescribing Information.

Skyrizi® risankizumab-rzaa

Indication and Important Safety Information[1]

SKYRIZI Indication[1]

SKYRIZI is indicated for the treatment of moderate to severe plaque psoriasis in adults who are candidates for systemic therapy or phototherapy.

Important Safety Information

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.

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.

Administration of Vaccines

Avoid use of live vaccines in patients treated with SKYRIZI. Medications that interact with the immune system may increase the risk of infection following administration of live vaccines. Prior to initiating SKYRIZI, complete all age appropriate vaccinations according to current immunization guidelines.

Adverse Reactions

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

SKYRIZI is available in a 150 mg/mL prefilled syringe and pen.

SKYRIZI COMPLETE PRESCRIPTION TERMS & CONDITIONS

Eligible patients must have commercial insurance, a valid prescription for SKYRIZI® (risankizumab-rzaa) for an FDA approved indication, a denial of insurance coverage based on a prior authorization request along with an appeal on file. Continued eligibility for the program requires the submission of an appeal of the coverage denial every 90 days. Program provides SKYRIZI 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.

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

Please see full Prescribing Information.

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