Skyrizi® COMPLETE

SMRD-042026-AP02

Adult Patient Enrollment & Prescription Form

Fax to Skyrizi Complete (1.678.727.0690)
Questions? Call 1.866.759.7494

SECTION 1: PATIENT + HCP

▼ Fields in 1-4 are necessary for enrollment into Skyrizi Complete ▼

Fields in 1-4 are necessary for enrollment into Skyrizi Complete. Required fields are marked with an asterisk (*).

1 PATIENT'S INFORMATION — To be completed by patient or legally authorized person. Please print clearly.

First Name*: Last Name*: Date of Birth (MM/DD/YYYY)*: / /

Address*: City*: State*: ZIP*:

Home Phone*: Mobile Phone*: Email Address*:

Sex (check one)*: ☐ M ☐ F Gender: ☐ Male ☐ Female ☐ Non-Binary ☐ Prefer Not to Answer ☐ Spanish interpreter needed

When did you start on treatment? ☐ Not Started ☐ 0-3 Months Ago ☐ 4-6 Months Ago ☐ 7-12 Months Ago ☐ Over 12 Months Ago

☐ I consent to receive automated and recurring text messages from Complete Treatment Support program, including service updates, medication reminders and marketing messages, to the provided mobile number. Message and data rates may apply. I am not required to consent as a condition of receiving goods or services. I can text HELP to 29279 for help, or call 1-866-759-7494. I can text STOP to 29279 to unsubscribe at any time. **View full Terms and Conditions**.

By enrolling, you may receive your own Ambassador provided by AbbVie. Ambassadors do not work under the direction of your healthcare 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 consent to the collection, use, and disclosure of my health-related personal data to receive communications from AbbVie regarding its products, programs, services, clinical trials, research opportunities and for online targeted advertising, as further described in the **"How we may use Personal Data," "How we may disclose Personal Data,"** and **"Cookies and similar tracking and data collection technologies"** sections of our **Privacy Notice**. 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"** on AbbVie's website.

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/PrivacyPatient**. Through my submission of the 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. 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"** on AbbVie's website.

2 INSURANCE INFORMATION ☐ Check box if you will attach a copy of your Insurance Cards. Please also provide supplemental insurance.

Beneficiary/Cardholder Name: _____ Prescription Insurance: _____ Medical Insurance: _____ Rx Group #: _____

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

SECTION 2: HCP

3 DIAGNOSIS* ☐ Plaque Psoriasis (Ps) ☐ Psoriatic Arthritis (PsA) ICD-10: _____ Date of Diagnosis: ____/____/_____

4 PRESCRIBER INFORMATION

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

NPI #*: _____

Office Phone*: _____

Office Contact Name: _____

Office Fax*: _____

Address*: _____

City*: _____ State*: _____ ZIP*: _____

▼ OPTIONAL ▼

SECTION 3: HCP

5 CLINICAL INFORMATION - Fax any necessary clinical/office notes to the preferred Specialty Pharmacy only.

Prior Therapies: ☐ Topical Corticosteroid ☐ Topical Calcineurin Inhibitor ☐ Immunosuppressant (e.g., methotrexate, cyclosporine, etc.) ☐ Oral Corticosteroid (e.g. prednisone, etc.) ☐ Phototherapy ☐ Biologics ☐ Oral JAK Inhibitors ☐ PDE4 Inhibitor ☐ TYK2 Inhibitor ☐ Other _____

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

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

SECTION 4: HCP

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

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

☐ Plaque Psoriasis (Ps) ☐ Psoriatic Arthritis (PsA)

Choose one SKYRIZI presentation:

☐ SKYRIZI PEN 150 mg

☐ SKYRIZI SYRINGE 150 mg

Check appropriate boxes to indicate quantity to dispense (one dose each) and directions:

☐ Initiation at Week 0: Inject 150 mg SC

☐ Initiation at Week 4: Inject 150 mg SC

☐ Inject 150 mg 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:** ____/____/_____

SECTION 5: HCP

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:

☐ SKYRIZI PEN 150 mg

☐ SKYRIZI SYRINGE 150 mg

Inject 150 mg SC at Week 0, Week 4, and every 12 weeks thereafter

Quantity: 1 dose of 150 mg

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 payer for any no charge product dispensed by an AbbVie-authorized pharmacy.

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

Through my submission of the 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. 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"** on AbbVie's website.

Please see Indications and Important Safety Information on page 2.

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

US-SKZD-260144

Skyrizi® risankizumab-rzaa

INDICATIONS AND IMPORTANT SAFETY INFORMATION
ABOUT SKYRIZI® (risankizumab-rzaa)[1] FOR HEALTHCARE PROFESSIONALS

SKYRIZI INDICATIONS

Plaque Psoriasis: SKYRIZI is indicated for the treatment of moderate to severe plaque psoriasis in adults and pediatric patients 6 years of age and older who are candidates for systemic therapy or phototherapy.

Psoriatic Arthritis: SKYRIZI is indicated for the treatment of active psoriatic arthritis in adults and pediatric patients 6 years of age and older.

IMPORTANT SAFETY INFORMATION

Hypersensitivity Reactions

SKYRIZI® (risankizumab-rzaa) is contraindicated in patients with a history of serious hypersensitivity reaction to risankizumab-rzaa or any of the excipients. Serious hypersensitivity reactions, including anaphylaxis, have been reported with the use of SKYRIZI. If a serious hypersensitivity reaction occurs, discontinue SKYRIZI and initiate appropriate therapy immediately.

Infection

SKYRIZI 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.

Immunizations

Avoid use of live vaccines in patients treated with SKYRIZI. Drugs 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.

In psoriatic arthritis phase 3 trials, the incidence of hepatic events was higher with SKYRIZI compared to placebo.

SKYRIZI is available in a 150 mg/mL prefilled syringe and pen, and a 55 mg/0.37 mL prefilled syringe.

Skyrizi Complete Prescription Terms & Conditions

Eligibility criteria: Available to patients aged 63 or younger with commercial insurance coverage. Patients must have a valid prescription for SKYRIZI® (risankizumab-rzaa) for an FDA approved indication 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 for SKYRIZI® (risankizumab-rzaa) 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.

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

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US-SKZD-260144

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Skyrizi® risankizumab-rzaa

Skyrizi® COMPLETE
Pediatric Enrollment & Prescription Form

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SECTION 1: PATIENT + HCP

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Fields in 1-4 are necessary for enrollment into Skyrizi Complete. Required fields are marked with an asterisk (*).

1 PATIENT'S INFORMATION — The healthcare professional (HCP) and the patient or legal guardian should fill out this form completely before leaving the office. Please print clearly.

First Name*: Last Name*: Date of Birth (MM/DD/YYYY)*: / /

Name of Patient's Legal Guardian*: Relationship to Patient: ☐ Spanish interpreter needed

Patient or Legal Guardian's Address*: City*: State*: ZIP*:

Patient or Legal Guardian's Mobile Phone*: Patient or Legal Guardian's Email Address*:

Legal Guardian's Date of Birth (MM/DD/YYYY)*: / / Sex (check one)*: ☐ M ☐ F Gender: ☐ Male ☐ Female ☐ Non-Binary ☐ Prefer Not to Answer

When did the patient start on treatment? ☐ Not Started ☐ 0-3 Months Ago ☐ 4-6 Months Ago ☐ 7-12 Months Ago ☐ Over 12 Months Ago

▶ ☐ I consent to receive automated and recurring text messages from Complete Treatment Support program, including service updates, medication reminders and marketing messages, to the provided mobile number. Message and data rates may apply. I am not required to consent as a condition of receiving goods or services. I can text HELP to 29279 for help, or call 1-866-759-7494. I can text STOP to 29279 to unsubscribe at any time. **View full Terms and Conditions.**

By enrolling, you may talk to an Ambassador provided by AbbVie. Ambassadors do not work under the direction of your healthcare 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 consent to the collection, use, and disclosure of my health-related personal data to receive communications from AbbVie regarding its products, programs, services, clinical trials, research opportunities and for online targeted advertising, as further described in the **"How we may use Personal Data," "How we may disclose Personal Data,"** and **"Cookies and similar tracking and data collection technologies"** sections of our **Privacy Notice**. 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"** on AbbVie's website.

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2 INSURANCE INFORMATION ☐ Check box if you will attach a copy of your Insurance Cards. Please also provide supplemental insurance.

Beneficiary/Cardholder Name: Prescription Insurance: Medical Insurance: Rx Group #:

Medical Insurance ID #: Rx ID #: Group #: Rx Bin #: Rx PCN #:

SECTION 2: HCP

3 DIAGNOSIS* ☐ Plaque Psoriasis (Ps) ☐ Psoriatic Arthritis (PsA) ICD-10: Date of Diagnosis: ____/____/_____

4 PRESCRIBER INFORMATION

Prescriber's Name (First, Last)*: Office Phone*: Address*:

Office Contact Name:

NPI #*: Office Fax*: City*: State*: ZIP*:

▼ **OPTIONAL** ▼

SECTION 3: HCP

5 CLINICAL INFORMATION - Fax any necessary clinical/office notes to the preferred Specialty Pharmacy only.

Prior Therapies: ☐ Topical Corticosteroid ☐ Topical Calcineurin Inhibitor ☐ Immunosuppressant (e.g., cyclosporine, etc.) ☐ Oral Corticosteroid (e.g. prednisone, etc.) ☐ Phototherapy ☐ Biologics ☐ Oral JAK Inhibitors ☐ PDE4 Inhibitor ☐ Other

Concomitant Medications: Drug Allergies: Plaque Psoriasis BSA%:

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

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.**

SECTION 4: HCP

7 PHARMACY PRESCRIPTION

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

☐ Plaque Psoriasis (Ps) in pediatric patients 6 years of age and older ☐ Psoriatic Arthritis (PsA) in pediatric patients 6 years of age and older

Choose one SKYRIZI presentation. The actual dose a patient will receive will be determined by their weight:

☐ SKYRIZI SYRINGE 55 mg for patients less than 88 lbs (40 kg)
☐ SKYRIZI SYRINGE 150 mg for patients greater than or equal to 88 lbs (40 kg)
☐ SKYRIZI PEN 150 mg for patients greater than or equal to 88 lbs (40 kg)

Check appropriate boxes to indicate quantity to dispense (one dose each) and directions:

Initiation at Week 0: Inject ☐ 55 mg ☐ 150 mg SC
Initiation at Week 4: Inject ☐ 55 mg ☐ 150 mg SC
Inject ☐ 55 mg ☐ 150 mg 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:** ____/____/_____

SECTION 5: HCP

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.

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Choose one SKYRIZI presentation. The actual dose a patient will receive will be determined by their weight:

☐ SKYRIZI SYRINGE 55 mg for patients less than 88 lbs (40 kg)
☐ SKYRIZI SYRINGE 150 mg for patients greater than or equal to 88 lbs (40 kg)
☐ SKYRIZI PEN 150 mg for patients greater than or equal to 88 lbs (40 kg)

Inject dosage at Week 0, Week 4, and 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. 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 payer for any no charge product dispensed by an AbbVie-authorized pharmacy.

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

Through my submission of the 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. 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**" on AbbVie's website.

Please see Indications and Important Safety Information on page 4.
Please see the full Prescribing Information, or visit https://www.rxabbvie.com/pdf/skyrizi_pi.pdf.

US-SKZD-260144

Skyrizi® risankizumab-rzaa

INDICATIONS AND IMPORTANT SAFETY INFORMATION
ABOUT SKYRIZI® (risankizumab-rzaa)[1] FOR HEALTHCARE PROFESSIONALS

SKYRIZI INDICATIONS[1]

Plaque Psoriasis: SKYRIZI is indicated for the treatment of moderate to severe plaque psoriasis in adults and pediatric patients 6 years of age and older who are candidates for systemic therapy or phototherapy.

Psoriatic Arthritis: SKYRIZI is indicated for the treatment of active psoriatic arthritis in adults and pediatric patients 6 years of age and older.

IMPORTANT SAFETY INFORMATION[1]

Hypersensitivity Reactions

SKYRIZI® (risankizumab-rzaa) is contraindicated in patients with a history of serious hypersensitivity reaction to risankizumab-rzaa or any of the excipients. Serious hypersensitivity reactions, including anaphylaxis, have been reported with the use of SKYRIZI. If a serious hypersensitivity reaction occurs, discontinue SKYRIZI and initiate appropriate therapy immediately.

Infection

SKYRIZI 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.

Immunizations

Avoid use of live vaccines in patients treated with SKYRIZI. Drugs 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.

In psoriatic arthritis phase 3 trials, the incidence of hepatic events was higher with SKYRIZI compared to placebo.

SKYRIZI is available in a 150 mg/mL prefilled syringe and pen, and a 55 mg/0.37 mL prefilled syringe.

Skyrizi Complete Prescription Terms & Conditions

Eligibility criteria: Available to patients aged 63 or younger with commercial insurance coverage. Patients must have a valid prescription for SKYRIZI® (risankizumab-rzaa) for an FDA approved indication 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 for SKYRIZI® (risankizumab-rzaa) 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.

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

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US-SKZD-260144

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Skyrizi® risankizumab-rzaa

Skyrizi® COMPLETE

SKYRIZI GETTING STARTED CHECKLIST

Use this checklist from Skyrizi Complete to start and **stay on track** with the prescribed treatment plan.

1 DETERMINE WHERE THE PRESCRIPTION IS BEING SENT

Before you leave the office, **ask your healthcare professional which Specialty Pharmacy the prescription is being sent to** and write down its number. This pharmacy will help you plan your SKYRIZI delivery.

- ☐ Expect a call from the Specialty Pharmacy
- ☐ Arrange for your co-pay and confirm where your SKYRIZI is being delivered

Specialty Pharmacy Name: _____

Specialty Pharmacy Number: _____

2 GET SAVINGS AND INSURANCE SUPPORT

A Skyrizi Complete Ambassador* may reach out to help you navigate your health insurance coverage and to find ways you may be able to save.

- ☐ Before you start treatment, explore your savings options at **https://www.skyrizi.com/skyrizi-complete/save-on-skyrizi-costs** You may be eligible to get SKYRIZI for **as little as $0 per dose.†**
- ☐ Get answers to your insurance questions at **https://www.skyrizi.com/skyrizi-complete/insurance-101**

Savings Information: _____

Insurance Information: _____

3 PREPARE FOR INJECTIONS

Two starter doses (at Weeks 0 and 4) will be administered at the beginning of treatment, usually at the doctor's office. Then, you and your doctor will decide whether quarterly doses happen at home or the doctor's office. If you're injecting at home, **ask an Ambassador if in-person or virtual supplemental injection training is available after you've received initial training by your healthcare provider.**

- ☐ Watch Pen or Syringe Injection Video at **https://www.skyrizi.com/skyrizi-complete/how-to-inject**
- ☐ Talk to an Ambassador about injection resources, or get additional information at **SkyriziComplete.com**

Injection Location (check one):

☐ Home **OR** ☐ Office

Date of Injection: ___/___/___

4 GET ONGOING SUPPORT FROM SKYRIZI COMPLETE INCLUDING:

- **Guiding** you through your insurance coverage and savings options, even if your health insurance changes
- **Injection training**, tips on managing your routine, and working with your Specialty Pharmacy
- **Complete App** where you can log injections, set treatment reminders, and access your Skyrizi Complete Savings Card

DOWNLOAD THE APP TODAY

Use your phone's camera to scan the QR code.

Search for "Complete App" at the App Store® or Google Play™

Download on the App Store | GET IT ON Google Play

Stay on track with support from SKYRIZI.
Reach out at **1.866.SKYRIZI** (1.866.759.7494), or Chat Live 24/7 at **SkyriziComplete.com**.

*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.

†For eligible, commercially insured patients only. See Terms and Conditions on next page. If eligible, you'll receive your Savings Card in the mail. Call your Nurse Ambassador if you do not receive your card.

Please see Uses and Important Safety Information on page 6.
Please see the full Prescribing Information, or visit https://www.rxabbvie.com/pdf/skyrizi_pi.pdf.

Skyrizi® risankizumab-rzaa

USES AND IMPORTANT SAFETY INFORMATION
ABOUT SKYRIZI® (risankizumab-rzaa) FOR PATIENTS

SKYRIZI USES

SKYRIZI is a prescription medicine used to treat:

- Adults and children 6 years of age and older with moderate to severe plaque psoriasis who may benefit from taking injections or pills (systemic therapy) or treatment using ultraviolet or UV light (phototherapy).
- Adults and children 6 years of age and older with active psoriatic arthritis.

IMPORTANT SAFETY INFORMATION

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

SKYRIZI is a prescription medicine that may cause serious side effects, including:

Serious allergic reactions:

- Stop using SKYRIZI and get emergency medical help right away if you get any of the following symptoms of a serious allergic reaction:
  - fainting, dizziness, feeling lightheaded (low blood pressure)
  - swelling of your face, eyelids, lips, mouth, tongue, or throat
  - trouble breathing or throat tightness
  - chest tightness
  - skin rash, hives
  - itching

Infections:

SKYRIZI 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
  - cough
  - shortness of breath
  - blood in your mucus (phlegm)
  - muscle aches
  - warm, red, or painful skin or sores on your body different from your psoriasis
  - weight loss
  - diarrhea or stomach pain
  - burning when you urinate or urinating more often than normal

Do not use SKYRIZI if you are allergic to risankizumab-rzaa or any of the ingredients in SKYRIZI. See the Medication Guide or Consumer Brief Summary for a complete list of ingredients.

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.
- become pregnant while taking SKYRIZI. You are encouraged to enroll in the Pregnancy Registry, which is used to collect information about the health of you and your baby. Talk to your healthcare provider or call 1-877-302-2161 to enroll in this registry.

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 in people treated for plaque psoriasis and psoriatic arthritis include: upper respiratory infections, headache, feeling tired, injection site reactions, and fungal skin infections.

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, and a 55 mg/0.37 mL prefilled syringe.

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/PatientAccessSupport to learn more.

Skyrizi Complete Savings Card Terms & Conditions

Eligibility: Available to patients with commercial insurance coverage for SKYRIZI® (risankizumab-rzaa) who meet eligibility criteria. This co-pay 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 termination without notice. Restrictions, including monthly maximums, may apply. This is not health insurance. **For full Terms and Conditions, visit SKYRIZISavingsCard.com or call 1.866.SKYRIZI for additional information. To learn about AbbVie's privacy practices and your privacy choices, visit https://abbv.ie/corpprivacy.**

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

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US-SKZD-260144

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