SKYRIZI GETTING STARTED CHECKLIST

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

1 NAVIGATE INSURANCE AND SAVINGS

Skyrizi Complete can help you understand your insurance and find possible ways to save.

- ☐ **If you have not talked with your Skyrizi Complete Nurse Ambassador* yet,** reach out by calling **1.866.SKYRIZI** (1.866.759.7494)
- ☐ **Ask your Nurse Ambassador about your savings options**
  Find out if your SKYRIZI could be as little as $5† per treatment

Your Nurse Ambassador is: _____

Your Nurse Ambassador's phone number: _____

2 PREPARE FOR YOUR INFUSIONS

You'll have 3 infusions; 1 every 4 weeks. Help understanding the infusion phase of your treatment is just a click away.

- ☐ **Watch the SKYRIZI Infusion Video**
- ☐ **Review the Infusion Checklist** with your Nurse Ambassador
- ☐ **Talk to your doctor about lab tests before, during, and up to 12 weeks of treatment with SKYRIZI**
- ☐ **Write down any questions** you may have for your next doctor appointment:

_____

_____

Infusion location: _____

_____

Phone number: _____

Infusion dates: *Completed!*

1. ___/___/_____ ☐
2. ___/___/_____ ☐
3. ___/___/_____ ☐

3 GET READY TO INJECT AT HOME

You can ask for supplemental injection training to be delivered in person or during a virtual visit with your Nurse Ambassador.

- ☐ **Watch the SKYRIZI On-Body Injection Training Video**
- ☐ **Talk to your Nurse Ambassador about injection resources, or get additional information at SkyriziComplete.com**
- ☐ **Date of first injection at home:** ___/___/_____
  - Call the specialty pharmacy to arrange delivery 2 weeks before this date

Specialty Pharmacy: _____

Phone number: _____

Skyrizi® COMPLETE

Not enrolled? Call 1.866.SKYRIZI (1.866.759.7494) to join today.
Once enrolled, you can expect a call from your Nurse Ambassador within 1 business day. The call may come from any area code.

*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 back. If eligible, you'll receive your Savings Card in the mail. Call your Ambassador if you do not receive your card.

Please see Use and Important Safety Information on page 2.

Please see full Prescribing Information, including Medication Guide, at https://www.rxabbvie.com/pdf/skyrizi_pi.pdf 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 moderate to severe Crohn's disease in adults.

IMPORTANT SAFETY INFORMATION[1]

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). Medicines 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?"

Liver problems in Crohn's disease: A person with Crohn's disease who received SKYRIZI through a vein in the arm developed changes in liver blood tests with a rash that led to hospitalization. Your healthcare provider will do blood tests to check your liver before, during, and up to 12 weeks of treatment and may stop treatment with SKYRIZI if you develop liver problems. Tell your healthcare provider right away if you notice any of the following symptoms: unexplained rash, nausea, vomiting, stomach (abdominal) pain, tiredness (fatigue), loss of appetite, yellowing of the skin and eyes (jaundice), and dark urine.

The most common side effects of SKYRIZI in people treated for Crohn's disease include: upper respiratory infections, headache, joint pain, stomach (abdominal) pain, injection site reactions, low red blood cells (anemia), fever, back pain, and urinary tract infection.

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 600 mg/10 mL vial for intravenous infusion and a 180 mg/1.2 mL or 360 mg/2.4 mL single-dose prefilled cartridge with on-body injector.

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.

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 SKYRIZICDSavingsCard.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 full Prescribing Information, including Medication Guide, at https://www.rxabbvie.com/pdf/skyrizi_pi.pdf and discuss with your doctor.

Skyrizi® risankizumab-rzaa

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Skyrizi® COMPLETE

SCD-100122-A10

Fax to Skyrizi Complete (1.678.727.0690)
Questions? Call 1.866.759.7494

Enrollment and Prescription Form

Sections in **BLUE** (1, 2, 3, 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 should fill out this form completely before leaving the office.

Please print clearly.

First Name*: Last Name*: Date of Birth (MM/DD/YY): / / Gender: (check one) ☐ M ☐ F

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

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

What was patient's last completed treatment? ☐ Not started ☐ Infusion 1 ☐ Infusion 2 ☐ Infusion 3 ☐ SKYRIZI On-Body Injector Date of Last Treatment: ____/____/____

▶ ☐ 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 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.

▶ ☐ 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 Please attach medical and prescription insurance cards, if available.

▼ FOR HEALTH CARE PROVIDER USE ONLY ▼

3 DIAGNOSIS* ☐ Crohn's disease (CD) ICD-10: _____ Date of Diagnosis: _____/_____/_____

4 PRESCRIBER INFORMATION I would like to receive a copy: ☐ IV Benefits ☐ OBI Benefits

Prescriber's Name (First, Last)*:

NPI #*:

Office Phone*:

Office Contact Name:

Office Fax*:

Address*:

City*: State*: ZIP*:

5 CLINICAL INFORMATION

Prior Therapies:

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

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

6 SITE OF INFUSION INFORMATION

☐ Prescriber's office (if checked, enter the Tax ID; then skip to section 7) ☐ Non-prescribing MD's office ☐ Hospital outpatient ☐ Infusion center ☐ Other:

Practice/Facility Name:

Site of Infusion NPI #: Tax ID:

Address:

ZIP:

Phone: Fax:

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

Fill out and sign pharmacy prescription 8a below.

8 PRESCRIPTION INFORMATION - Fill out and sign corresponding prescription(s) below

Check appropriate boxes to indicate quantity to dispense and directions:

Induction Therapy†—SKYRIZI 600 mg/10 mL single use vial

☐ Week 0: 600 mg to be administered via IV Infusion
1 vial; no refills

☐ Week 4: 600 mg to be administered via IV Infusion
1 vial; no refills

☐ Week 8: 600 mg to be administered via IV Infusion
1 vial; no refills

†For the treatment of Crohn's disease, evaluate liver enzymes and bilirubin at baseline, and during induction at least up to 12 weeks of treatment. Monitor thereafter according to routine patient management.

Select ONE Ongoing Therapy‡—SKYRIZI prefilled cartridge with SKYRIZI On-Body Injector—Week 12:

☐ Inject **180 mg/1.2 mL** SC and every 8 weeks
1 device with prefilled cartridge; Refills: ____

☐ Inject **360 mg/2.4 mL** SC and every 8 weeks
1 device with prefilled cartridge; Refills: ____

‡The recommended maintenance dosage is dependent on therapeutic response. Use the lowest effective dosage needed to maintain response.

8a. PHARMACY PRESCRIPTION (OPTIONAL) – Rx will be forwarded to pharmacy listed below or appropriate pharmacy, if blank

Patient's preferred Specialty Pharmacy: IV: _____ OBI: _____

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:** ____/____/_____

8b. SKYRIZI COMPLETE PRESCRIPTION - required in the event a commercially insured patient with a valid Rx for SKYRIZI experiences an insurance delay or denial

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.

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. I confirm my patient has or will complete IV initiation therapy as recommended in the FDA-approved prescribing information.

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

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

US-SKZG-230438

Skyrizi® risankizumab-rzaa

INDICATION AND IMPORTANT SAFETY INFORMATION[1]

SKYRIZI INDICATION[1]

SKYRIZI is indicated for the treatment of moderately to severely active Crohn's disease in adults.

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.

Hepatotoxicity in Treatment of Crohn's Disease

Drug-induced liver injury was reported in a patient with Crohn's disease who was hospitalized for a rash during induction dosing of SKYRIZI. For the treatment of Crohn's disease, evaluate liver enzymes and bilirubin at baseline and during induction (12 weeks); monitor thereafter according to routine patient management. Consider an alternate treatment for patients with evidence of liver cirrhosis. Interrupt treatment if drug-induced liver injury is suspected, until this diagnosis is excluded. Instruct your patient to seek immediate medical attention if they experience symptoms suggestive of hepatic dysfunction.

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 (>3%) adverse reactions associated with SKYRIZI in Crohn's disease are upper respiratory infections, headache, and arthralgia in induction and arthralgia, abdominal pain, injection site reactions, anemia, pyrexia, back pain, arthropathy, and urinary tract infection in maintenance.

Lipid Elevations: Increases from baseline and increases relative to placebo were observed at Week 4 and remained stable to Week 12 in patients treated with SKYRIZI in Crohn's disease.

Dosage Forms and Strengths: SKYRIZI is available in a 600 mg/10 mL single-dose vial for intravenous infusion and a 180 mg/1.2 mL or 360 mg/2.4 mL single-dose prefilled cartridge with on-body injector.

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

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. For medical coverage, a pre-certification submission will be required. 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 full Prescribing Information.

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Skyrizi®
risankizumab-rzaa