

Thank you for downloading this prescription assistance document from NeedyMeds. We hope this program will help you get the medicine you need.

**REMEMBER — Send your completed application to the address on the form, NOT to NeedyMeds.**

Did you know that NeedyMeds has thousands of other free resources?

Here's a look at more ways we can help you save money on medicine and healthcare costs. Each one can be found under the "**Healthcare Savings**" tab on our website:


- **Diagnosis-Based Assistance** — NeedyMeds lists thousands of assistance programs for almost any health condition. If you are going through chemo treatment for cancer, there are programs that can help with wig costs and scalp-cooling products. We also list resources for free diabetes testing supplies, caregiver lodging support, and much more.
- **Free, Low-Cost, and Sliding Scale Clinics** — This popular collection contains information on 18,000+ free, low-cost, and sliding scale medical, dental, mental health and substance abuse clinics across the U.S. It's a great resource if you need affordable medical treatment and don't know where to go.
- **Coupons, Rebates & More** — You can use the NeedyMeds website to find 2,600+ cost-saving opportunities for both prescription and over-the-counter drugs and medical supplies.
- **Medical Transportation** — Need help getting to the doctor's office or medical facility? You may be eligible for financial assistance if you meet certain requirements.

NeedyMeds also offers information on diagnosis-based camps and retreats, recreational programs, scholarships, government programs, \$4 generic drug programs, and more.

Finally, I want to tell you about the NeedyMeds Drug Discount Card. Thousands of people use this free, anonymous, and easy-to-use tool to get the best price on their medications. Use the card to get discounts on lab tests and also to save 40% on durable medical equipment. To date, our drug discount card has saved patients over \$300,000,000. Check out the following page to learn more.


Feel free to call our toll-free helpline if you have any questions. We can be reached at 1-800-503-6897 Monday-Friday, 9am-5pm Eastern Time.

Thank you for using NeedyMeds. Please let us know if we can do anything else to help you afford the costs of your healthcare.



Rich Sagall, MD  
President, NeedyMeds

# Clip the card and save



**DRUG DISCOUNT CARD**

BIN: 020750  
RX PCN: NMeds  
RX GRP: PDFPDF  
ID: NMNA019309901930

**Customer Care**  
1-888-602-2978

**This is a drug discount program, not an insurance plan.**

**NeedyMeds Drug Discount Card**  
[www.needymeds.org](http://www.needymeds.org)

**Patient:** You may use this card at any of over 65,000 participating pharmacies to save on all prescription medicines. You cannot use this card with Medicare including part D, Medicaid, or any other state or federal programs unless you choose not to use your government-sponsored program. In addition, you cannot use this card with any health insurance program, but you can use it in place of your insurance if the card offers a better price. For questions call 1-888-602-2978 or visit [www.drugdiscountcardinfo.com](http://www.drugdiscountcardinfo.com).

**Pharmacist:** Administered by Medical Security Company, LLC, Tucson, AZ.

**Pharmacy Help Desk:** 1-800-404-1031.



- Save up to 80% on medications\*
- Use at over 65,000 pharmacies nationwide including all major chains
- Share the card with friends and family

- Use the card as often as needed
- Free, no fees or registration
- Never expires

## What will receive a discount?

All prescription medications are eligible for savings, including over-the-counter medicines and medical supplies written as a prescription, as well as human-equivalent pet medications with a prescription by a veterinarian.

Save up to 40% off durable medical equipment, including canes, crutches, splints, incontinence supplies and more. You can also save on diabetic supplies such as glucose meters, test strips, lancets and diabetic shoes. Visit [www.needymeds.org/dme](http://www.needymeds.org/dme) to learn more.

You can also save an extra 5% on affordable lab tests and online results. No doctor's order or insurance needed. Visit [www.needymeds.org/L2L](http://www.needymeds.org/L2L) for more information.

## What if I have insurance?

Anyone can use the card, but it can't be combined with state or federal insurance. You can use the card instead of insurance if:

- A drug isn't covered by your insurance
- Your insurance has no drug coverage
- You have a high drug deductible
- You have met a low medicine cap
- The card offers a better price than your copay
- You are in the Medicare Part D donut hole

To obtain a plastic drug discount card, send a self-addressed, stamped envelope to:

NeedyMeds Drug Discount Card  
50 Whittemore St.  
Gloucester, MA 01930

*The card is not valid in combination with insurance plans, including Medicare, Medicaid or any state or federal prescription insurance. The card can be used only if you decide not to use your government-sponsored drug plan for your purchases.*

\* Average savings of 60%, with potential savings of up to 80% or more (based on 2018 national program savings data). All prescription medications are eligible for savings.

**This is a drug discount program, not an insurance plan.** Discounts are available exclusively through participating pharmacies. The range of the discounts will vary depending on the type of prescription and the pharmacy chosen. This program does not make payments directly to pharmacies. Users are required to pay for all prescription purchases. Cannot be used in conjunction with insurance. You may call 1-888-602-2978 with questions or concerns or to obtain further information.

## APPLICATION FOR HUMIRA® (adalimumab)

myAbbVie Assist provides free medicine to qualifying patients. We review all applications on a case-by-case basis. Participation in our program is free; we do not collect any fees from people seeking our assistance.

### CHECKLIST FOR SUBMITTING AN APPLICATION

**IF YOU ARE THE PRESCRIBER, COMPLETE PAGE 2**

- **SECTION 1:** Prescriber Information and Shipping Preference
- **SECTION 2:** Patient History, Diagnosis
- **SECTION 3:** Prescription
- **SECTION 4:** Prescriber Certification and Signature

**IF YOU ARE A PATIENT, COMPLETE PAGE 3. PLEASE READ PAGE 4**

- **SECTION 5:** Patient Information
- **SECTION 6:** Financial and Medical Information
  - **REQUIRED:** Please include proof of income for all in household. A copy of your current federal tax return is preferred. If you do not file taxes, alternate documents are acceptable such as W-2 form, Social Security Statement or Pay Stubs.
- **SECTION 7:** Insurance Information
  - If you have Insurance, include front and back copies of all prescription insurance cards.
  - To help us determine your eligibility please also include a detailed list of prescription and medical out of pocket expenses for the household. If you have multiple prescriptions, your pharmacy can print you a list.
- **SECTION 8:** Additional Permission for Program Purposes (Optional)
- **SECTION 9:** Patient Consent and Signature
  - Carefully read the HIPAA authorization, patient terms of participation and privacy notice in Section 10 on Page 4.
  - Provide your consent for eligibility determination by checking the box in Section 9
  - Confirm your understanding of our privacy policy by providing your signature and date in Section 9.

**Please keep a copy for your records.**

**Please do not staple documents together when mailing.**

### FAX OR MAIL THE COMPLETED APPLICATION AND DOCUMENTATION TO THE FOLLOWING

myAbbVie Assist  
D-617927, AP5 NE  
1 N. Waukegan Rd.  
North Chicago, IL 60064

Phone: 1-800-222-6885  
**Fax: 1-866-250-2803**

Upon review of a completed application, we will notify the prescriber and patient about eligibility. If approved, we will ship the medication to the patient's home unless otherwise indicated on the application. Prior to each subsequent shipment, we will call the patient or prescriber to schedule the next delivery.

Please contact us at 1-800-222-6885 Monday through Friday for additional assistance.

**APPLICATION FOR HUMIRA® (adalimumab)**

PHONE: 1-800-222-6885 FAX: 1-866-250-2803

**1 PRESCRIBER INFORMATION • SHIPPING PREFERENCE**

**Prescriber Name:** \_\_\_\_\_  MD  DO  Other: \_\_\_\_\_  Rheum  Derm  Gastro  Other: \_\_\_\_\_

Office Name: \_\_\_\_\_ Office Contact Name: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

NPI or SLN: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Collaborating MD Name and NPI (if applicable) Name: \_\_\_\_\_ NPI: \_\_\_\_\_

**Check ONLY if you prefer shipping to the Prescriber's office:**

For additional information on how AbbVie processes your personal information, please visit [www.abbvie.com/privacy.html](http://www.abbvie.com/privacy.html).

**2 PATIENT MEDICAL HISTORY**

**Patient's Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **Patient Phone:** \_\_\_\_\_  Cellphone  Work  Home

No known allergies  Allergies (Please list): \_\_\_\_\_ **Patient Weight\*** (if under age 18): \_\_\_\_\_

No other medications  Other Medications (Please list): \_\_\_\_\_

RHEUMATOID ARTHRITIS  PSORIATIC ARTHRITIS  PLAQUE PSORIASIS  ANKYLOSING SPONDYLITIS

CROHN'S DISEASE (CD)  ULCERATIVE COLITIS (UC)  HIDRADENITIS SUPPURATIVA (HS)\*  UVEITIS\*

PEDIATRIC CROHN'S DISEASE\*  PEDIATRIC ULCERATIVE COLITIS\*  JUVENILE IDIOPATHIC ARTHRITIS (JIA)\*  OTHER: \_\_\_\_\_

**3 RX: MUST BE COMPLETED BY A LICENSED PRESCRIBER AND FAXED DIRECTLY FROM PRESCRIBER'S OFFICE**

HUMIRA STARTING THERAPY OPTIONS	QTY	CHOOSE ONE DIRECTION FOR USE	
<b>PSORIASIS / UVEITIS / ADOLESCENT HS</b> (Age 12 & older: 30kg (66 lbs) to < 60kg (132 lbs))			
<input type="checkbox"/> HUMIRA 80 mg/0.8 mL (1) & 40 mg/0.4 mL (2) CITRATE FREE PEN....	3 PEN KIT	<input type="checkbox"/> Inject 80 mg SQ on Day 1, 40 mg on Day 8, and 40 mg every other week	No refills
<input type="checkbox"/> HUMIRA 40 mg/0.4 mL CITRATE FREE SYRINGE.....	4 SYRINGES		
<b>CROHN'S DISEASE / ULCERATIVE COLITIS / HS</b>			
<input type="checkbox"/> HUMIRA 80 mg/0.8 mL CITRATE FREE PEN .....	3 PEN KIT	<input type="checkbox"/> Inject 160mg SQ on Day 1 and 80 mg on Day 15	No refills
<input type="checkbox"/> HUMIRA 40 mg/0.4 mL CITRATE FREE SYRINGE.....	6 SYRINGES	<input type="checkbox"/> Inject 80mg SQ on Day 1, Day 2, and Day 15	No refills
<b>PEDIATRIC CROHN'S DISEASE</b> (Weight: 17kg (37 lbs) to < 40kg (88 lbs))			
<input type="checkbox"/> HUMIRA 80 mg/0.8 mL & 40 mg/0.4 mL CITRATE FREE SYRINGE .....	2 SYRINGE KIT	<input type="checkbox"/> Inject 80 mg SQ on Day 1 and 40 mg on Day 15	No refills
<b>PEDIATRIC CROHN'S DISEASE</b> (Weight: ≥ 40kg (88 lbs))			
<input type="checkbox"/> HUMIRA 80 mg/0.8 mL CITRATE FREE SYRINGE .....	3 SYRINGE KIT	<input type="checkbox"/> Inject 160mg SQ on Day 1 and 80 mg on Day 15	No refills
<input type="checkbox"/> HUMIRA 80 mg/0.8 mL CITRATE FREE SYRINGE .....	3 SYRINGE KIT	<input type="checkbox"/> Inject 80mg SQ on Day 1, Day 2, and Day 15	No refills
<b>PEDIATRIC ULCERATIVE COLITIS</b> (Weight: 20kg (44lbs) to < 40kg (88lbs))			
<input type="checkbox"/> HUMIRA 40 mg/0.4 mL (4) CITRATE FREE PEN.....	4 PENS	<input type="checkbox"/> Inject 80mg SQ on Day 1, 40mg on Day 8 and Day 15	No refills
<input type="checkbox"/> HUMIRA 40 mg/0.4 mL (4) CITRATE FREE SYRINGE.....	4 SYRINGES		
<b>PEDIATRIC ULCERATIVE COLITIS</b> (Weight: ≥ 40kg (88lbs))			
<input type="checkbox"/> HUMIRA 80 mg/0.8 mL (4) CITRATE FREE PEN .....	4 PEN KIT	<input type="checkbox"/> Inject 160mg SQ on Day 1, 80mg on Day 8 and Day 15	No refills
<input type="checkbox"/> HUMIRA 80 mg/0.8 mL (4) CITRATE FREE PEN .....	4 PEN KIT	<input type="checkbox"/> Inject 80mg SQ on Day 1, Day 2, Day 8 and Day 15	No refills

HUMIRA ONGOING THERAPY OPTIONS	CHOOSE ONE DIRECTION FOR USE OR WRITE IN BELOW	QUANTITY	REFILLS
<input type="checkbox"/> HUMIRA 40 mg/0.4mL CITRATE FREE PEN	<input type="checkbox"/> 40 mg SQ EVERY <b>OTHER</b> week <input type="checkbox"/> 40 mg SQ EVERY week	84 Days Supply– Program Standard	1 year
<input type="checkbox"/> HUMIRA 40 mg/0.4mL CITRATE FREE SYRINGE			
<input type="checkbox"/> HUMIRA 20 mg/0.2mL CITRATE FREE SYRINGE	<input type="checkbox"/> 20 mg SQ EVERY <b>OTHER</b> week <input type="checkbox"/> 20 mg SQ EVERY week	<input type="checkbox"/> Other: _____	Other: _____
<input type="checkbox"/> HUMIRA 80 mg/0.8mL CITRATE FREE PEN	<input type="checkbox"/> 80 mg SQ EVERY <b>OTHER</b> week		<input type="checkbox"/> _____

HUMIRA: \_\_\_\_\_ Directions: \_\_\_\_\_ Qty: \_\_\_\_\_ Refills: \_\_\_\_\_

Please contact myAbbVie Assist for questions about other available HUMIRA presentations

**PLEASE SUBMIT PRESCRIPTIONS ACCORDING TO YOUR SPECIFIC STATE LAWS, RULES AND REGULATIONS**

**4 PRESCRIBER PLEASE SIGN AND DATE • PRESCRIBER MUST MANUALLY SIGN BELOW**  
RUBBER STAMPS, SIGNATURE BY OTHER OFFICE PERSONNEL OR COMPUTER-GENERATED IMAGES ARE NOT ALLOWED

**PRESCRIBER SIGNATURE** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**AND DATE:**  Substitution Permitted  Dispense as Written

I verify that the information provided is current, complete and accurate to the best of my knowledge. myAbbVie Assist reserves the right to request additional information if needed and to change or discontinue the program at any time, without notice. I shall not seek reimbursement for any medication dispensed hereunder from any government program or third party, including patient, nor will I sell, trade or distribute any such medication. I also understand that the applicant's acceptance into the program should not influence treatment decisions. By signing this form, I authorize the program and its representatives to transmit this prescription form electronically, by facsimile, or by mail to a pharmacy designated by the program for the dispensing of the medication called for herein. I understand that I may not delegate signature authority. I certify that treatment with this medication is medically necessary.

APPLICATION FOR HUMIRA® (adalimumab)

D-617927, AP5 NE; 1 N. WAUKEGAN RD  
NORTH CHICAGO, IL 60064  
PHONE: 1-800-222-6885 FAX: 1-866-250-2803

**5 PATIENT INFORMATION**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex:  M  F

SSN (last four digits ONLY):    |    |    |    If you do not have an SSN, check here:

Mailing Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Shipping Address (No P.O. Box): \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Preferred Phone: \_\_\_\_\_  Cellphone  Work  Home Alternate Phone: \_\_\_\_\_  Cellphone  Work  Home

Check the Box for Text Messages\*  Mobile Phone: \_\_\_\_\_ Email address: \_\_\_\_\_

\* I consent to receive automated and recurring text messages from myAbbVie Assist, including service updates and medication and refill reminders to the above number. Message and data rates may apply. I am not required to consent or provide my consent as a condition of receiving any goods or services. I can reply HELP for help. I can text STOP to unsubscribe any time.

**6 FINANCIAL AND MEDICAL INFORMATION**

**Please include financial documentation for everyone in the household. A copy of your current federal tax return is preferred. If you do not file taxes, alternate documents are acceptable such as W-2 forms, Social Security Statements and Pay Stubs.**

Monthly Household Income \$ \_\_\_\_\_ Number in Household (including yourself) : \_\_\_\_\_ Number in household over 18 yrs old with income : \_\_\_\_\_

Treating Physician Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**\*\*If you have any changes to your medical information please call us at 1-800-222-6885\*\***

**7 INSURANCE INFORMATION**  I have no insurance coverage – go to Section 8

INSURANCE TYPE:  Medicare  Medicaid  Private/Commercial  Other: \_\_\_\_\_

Please provide insurance details below and attach a front and back copy of all insurance cards. Also include a detailed list of prescriptions such as a Pharmacy print-out and medical expenses for the household to help us determine eligibility for our program.

MEDICAL INSURANCE		PRESCRIPTION INSURANCE	
Insurance Company: _____		Insurance Company: _____	
Insurance Co. Phone: _____		Insurance Co. Phone: _____	
Policy ID #: _____	Group #: _____	Policy ID #: _____	Group #: _____
Policyholder Name: _____	Relationship: _____	BIN #: _____	PCN #: _____

Do you have secondary insurance?  Yes  No  Unsure

Please provide your Medicare Part A Identification #: \_\_\_\_\_

**8 ADDITIONAL PERMISSION FOR PURPOSES OF THE PROGRAM (optional)**

I permit myAbbVie Assist to speak with the following person about this application:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**9 PATIENT CONSENT** PLEASE REVIEW HIPAA AUTHORIZATION, PATIENT TERMS OF PARTICIPATION AND PRIVACY NOTICE IN SECTION 10 TO UNDERSTAND HOW WE USE YOUR PERSONAL INFORMATION

*I acknowledge that I have provided accurate and complete information and understand the Patient Terms of Participation in Section 10.*

CHECK THE BOX:  **I understand that I am providing written instructions to the Program under the Fair Credit Reporting Act authorizing the Program to obtain information about my credit profile from credit reporting agencies or other sources. I authorize the Program to obtain such information solely to determine PAP eligibility.**

PLEASE SIGN AND DATE: **X** *My signature below certifies that I have read, understood and agree to the release of my protected health information pursuant to the HIPAA Authorization in Section 10.* **X**

\_\_\_\_\_ PATIENT SIGNATURE / LEGAL REPRESENTATIVE (indicate relationship) \_\_\_\_\_ DATE

## APPLICATION FOR HUMIRA® (adalimumab)

D-617927, AP5 NE; 1 N. WAUKEGAN RD  
NORTH CHICAGO, IL 60064  
PHONE: 1-800-222-6885 FAX: 1-866-250-2803

### 10 HIPAA AUTHORIZATION, PATIENT TERMS OF PARTICIPATION AND PRIVACY NOTICE

#### HIPAA AUTHORIZATION Please provide signature in Section 9 of Enrollment Form

I authorize my healthcare providers, pharmacies, insurers, and laboratory testing facilities (my “Healthcare Companies”) to disclose information about me, my medical condition, treatment, insurance coverage, and payment information in relation to my use of AbbVie products, to AbbVie to enroll me in and provide me with patient assistance and support for AbbVie products. I understand that information released under this Authorization will no longer be protected by HIPAA. I also understand that if my Healthcare Companies use or disclose my Personal Information for marketing purposes, they may receive financial remuneration.

I understand that I am not required to sign this Authorization and that my Healthcare Companies will not condition my treatment, payment, enrollment, or eligibility for benefits on whether I sign this Authorization. However, I understand that if I do not sign this Authorization, I cannot take part in myAbbVie Assist (should I qualify). This Authorization will expire in 10 years or a shorter period if required by state law, unless I cancel it sooner by calling 1-800-222-6885 or by writing to myAbbVie Assist, D-617927, AP5 NE; 1 N. Waukegan Rd, North Chicago, IL 60064. I understand that cancelling my Authorization will not affect any use of my information that occurred before my request was processed.

#### PATIENT TERMS OF PARTICIPATION

myAbbVie Assist provides free medicine to qualifying patients. Participation in our program is free; we do not collect any fees from people seeking our assistance. Medication assistance is dependent on your ability to meet the eligibility criteria for program as determined by myAbbVie Assist. myAbbVie Assist does not have any obligation to provide the program services to you and is not liable in the provision of these services. The program may be changed or discontinued without notice. You will not seek reimbursement for any products dispensed under the program. You will notify the program if your insurance or financial situation changes. If this application has been completed by a personal representative, the personal representative will provide a copy of this completed application to you.

If you are a member of a Medicare plan including a Medicare Prescription Drug Plan and are qualified for program assistance, you will: (i) be eligible to obtain the medication from the program for a calendar year term (ii) not purchase this medication under your Medicare plan while enrolled in the program; (iii) not submit claims nor seek true out-of-pocket (TrOOP) credit for the medication provided during your enrollment; (iv) myAbbVie Assist will inform your Medicare Prescription Drug Plan, if applicable that you are receiving your medication at no cost outside of the Medicare Part D benefit.

If you have questions, want to update your information, or terminate your enrollment, please call 1-800-222-6885 or write to us at D-617927, AP5 NE; 1 N. Waukegan Rd, North Chicago, IL 60064.

#### PATIENT PRIVACY NOTICE

myAbbVie Assist will use and disclose with authorized third parties your personal information including your financial and health information collected on this enrollment form and through participation in the program for the following purposes:

- (1) To determine your eligibility for the program and to provide you with related services, including transfer to a separate private or public payer program, reimbursement services, services to ship your medication, and other support services.
- (2) To obtain information from your credit profile about your income for the sole purpose of determining eligibility for the program. This notice serves as written instruction under the Fair Credit Reporting Act authorizing myAbbVie Assist to obtain this information.
- (3) To perform research and data analytics to develop and evaluate products, services, materials, and treatments.
- (4) To administer and maintain the quality of the program, including but not limited to case review, compliance checks, audit review and accounting purposes.

For additional information on how AbbVie processes your personal information, please visit [www.abbvie.com/privacy.html](http://www.abbvie.com/privacy.html).