HUMIRA® (adalimumab) CITRATE-FREE REFERRAL AND PRESCRIPTION FORM

Sign and fax this form to Complete by AbbVie at 877-314-8427 or the pharmacy of your choice. For questions, please call 800-448-6472.

DERMATOLOGY

PATIENT AND PRESCRIBER INFORMATION

PATIENT INFORMATION SSN (Last 4 ONLY) 0 | 6 | 6 | 8

First Name: Jeffery MI: G

Last Name: Waldron

DOB: 3/6/1973 Weight (lbs): 208 Sex: ☒ M ☐ F

Address: 1972 James Avenue

City/State/Zip: Syracuse, NY 13221

Primary Phone: 315-951-2781 ☐ H ☐ W ☒ M

Alternate Phone: 315-373-7846 ☐ H ☒ W ☐ M

Drug Allergies: Penicillin

PRESCRIBER INFORMATION ☒ MD ☐ DO ☐ Other: _____

Prescriber Name: Allison Sheilds

Specialty: ☒ Derm ☐ Other: _____

NPI/Provider #: 4962830293 State License #: 052313037L

Office Name: James Martinez Family Health Center

Contact: Todd Evans

Address: 3161 Buckhannan Avenue

City/State/Zip: Liverpool, NY 13088

Phone: 541-875-3374 Fax: 541-337-6466

INSURANCE INFORMATION

Fax a copy of the front and back of prescription insurance card(s) or fill in the information below

Primary Insurance: OPtum RX

Phone: 1-800-726-4299

Cardholder ID #: 460991501 Group #: 460011

PCN: IRX BIN: 610011

Policyholder Name: Jeffery Waldon DOB: 3/6/1973

Secondary Insurance: _____

Phone: _____

Cardholder ID #: _____ Group #: _____

PCN: _____ BIN: _____

Policyholder Name: _____ DOB: _____

BV

BENEFIT VERIFICATION ONLY ☐ I do **not** want to prescribe HUMIRA at this time, but please verify drug coverage.

CLINICAL AND PRESCRIPTION INFORMATION

PATIENT'S DIAGNOSIS Date of Diagnosis: 5/7/25

☐ Plaque Psoriasis ICD-10: _____

☒ Adolescent Hidradenitis Suppurativa ICD-10: L73.2

☐ Hidradenitis Suppurativa ICD-10: _____

☐ Psoriatic Arthritis ICD-10: _____

☐ Other (include code): _____

Prior medications: _____

TB Test (Date) 5/7/2025 ☐ Pos _____ ☒ Neg _____

Please attach any clinical or office notes relevant to therapy.

SHIPPING PREFERENCE Date needed: 5/12/2025

☒ Deliver medication to the patient

☐ Deliver medication to the prescriber

PRESCRIPTION

☒ New ☐ Restart ☐ Continuing

Current filling pharmacy: _____

Plaque Psoriasis or Adolescent Hidradenitis Suppurativa 30 kg (66 lbs) to < 60 kg (132 lbs)

Starting Therapy

☐ **Syringe:** HUMIRA 40 mg/0.4 mL *NDC: 0074-0243-02* — Two 40 mg SQ inj. Day 1, one 40 mg SQ inj. Day 8, one 40 mg SQ inj. Day 22 — #4 — No Refills

Or

☐ **Pen:** HUMIRA Starter Pkg 80 mg/0.8 mL, 40 mg/0.4 mL *NDC: 0074-1539-03* — One 80 mg SQ inj. Day 1, one 40 mg SQ inj. Day 8, one 40 mg SQ inj. Day 22 — #3 — No Refills

Ongoing Therapy

Or ☐ **Syringe:** HUMIRA 40 mg/0.4 mL *NDC: 0074-0243-02*
☐ **Pen:** HUMIRA 40 mg/0.4 mL *NDC: 0074-0554-02* — One 40 mg SQ inj. QOW — ☐ #2 (1 month) ☐ #6 (3 month) Refills: ____

Hidradenitis Suppurativa for Adults or Adolescents ≥ 60 kg (132 lbs)

Starting Therapy

☒ **Pen:** HUMIRA Starter Pkg 80 mg/0.8 mL *NDC: 0074-0124-03* — ☒ Two 80 mg SQ inj. Day 1, one 80 mg SQ inj. Day 15 — #3 — No Refills
☐ One 80 mg SQ inj. Day 1, one 80 mg SQ inj. Day 2, one 80 mg SQ inj. Day 15

Ongoing Therapy

Or ☐ **Syringe:** HUMIRA 40 mg/0.4 mL *NDC: 0074-0243-02*
☐ **Pen:** HUMIRA 40 mg/0.4 mL *NDC: 0074-0554-02* — One 40 mg SQ inj. Day 29 & every week thereafter — ☐ #4 (1 month) ☐ #12 (3 month) Refills: ____

Psoriatic Arthritis Therapy

Or ☐ **Syringe:** HUMIRA 40 mg/0.4 mL *NDC: 0074-0243-02*
☐ **Pen:** HUMIRA 40 mg/0.4 mL *NDC: 0074-0554-02* — One 40 mg SQ inj. QOW — ☐ #2 (1 month) ☐ #6 (3 month) Refills: ____

Other ☐ HUMIRA _____ SIG: _____ Qty: _____ Refills: _____

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.

_____ 05/07/25

☐ **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.)

Please see Important Safety Information on next page.

Please see accompanying full Prescribing Information, including BOXED WARNING, or visit www.rxabbvie.com/pdf/humira.pdf.