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) ___|___|___|___

First Name: Ivette MI: ____

Last Name: Drumm

DOB: 10/20/2011 Weight (lbs): 126 Sex: ☐ M ☒ F

Address: 1384 Leverton Cove Road

City/State/Zip: Palmer, MA 01069

Primary Phone: 413 284 5899 ☐ H ☐ W ☒ M

Alternate Phone: ____ ☐ H ☐ W ☐ M

Drug Allergies: Sulfonamides

PRESCRIBER INFORMATION ☐ MD ☐ DO ☐ Other: ____

Prescriber Name: Kathleen Schmidt

Specialty: ☒ Derm ☐ Other: ____

NPI/Provider #: 9523636869 State License #: 0209679674

Office Name: Springfield Dermatology Center

Contact: Anna Myers

Address: 2949 Hilltop Street

City/State/Zip: Springfield, MA 01103

Phone: 4137348946 Fax: 4138835992

INSURANCE INFORMATION

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

Primary Insurance: Express Scripts

Phone: 1800 756 4574

Cardholder ID #: CWK000100002 Group #: UTSYSRX

PCN: A4 BIN: 610014

Policyholder Name: Roger Drumm DOB: 7/16/1987

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: 5/26/2025

☐ 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) 5/26/2025 ☐ Pos ____ ☒ Neg ____

Please attach any clinical or office notes relevant to therapy.

SHIPPING PREFERENCE Date needed: 6/2/2025

☐ 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 ☐ One 80 mg SQ inj. Day 1, one 80 mg SQ inj. Day 2, one 80 mg SQ inj. Day 15 — #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. 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.

☐ **Dispense as written/Do not substitute** **Date**

☒ **Substitution permitted/Brand exchange permitted** **Date** 5/26/2025

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.