

1/110

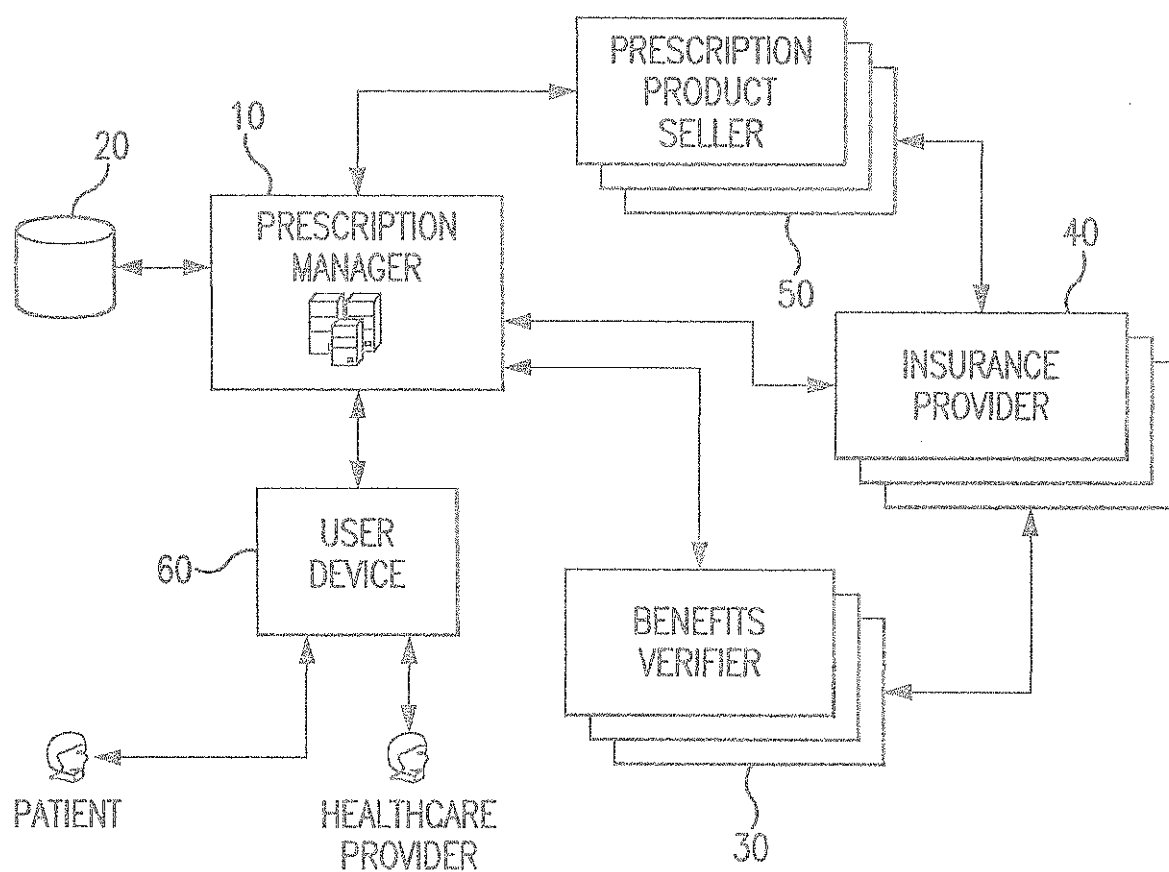


FIG. 1

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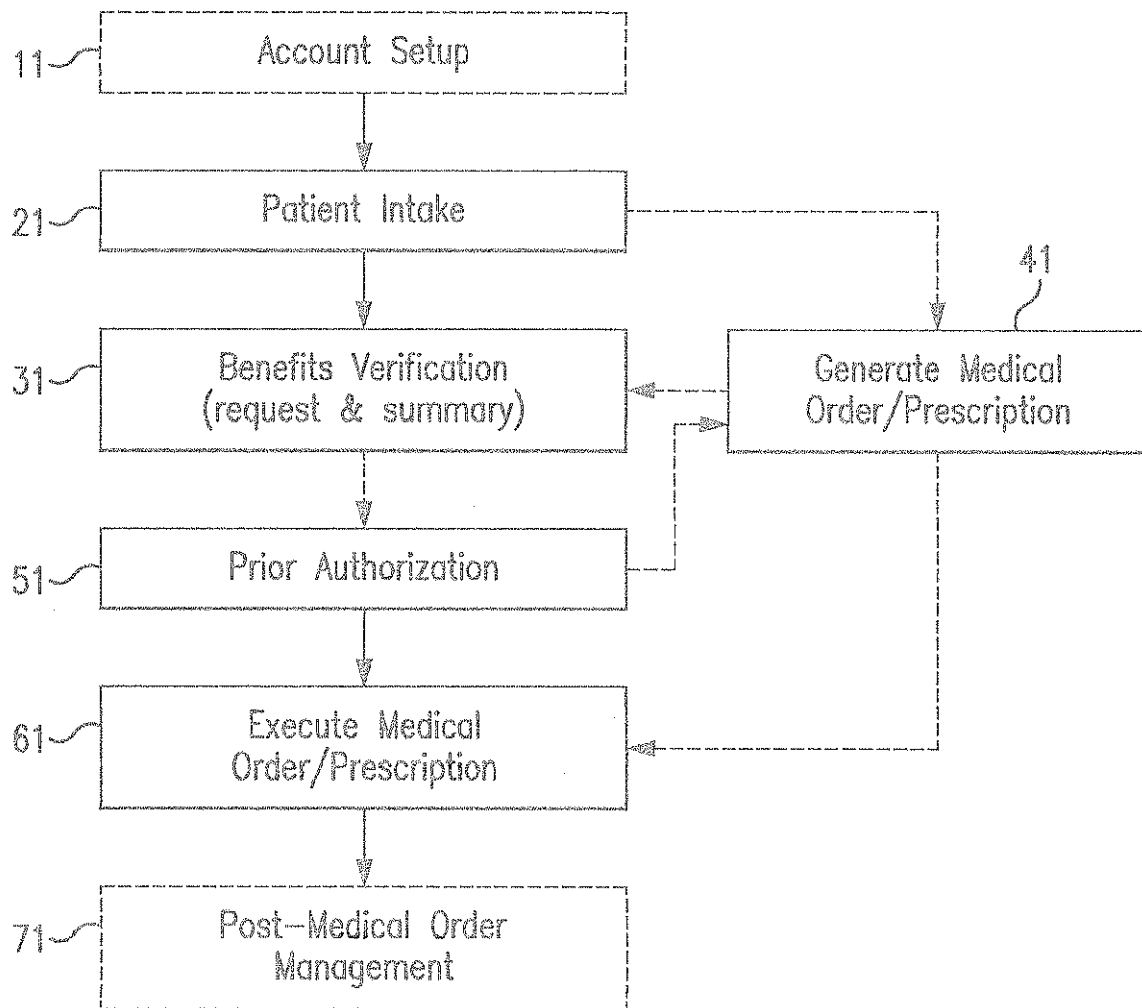


FIG. 2

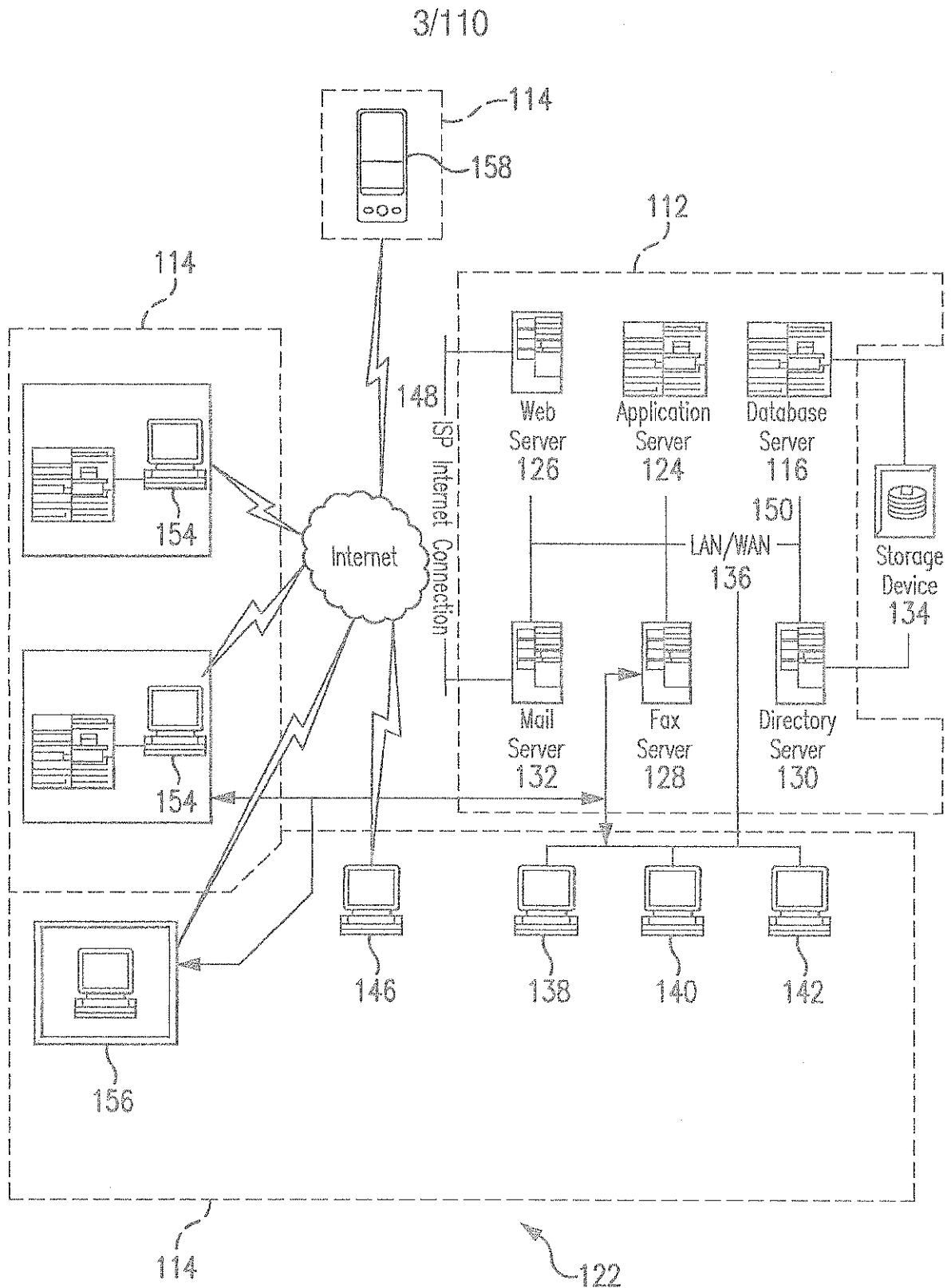


FIG. 3A

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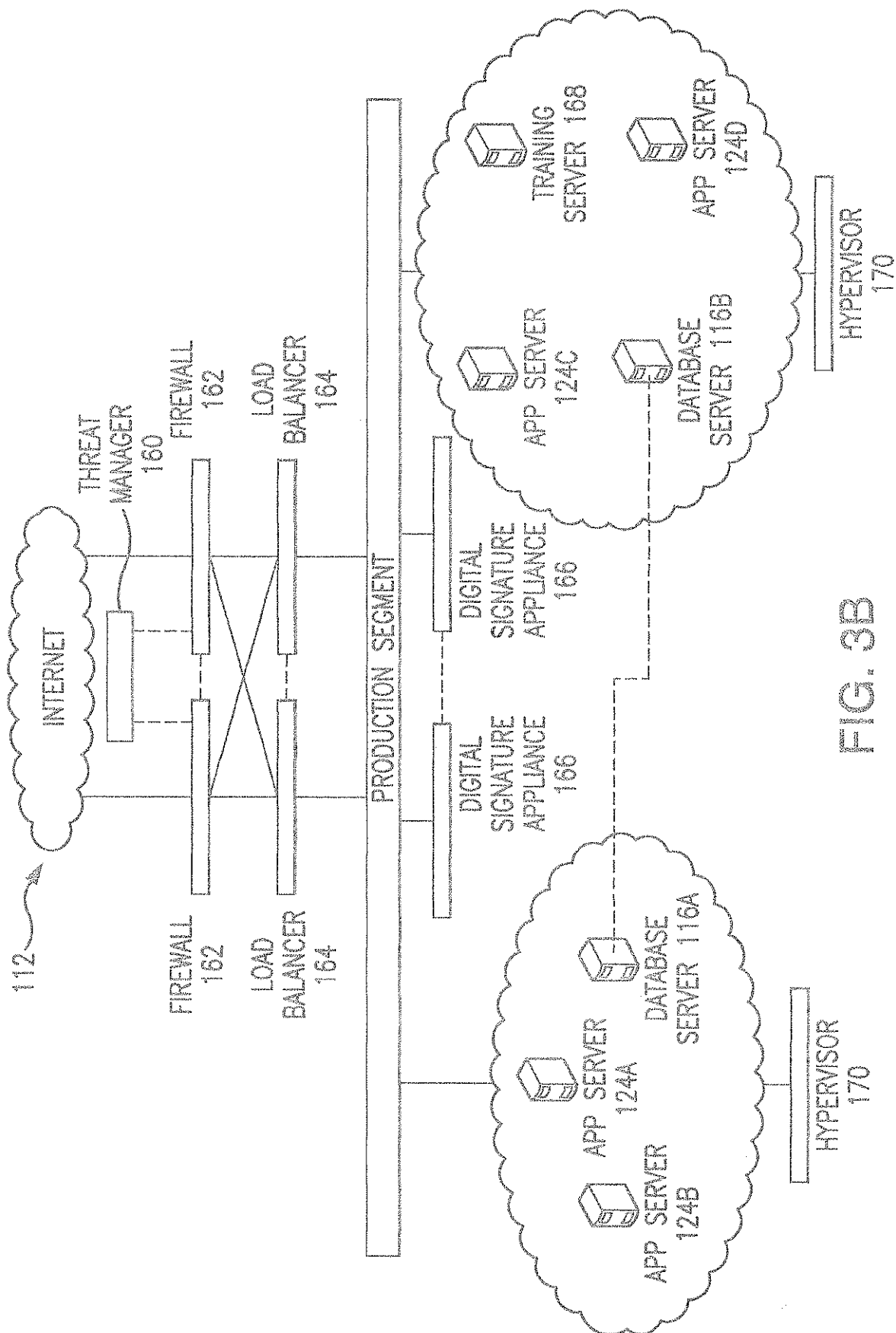


FIG. 3B

5/110

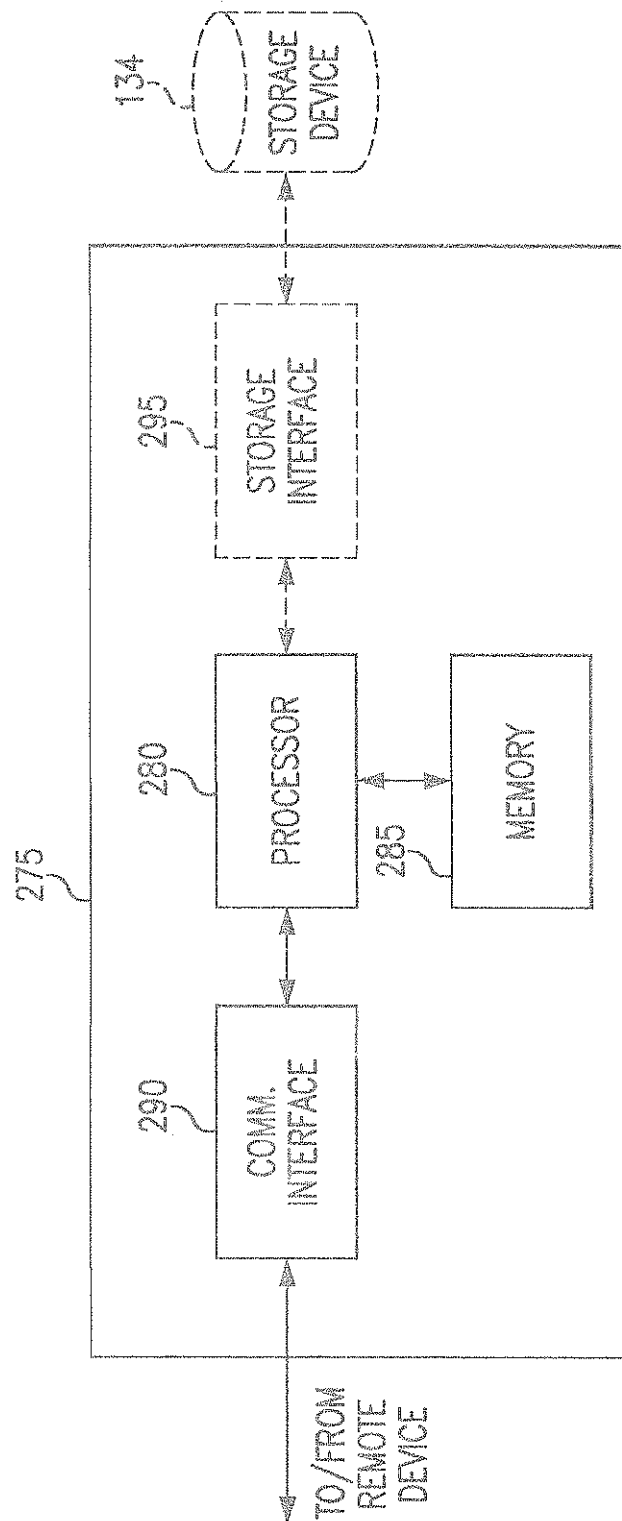


FIG. 3C

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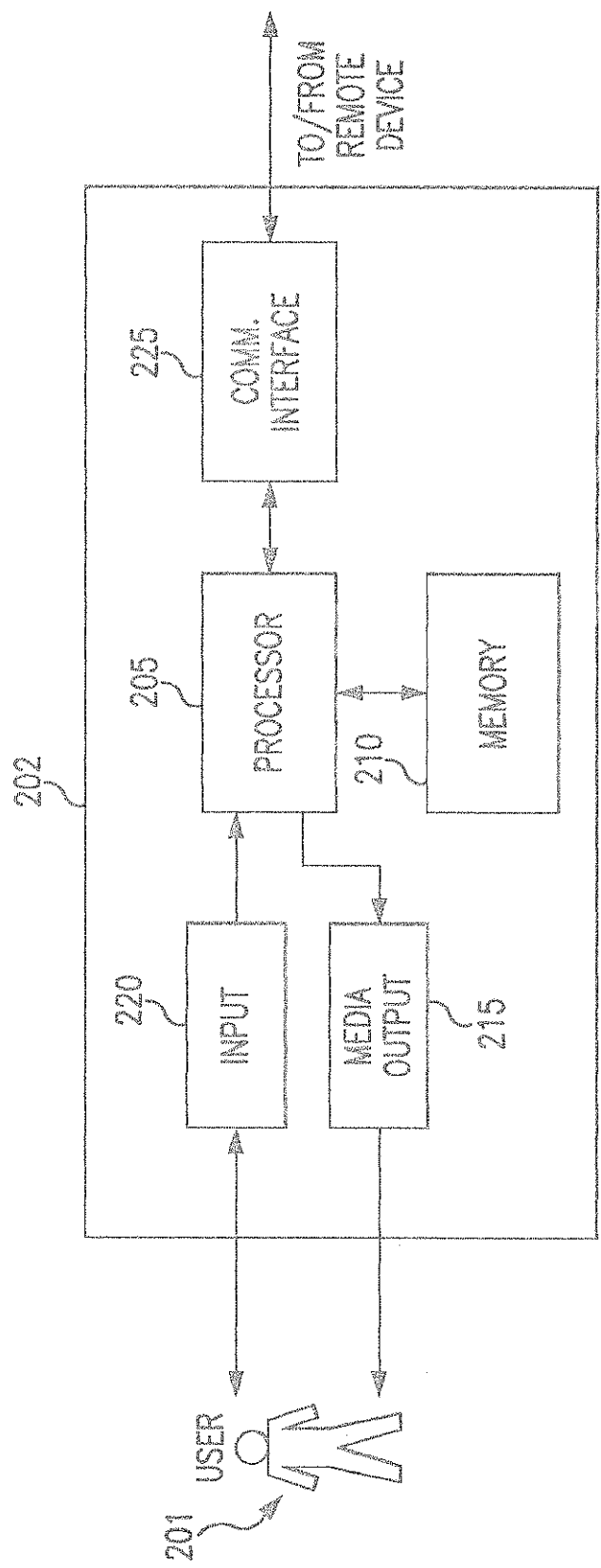


FIG. 4

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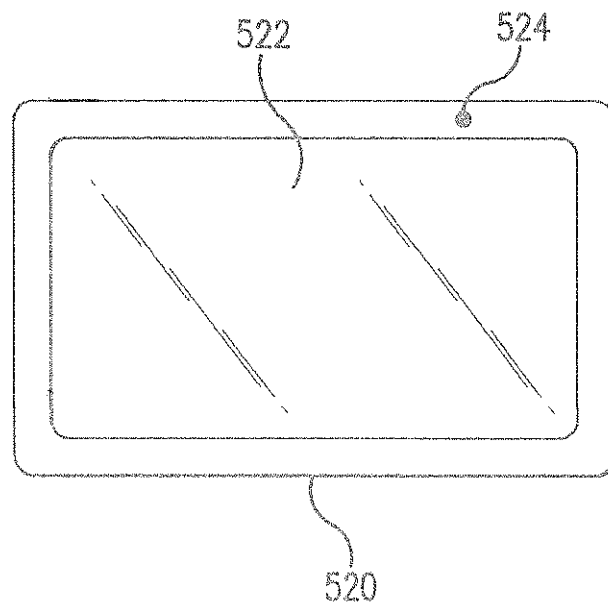


FIG. 5A

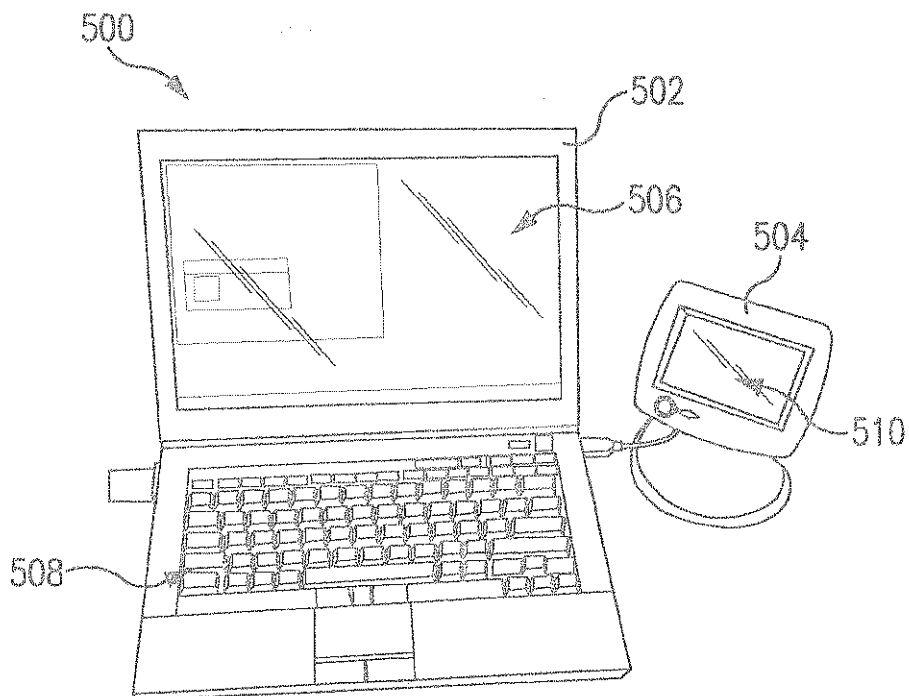


FIG. 5B

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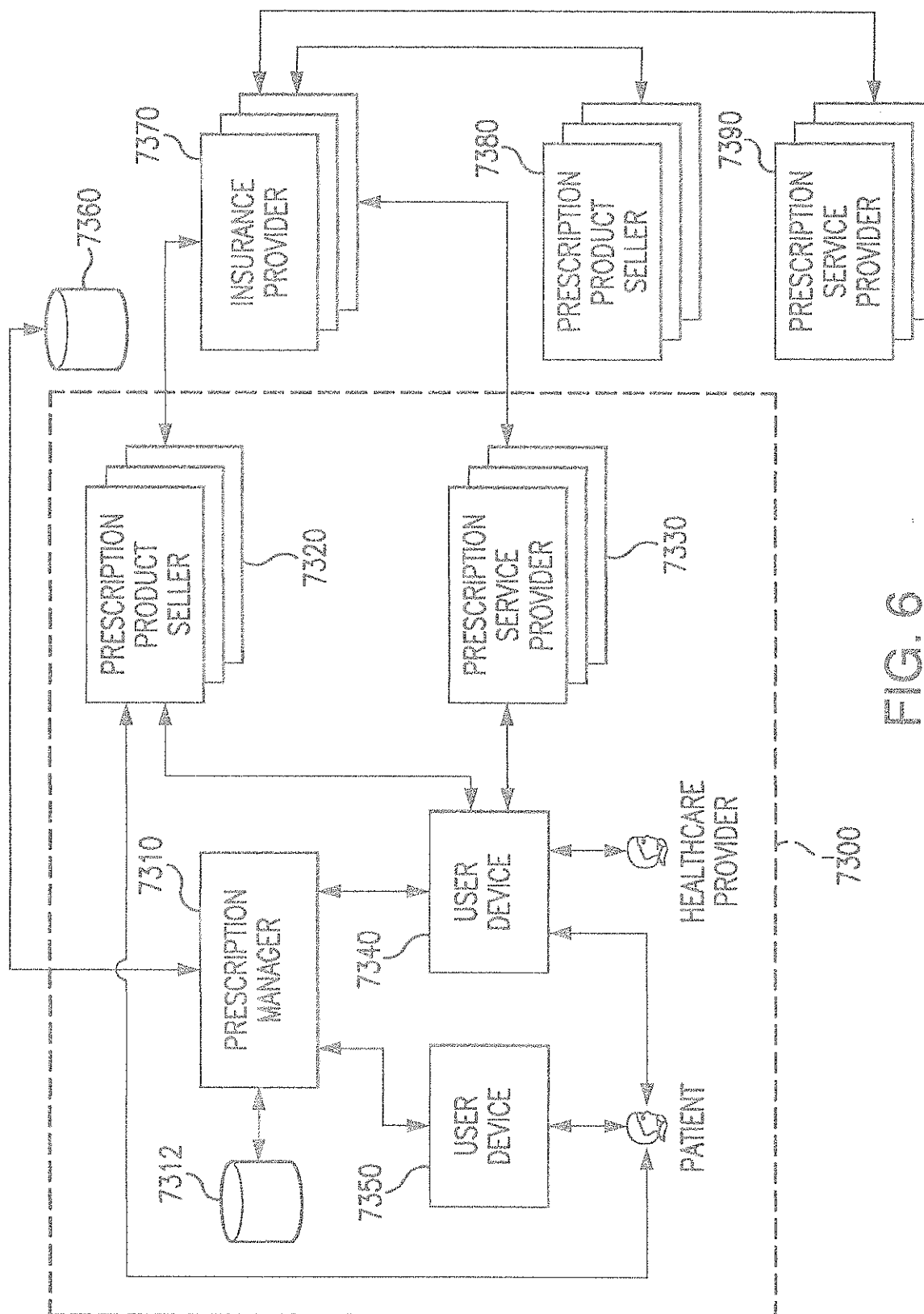


FIG. 6

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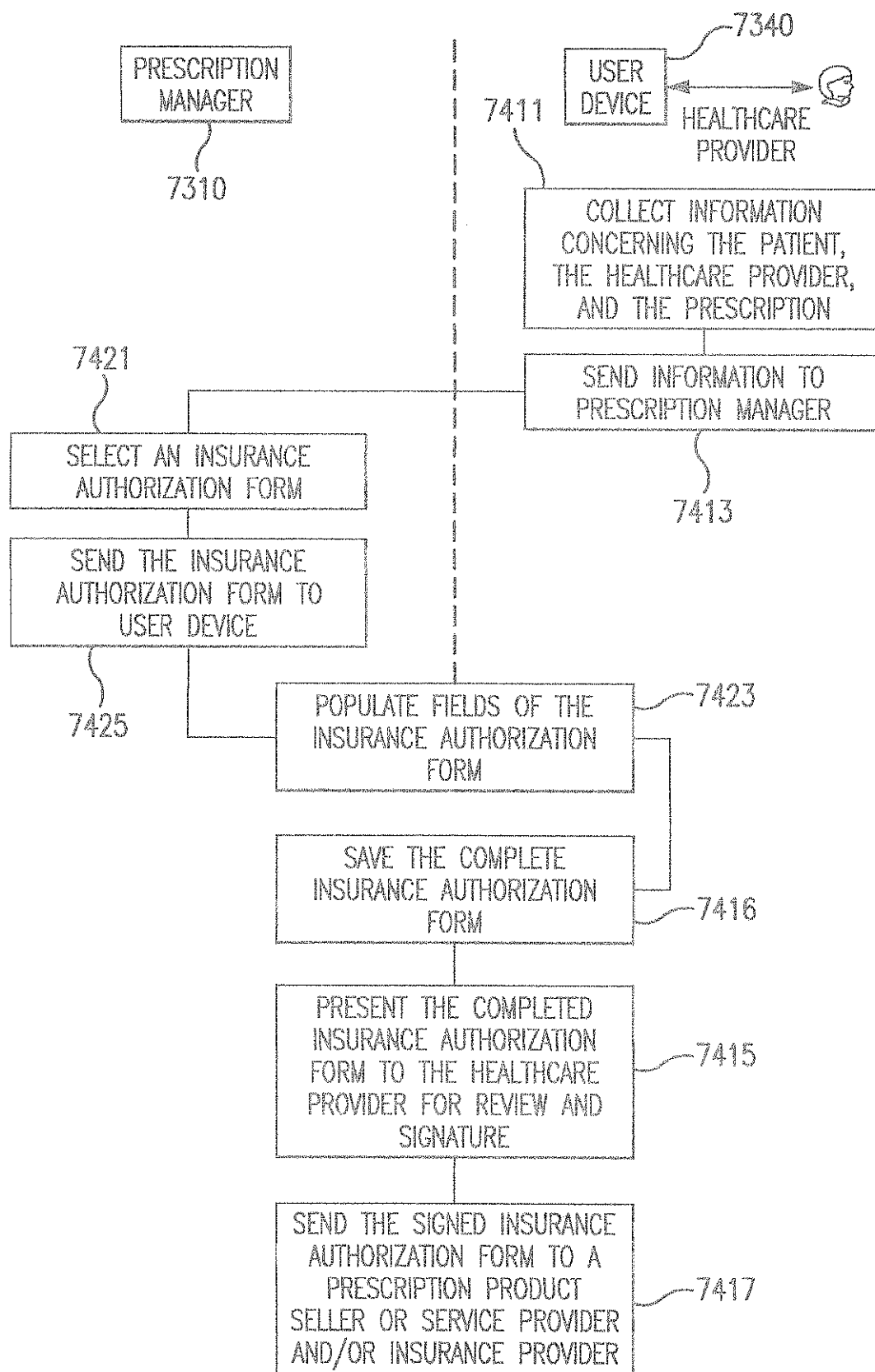


FIG. 7

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800

A login form labeled 800. It features a header bar with a small square icon on the left. Below the header, there are two input fields: "User Name" and "Password". Below these fields is a button labeled "Continue >".

FIG. 8

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FIG. 9

900

0.14 Important Safety Information (Practice Administrator)

☐ Healthcare Professionals Practice Administrator Logout Hi, <Variable Username>
User Guide

[Important Safety Information](#)
[Full Subscribing Information](#)

Important Safety Information about DRUG(H)¹

SERIOUS INFECTIONS

• _____

• _____

• _____

• _____

• _____

MALIGNANCY

• _____

• _____

• _____

HYPERSENSITIVITY

• _____

• _____

HEPATITIS B VIRUS REACTIVATION

• _____

• _____

• _____

• _____

NEUROLOGIC REACTIONS

• _____

• _____

HEMATOLOGIC REACTIONS

• _____

• _____

CONGESTIVE HEART FAILURE

• _____

• _____

AUTOIMMUNITY

• _____

• _____

IMMUNIZATIONS

• _____

• _____

ADVERSE REACTIONS

• _____

INDICATIONS¹

• _____

• _____

• _____

Click here for [Full Prescribing Information](#)
Reference¹ _____

[Continue](#)

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1000	1.0 My Profile	Healthcare Professionals - Practice Administrator	Logout	Hi, <Variable Username> User Guide
			Important Safety Information Full Subscribing Information	
1002	My Profile			
	* denotes a required field			
	First Name*:		Middle Initial:	
	Last Name*:		☒ Password Expiry Policy (Days):	
	User ID:		Password*:	
	Work Number*:		Cell Number:	
	Email Address*:		Practice Details:	
	Practice Name:			
	☒ Receive Updates via E-Mail			
1004	Location of Service			
1006	HCP Profile			
1008	Office Staff Profile			
1010	Associations			
	Click here for Full Prescribing Information			

FIG. 10

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1.1 Location of Service

Healthcare Professionals - Practice Administrator

Logout

Hi, <Variable Username>
User Guide

Important Safety Information

Full Subscribing Information

1002 My Profile

1004 Location of Service

	Facility Name	Facility Address	Facility City	Facility Phone
☐	<Variable Facility Name>	<Variable Facility Address>	<Variable Facility City>	<Variable Facility Phone>
☐	<Variable Facility Name>	<Variable Facility Address>	<Variable Facility City>	<Variable Facility Phone>

Edit

Delete

Add New Location of Service

* denotes a required field

Practice Name:

Facility Address 1*:

City*:

Zip*:

Phone Number 1*:

Facility Name*1:

Facility Address 2:

State*:

Fax Number*:

Phone Number 2:

Preferred Specialty Pharmacy Partner:

Save

Cancel

1006 HCP Profile

1008 Office Staff Profile

1010 Associations

Click here for Full Prescribing Information

FIG. 11

14/110

1.2 HCP Profile

☐ Healthcare Professionals - Practice Administrator		Logout	HI, <Variable Username> User Guide
Important Safety Information Full Prescribing Information			
My Profile			
Location of Service			
HCP Profile			
1200	☐	First Name <Variable First Name> <Variable First Name> <Variable First Name> <Variable First Name> <Variable First Name>	Last Name <Variable Last Name> <Variable Last Name> <Variable Last Name> <Variable Last Name> <Variable Last Name>
	☐	Primary Specialty <Variable Specialty> <Variable Specialty> <Variable Specialty> <Variable Specialty> <Variable Specialty>	Status <Variable Status> <Variable Status> <Variable Status> <Variable Status> <Variable Status>
<div>1 2 3</div>			
<div> <input type="button" value="Edit"/> <input type="button" value="Delete"/> <input type="button" value="Add New HCP"/> </div>			
Office Staff Profile			
Associations			
Click here for Full Prescribing Information			

FIG. 12

15/110

1.2.1 Add New HCP

☐ Healthcare Professionals - Practice Administrator		Logout		Hi, <Variable Username> User Guide	
Important Safety Information Full Subscribing Information					
My Profile					
Location of Service					
HCP Profile					
☐	First Name	Last Name	Primary Specialty	Status	
☐	<Variable First Name>	<Variable Last Name>	<Variable Specialty>	<Variable Status>	
☐	<Variable First Name>	<Variable Last Name>	<Variable Specialty>	<Variable Status>	
		1 2 3			
<input type="button" value="Edit"/> <input type="button" value="Delete"/>		<input type="button" value="Add New HCP"/>			
* denotes a required field First Name*: <input type="text"/> Last Name*: <input type="text"/> Secondary Specialty: <input type="text"/> Work Number*: <input type="text"/> Email Address*: <input type="text"/> State License #: <input type="text"/> Location of Service: <input type="text"/>					
Middle Initial: <input type="text"/> Primary Specialty*: <input type="text"/> Designation*: <input type="text"/> Cell Number: <input type="text"/> NPI Number*: <input type="text"/> Issue State: <input type="text"/> <input type="button" value="-Select-"/> DEA Number: <input type="text"/>		EIN Expiry Date: <input type="text"/> DEA Expiry Date: <input type="text"/> DEA Expiry Date: <input type="text"/> DEA Expiry Date: <input type="text"/>			
Facility Name <Variable Facility Name>		DEA Number <Variable DEA Number>			
<input type="button" value="Save"/> <input type="button" value="Cancel"/>					
Office Staff Profile					
Associations					
Click here for Full Prescribing Information					

FIG. 13

U.S. Office
of Statistics
Washington, D.C.

<input type="text"/>	Healthcare Professionals - Practice Administrator	Logout	Hi, <Variable Username> User Guide																														
Important Safety Information																																	
Full Subscribing Information																																	
1002	My Profile																																
1004	Location of Service																																
1006	HCP Profile																																
1008	Office Staff Profile																																
1400	<table border="1"> <thead> <tr> <th></th> <th>First Name</th> <th>Last Name</th> <th>Phone Number</th> <th>Status</th> </tr> </thead> <tbody> <tr> <td>☐</td> <td><Variable First Name></td> <td><Variable Last Name></td> <td><Variable Phone Number></td> <td><Variable Status></td> </tr> <tr> <td>☐</td> <td><Variable First Name></td> <td><Variable Last Name></td> <td><Variable Phone Number></td> <td><Variable Status></td> </tr> <tr> <td>☐</td> <td><Variable First Name></td> <td><Variable Last Name></td> <td><Variable Phone Number></td> <td><Variable Status></td> </tr> <tr> <td>☐</td> <td><Variable First Name></td> <td><Variable Last Name></td> <td><Variable Phone Number></td> <td><Variable Status></td> </tr> <tr> <td>☐</td> <td><Variable First Name></td> <td><Variable Last Name></td> <td><Variable Phone Number></td> <td><Variable Status></td> </tr> </tbody> </table>				First Name	Last Name	Phone Number	Status	☐	<Variable First Name>	<Variable Last Name>	<Variable Phone Number>	<Variable Status>	☐	<Variable First Name>	<Variable Last Name>	<Variable Phone Number>	<Variable Status>	☐	<Variable First Name>	<Variable Last Name>	<Variable Phone Number>	<Variable Status>	☐	<Variable First Name>	<Variable Last Name>	<Variable Phone Number>	<Variable Status>	☐	<Variable First Name>	<Variable Last Name>	<Variable Phone Number>	<Variable Status>
	First Name	Last Name	Phone Number	Status																													
☐	<Variable First Name>	<Variable Last Name>	<Variable Phone Number>	<Variable Status>																													
☐	<Variable First Name>	<Variable Last Name>	<Variable Phone Number>	<Variable Status>																													
☐	<Variable First Name>	<Variable Last Name>	<Variable Phone Number>	<Variable Status>																													
☐	<Variable First Name>	<Variable Last Name>	<Variable Phone Number>	<Variable Status>																													
☐	<Variable First Name>	<Variable Last Name>	<Variable Phone Number>	<Variable Status>																													
<div style="float: right;">Add New HCP</div> <div> <input type="button" value="Edit"/> <input type="button" value="Delete"/> </div>																																	
1010	Associations																																
Click here for Full Prescribing Information																																	

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1.3.1 Add New Office Staff

☐ Healthcare Professionals - Practice Administrator

Logout

HI, <Variable Username>
User Guide

My Profile
 Location of Service
 HCP Profile
 Office Staff Profile

Important Safety Information
Full Subscribing Information

☐

First Name
<Variable First Name>
<Variable First Name>
<Variable First Name>
<Variable First Name>
<Variable First Name>

Last Name
<Variable Last Name>
<Variable Last Name>
<Variable Last Name>
<Variable Last Name>
<Variable Last Name>

1 2 3

Phone Number
<Variable Phone Number>
<Variable Phone Number>
<Variable Phone Number>
<Variable Phone Number>
<Variable Phone Number>

Status
<Variable Status>
<Variable Status>
<Variable Status>
<Variable Status>
<Variable Status>

* denotes a required field

First Name*:
 Last Name*:
 Work Number*:

Middle Initial:
Email Address*:
Cell Number:

Associations

Click here for Full Prescribing Information

FIG. 15

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1.4 Associations

☐ Healthcare Professionals - Practice Administrator

Hi, <Variable Username>
 User Guide

Logout

Important Safety Information
 Full Prescribing Information

1002

My Profile

1004

Location of Service

1006

HCP Profile

1008

Office Staff Profile

1010

Associations

Office Staff Name	Location of Service	Associated HCPs
☐ <Variable Office Staff Name>	<Variable Location of Service>	<Variable Associated HCPs>
☐ <Variable Office Staff Name>	<Variable Location of Service>	<Variable Associated HCPs>
☐ <Variable Office Staff Name>	<Variable Location of Service>	<Variable Associated HCPs>
☐ <Variable Office Staff Name>	<Variable Location of Service>	<Variable Associated HCPs>
1	2	3

Click here for Full Prescribing Information

FIG. 16

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1.4.1 New Association

☐ Healthcare Professionals - Practice Administrator

Logout

HI, <Variable Username>
[User Guide](#)

[Important Safety Information](#)
[Full Subscribing Information](#)

My Profile

Location of Service

HCP Profile

Office Staff Profile

Associations

	Office Staff Name	Location of Service	Associated HCPs
☐	<Variable Office Staff Name>	<Variable Location of Service>	<Variable Associated HCPs>
☐	<Variable Office Staff Name>	<Variable Location of Service>	<Variable Associated HCPs>
☐	<Variable Office Staff Name>	<Variable Location of Service>	<Variable Associated HCPs>
☐	<Variable Office Staff Name>	<Variable Location of Service>	<Variable Associated HCPs>

1

2

3

Edit

Delete

New Association

Select Office Staff:

-Select-

<Variable Location of Service>

<Variable Location of Service>

Location of Service:

>>

>

<

<<

HCPs:

<Variable HCPs>

<Variable HCPs>

<Variable HCPs>

<Variable HCPs>

<

>

Save

Cancel

Click here for [Full Prescribing Information](#)

FIG. 17

1600

20/110

2.0 MyProfile (HCP)

Health Care Professionals | Dashboard | New Patient | **My Profile** | Logout

Hi, <Variable Username>
User Guide

Intake >> Referral Submitted >> PA & BV Received >> PA/Rx Faxed to Insurance & Pharmacy >> End

Important Safety Information
Full Subscribing Information

My Profile

* denotes a required field

First Name*:

Last Name*:

User ID:

Work Number*:

Primary Specialty*:

Email Address*:

State License Number:

Issue State: SLN Expiry Date:

Middle Initial:

Designation:

Password*:

Cell Number:

NPI Number*:

Location of Service & DEA Number:

Associated Office Staff:

☒ Receive Updates via E-Mail

[Click here for Full Prescribing Information](#)

Signature

Save Cancel

Edit

FIG. 18

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2.3 Signature

1802

Health Care Professionals | Dashboard | New Patient | My Profile | Logout | Hi, <Variable Username> User Guide

Intake >> Referral Submitted >> PA & BV Received >> PA/Rx Faxed to Insurance & Pharmacy >> End

Important Safety Information
Full Subscribing Information

My Profile

1804 Signature

1900

You have registered to use the System to assist your patients. We thank-you for registering and we are looking forward to working with you. During your participation in the use of the System, there may be times when the System will need to apply your signature to:

1. Pharmacy Referral documents
2. Prescription documents
3. Insurance Prior Authorization documents

In order to decrease the time and inconvenience of obtaining your hand-signed signature each time a document in the System requires your signature, we will electronically capture and store your signature and then apply it electronically when you want to sign a document. Please be advised that the System will not utilize your signature in any other manner. You will be prompted to enter your unique User Name and Password each time before your signature is applied to confirm your intention and act of signature.

Capture the signature

<Variable HCP signature images>

By clicking the save button below, I hereby authorize the System to capture and store an electronic copy of my signature so that I can use it to electronically sign documents in the System instead of signing each one by hand, subject to the conditions of use listed above.

Click here for [Full Prescribing Information](#)

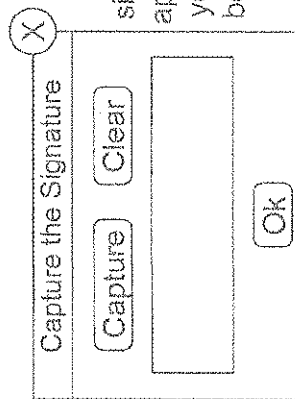
Save Cancel

FIG. 19

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2.4 Signature Capture

<input type="button" value="Health Care Professionals"/> <input type="button" value="Dashboard"/> <input type="button" value="New Patient"/> <input type="button" value="My Profile"/> <input type="button" value="Logout"/>	Hi, <Variable Username> User Guide
<input type="button" value="Intake"/> <input type="button" value="Referral Submitted"/> <input type="button" value="PA & BV Received"/> <input type="button" value="PA/Rx Faxed to Insurance & Pharmacy"/> <input type="button" value="End"/>	Important Safety Information Full Subscribing Information
My Profile	
Signature	
<p>You have registered to use the System to assist your patients. We thank-you for registering and we are looking forward to working with you. During your participation in the use of the System, there may be times when the System will need to apply your signature to:</p> <ol style="list-style-type: none"> 1. Pharmacy Referral documents 2. Prescription documents 3. Insurance Prior Authorization documents <p>In order to decrease the time and inconvenience of the System requires your signature, we will electronically capture and then apply it electronically your signature in any other manner. You will be prompted to enter your unique User Name and confirm your intention and act of signature.</p> <div style="border: 1px solid black; padding: 5px; margin: 10px auto; width: fit-content;"> <input type="button" value="Capture the signature"/> </div> <p><Variable HCP signature images></p> <p>By clicking the save button below, I hereby authorize the System to capture and store an electronic copy of my signature so that I can use it to electronically sign documents in the System instead of signing each one by hand, subject to the conditions of use listed above.</p> <p>Click here for Full Prescribing Information</p> <div style="text-align: right;"> <input type="button" value="Save"/> <input type="button" value="Cancel"/> </div>	



signature each time a document is
 apture and then apply it electronically
 your signature in any other manner.
 before your signature is applied to

2000

FIG. 20

23/110

1802

3.0 My Profile

☐ Health Care Professionals	☐ Dashboard	☐ New Patient	☐ My Profile	☐ Logout	HI, <Variable Username> User Guide
--	------------------------------------	--------------------------------------	-------------------------------------	---------------------------------	---------------------------------------

Intake	Referral Submitted	PA & BV Received	PA/Rx Faxed to Insurance & Pharmacy	End
--------	--------------------	------------------	-------------------------------------	-----

[Important Safety Information](#)
[Full Prescribing Information](#)

My Profile

* denotes a required field

First Name*:	<input type="text"/>
Last Name*:	<input type="text"/>
User ID:	<input type="text"/>
Work Number*:	<input type="text"/>
Primary Specialty*:	<input type="text"/>
Email Address*:	<input type="text"/>

Location of Service & DEA Number:	<input type="text"/>
-----------------------------------	----------------------

☐ Receive Updates via E-Mail

Middle Name:	<input type="text"/>
Password*:	<input type="password"/>
Cell Number:	<input type="text"/>

Associated HCPs:	<input type="text"/>
HCPs Authorized to Sign:	<input type="text"/>

[Click here for Full Prescribing Information](#)

FIG. 21

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4.0 Dashboard 2210

Health Care Professionals 2200

Dashboard | New Patient | My Profile | Logout

Hi, <Variable Username>
User Guide

Intake > Referral Submitted > PA & BV Received > PA/Rx Faxed to Insurance & Pharmacy > End

Important Safety Information
Full Subscribing Information

Search for Patient:

View Summary 2212

Name	Created Date	Status	Days since last update	Delete
<Variable Patient Name>	<Variable Created Date>	Patient Intake - In Progress	0 days ago	X
<Variable Patient Name>	<Variable Created Date>	Patient Intake - In Progress	3 days ago	X
<Variable Patient Name>	<Variable Created Date>	Patient Intake - In Progress	3 days ago	X

Open Referral

Name	Created Date	Status	Days since last update	Pending Action
<Variable Patient Name>	<Variable Created Date>	PA & BV Received	0 days ago	Fill PA Form
<Variable Patient Name>	<Variable Created Date>	PA Submitted to Insurance	0 days ago	Update Status
<Variable Patient Name>	<Variable Created Date>	Referral Submitted	0 days ago	
<Variable Patient Name>	<Variable Created Date>	Referral Submitted	0 days ago	
<Variable Patient Name>	<Variable Created Date>	Referral Submitted	1 days ago	
<Variable Patient Name>	<Variable Created Date>	PA & BV Received	1 days ago	Fill PA Form
<Variable Patient Name>	<Variable Created Date>	Referral Submitted	0 days ago	
<Variable Patient Name>	<Variable Created Date>	PA & BV Received	1 days ago	Fill PA Form

Closed

Name	Created Date	Status
<Variable Patient Name>	<Variable Created Date>	Successfully Filled

FIG. 22

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4.6 Signature Required

HLINK

Hi, <Variable User Name> | LOGOUT

DASHBOARD NEW PATIENT MY PROFILE HELP

HEALTH CARE PROFESSIONALS IMPORTANT SAFETY INFORMATION FULL PRESCRIBING INFORMATION

SEARCH

View Summary

SIGNATURE REQUIRED (1) PATIENT INTAKE (1) SUBMITTED FOR BENEFITS (1) READY FOR PA (1) READY FOR RX (1) RX SENT (1) CLOSED (1)

Patient Name	PA Status	Rx Status	Pharmacy	Created Date	Last Updated	Patient Services	Update Status
<Patient Name>	<PA Status>	<Rx Status>	<Pharmacy Name>	<Created Date/Time>	<# Days ago>		
<Patient Name>	<PA Status>	<Rx Status>	<Pharmacy Name>	<Created Date/Time>	<# Days ago>		

FIG. 22B

26/110

4.1 Summary Dashboard

<input type="text"/> Health Care Professionals		<input type="button" value="Dashboard"/>		<input type="button" value="New Patient"/>		<input type="button" value="My Profile"/>		<input type="button" value="Logout"/>		Hi, <Variable Username> User Guide																																																	
<input type="button" value="Intake"/>		<input type="button" value="Referral Submitted"/>		<input type="button" value="PA & BV Received"/>		<input type="button" value="PA/Rx Faxed to Insurance & Pharmacy"/>		<input type="button" value="End"/>		Important Safety Information Full Subscribing Information																																																	
Search for Patient: <input type="text"/>										<input checked="" type="button" value="X"/> View Summary																																																	
<div> <div>Summary Dashboard</div> <table border="1"> <thead> <tr> <th colspan="4">Number of Referral</th> <th colspan="4">Processing Time</th> </tr> <tr> <th>Intake</th> <th>Referral Submitted</th> <th>PA/BV Received</th> <th>PA Closed</th> <th>Referral Submitted</th> <th>PA/BV Received</th> <th>PA Closed</th> <th></th> </tr> </thead> <tbody> <tr> <td>This week</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> </tr> <tr> <td>Last 30 days</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> </tr> <tr> <td>Last 90 days</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> </tr> <tr> <td>Till Date</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> </tr> </tbody> </table> </div>												Number of Referral				Processing Time				Intake	Referral Submitted	PA/BV Received	PA Closed	Referral Submitted	PA/BV Received	PA Closed		This week	0	0	0	0	0	0	0	Last 30 days	0	0	0	0	0	0	0	Last 90 days	0	0	0	0	0	0	0	Till Date	0	0	0	0	0	0	0
Number of Referral				Processing Time																																																							
Intake	Referral Submitted	PA/BV Received	PA Closed	Referral Submitted	PA/BV Received	PA Closed																																																					
This week	0	0	0	0	0	0	0																																																				
Last 30 days	0	0	0	0	0	0	0																																																				
Last 90 days	0	0	0	0	0	0	0																																																				
Till Date	0	0	0	0	0	0	0																																																				
<div> <div> <div>Intake</div> <div> <div>Name</div> <div> <div><Variable Patient Name></div> <div><Variable Patient Name></div> <div><Variable Patient Name></div> </div> </div> </div> <div> <div>Open Referral</div> <div> <div>Name</div> <div> <div><Variable Patient Name></div> <div><Variable Patient Name></div> <div><Variable Patient Name></div> <div><Variable Patient Name></div> <div><Variable Patient Name></div> <div><Variable Patient Name></div> <div><Variable Patient Name></div> <div><Variable Patient Name></div> </div> </div> </div> </div>																																																											
<div> <div> <div>ast update</div> <div>Delete</div> </div> <div> <div>X</div> <div>X</div> <div>X</div> </div> </div>																																																											
<div> <div>ast update</div> <div>Pending Action</div> </div> <div> <div><input type="button" value="Fill PA Form"/></div> <div><input type="button" value="Update Status"/></div> </div>																																																											
<div> <div><input type="button" value="Fill PA Form"/></div> </div>																																																											
<div> <div><input type="button" value="Fill PA Form"/></div> </div>																																																											

FIG. 23

2300

27/110

5.0 New Patient

2402

Health Care Professionals

Dashboard

New Patient

My Profile

Logout

HI, <Variable Username>
User Guide

Intake

Referral Submitted

PA & BV Received

PA/Rx Faxed to Insurance & Pharmacy

End

Important Safety Information

Full Subscribing Information

Close

2404

Patient Information

Step 1 of 6

2406

Insurance Information

Step 2 of 6

2408

HCP Information

Step 3 of 6

2410

Diagnosis Information

Step 4 of 6

2412

Patient Contact Information

Step 5 of 6

2414

HCP Decisions & Signature

Step 6 of 6

FIG. 24

Scholarship

A detailed diagram of a cell with various organelles labeled with letters A through Z. The labels are as follows:

- A: Nucleus
- B: Nuclear envelope
- C: Nuclear pore
- D: Rough endoplasmic reticulum
- E: Smooth endoplasmic reticulum
- F: Golgi apparatus
- G: Mitochondrion
- H: Chloroplast
- I: Centrioles
- J: Lysosome
- K: Peroxisome
- L: Vacuole
- M: Tonoplast
- N: Plasma membrane
- O: Cell wall
- P: Microvilli
- Q: Flagellum
- R: Cilia
- S: Cytoplasm
- T: Cytoskeleton
- U: Ribosome
- V: Spindle fiber
- W: Spindle pole
- X: Spindle plate
- Y: Spindle equator
- Z: Spindle axis

[DASHBOARD](#) [NEW PATIENT](#) [MY PROFILE](#) [HELP](#)

LOGOUT

LOGOUT

HEALTH CARE PROFESSIONALS	IMPORTANT SAFETY INFORMATION	FULL PRESCRIBING INFORMATION
<p>PATIENT INFORMATION</p> <p>*denotes a required field</p> <p>Scan patient's drivers license or type in the patient's demographics manually.</p> <div style="margin-top: 20px;">  <div style="border: 1px solid black; padding: 5px; display: inline-block; margin-left: 10px;">Scan</div> </div> <hr/> <p>Scanned Image</p>	<p>INSURANCE INFORMATION > HCP INFORMATION > DIAGNOSIS INFORMATION</p> <p>Name* <input type="text"/> <input type="text"/> <input type="text"/></p> <p>Gender* Male ☐ Female ☐</p> <p>Date of Birth* <input type="text"/> </p> <p style="padding-left: 150px;">mm/dd/yyyy</p> <p>Address* <input type="text"/> <input type="text"/> <input type="text"/></p> <p>City* <input type="text"/></p> <p>State* <input type="text"/>-<input type="text"/> Zip* <input type="text"/></p> <p>Drug Allergies <input type="text"/></p> <p>Preferred Phone Number* <input type="text"/> <input type="text"/> <input type="text"/> -Select-</p> <p>Secondary Phone Number <input type="text"/> <input type="text"/> <input type="text"/> -Select-</p>	
<div style="border: 1px solid black; padding: 5px; display: inline-block;">CONTINUE</div>		

Phone Number Options:

▶	—Select—	
	—Select—	
	Work	
	Home	
	Cell	





 ✱



 1888



5.1 Patient Information

Health Care Professionals | Dashboard | **New Patient** | My Profile | Logout | Hi, <Variable Username>
User Guide

Intake >> Referral Submitted >> PA & BV Received >> PA/Rx Faxed to Insurance & Pharmacy >> End

Patient Information [Close]

Step 1 of 6

Scan patient's drivers license or type in the patient's demographics manually.

Scan
Scanned image

Name*:

Gender*: ☐ Male ☐ Female

Date of Birth*:

Address*:

City*:

State*: Zip*:

[Continue >]

- Insurance Information Step 2 of 6
- HCP Information Step 3 of 6
- Diagnosis Information Step 4 of 6
- Patient Contact Information Step 5 of 6
- HCP Decisions & Signature Step 6 of 6

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30/110

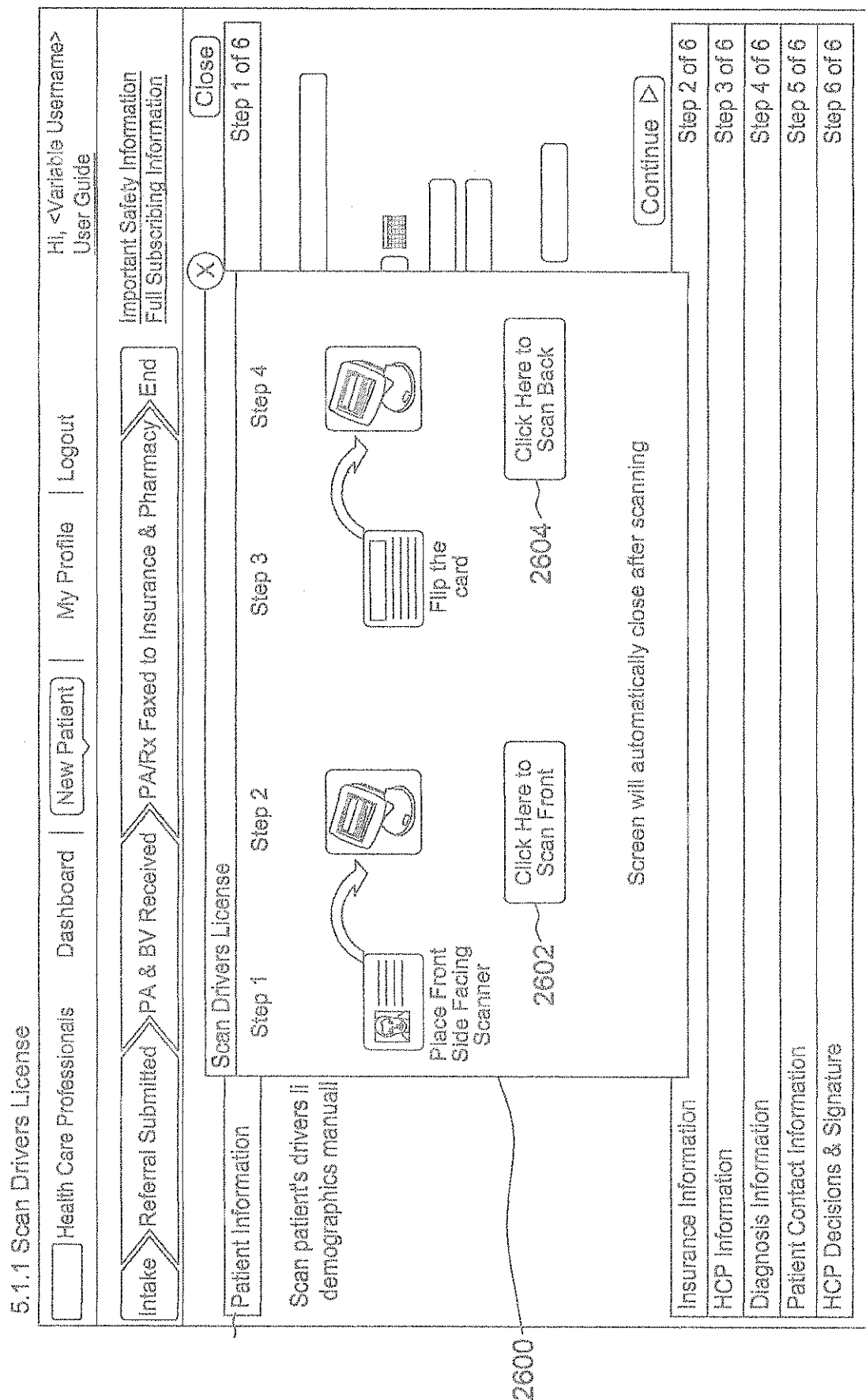


FIG. 26

31/11/10

5.1.2a Display Duplicate Profile

Health Care Professionals	Dashboard	New Patient	My Profile	Logout	Hi, <Variable Username> User Guide
---------------------------	-----------	-------------	------------	--------	---------------------------------------

Intake	Referral Submitted	PA & BV Received	PA/Rx Faxed to Insurance & Pharmacy	End
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Important Safety Information Full Subscribing Information	
Insurance Information	Step 2 of 6
HCP Information	Step 3 of 6
Diagnosis Information	Step 4 of 6
Patient Contact Information	Step 5 of 6
HCP Decisions & Signature	Step 6 of 6

Patient Information Scan patient's driver demographics ma	Display Duplicate Profile <div style="border: 1px solid black; padding: 10px;"> <Variable Identification Card Image> </div>
--	---

Name: <input type="text"/> Gender: ☐ Male ☐ Female Date of Birth: <input type="text"/> Address: <input type="text"/> City: <input type="text"/> State: <input type="text"/> Zip: <input type="text"/>	<input type="button" value="Close"/> Step 1 of 6
--	---

<input type="button" value="Use Patient Profile"/> <input type="button" value="Ignore Patient Profile"/>
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2025

5.2 Insurance Information

Health Care Professionals

Dashboard

Intake > Referral Submitted > PA & BV Received > PA/Rx Faxed to Insurance & Pharmacy > End

2200

2400

1802

My Profile

Logout

Hi, <Variable Username>

User Guide

Important Safety Information

Full Subscribing Information

Close

2406

2800

2802

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Patient Information

Insurance Information

Scan patient's prescription/medical insurance card(s) or type in patient insurance information manually.

Prescription Insurance Card

Patient Name: [Text Box]

Policy Holder ID: [Text Box]

Rx BIN: [Text Box]

Rx GRP: [Text Box]

Rx PCN: [Text Box]

Issuer: [Text Box]

Medical Insurance Card

Patient Name: [Text Box]

Policy Holder Name: [Text Box]

Policy Holder ID: [Text Box]

Payer ID: [Text Box]

Group Number: [Text Box]

Card Holder ID: [Text Box]

Plan Number: [Text Box]

Secondary Medical Insurance Card

Patient Name: [Text Box]

Policy Holder Name: [Text Box]

Policy Holder ID: [Text Box]

Payer ID: [Text Box]

Group Number: [Text Box]

Card Holder ID: [Text Box]

Plan Number: [Text Box]

Protection Plan Card

Rx ID: [Text Box]

Rx BIN: [Text Box]

Rx GRP: [Text Box]

Rx PCN: [Text Box]

SUF: [Text Box]

Scanned Image

Scanned Image

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Add Medical Insurance Card

HCP Information

Diagnosis Information

Patient Contact Information

HCP Decisions & Signature

Add Protection Plan Card

Continue >

Step 1 of 6

Step 2 of 6

Step 3 of 6

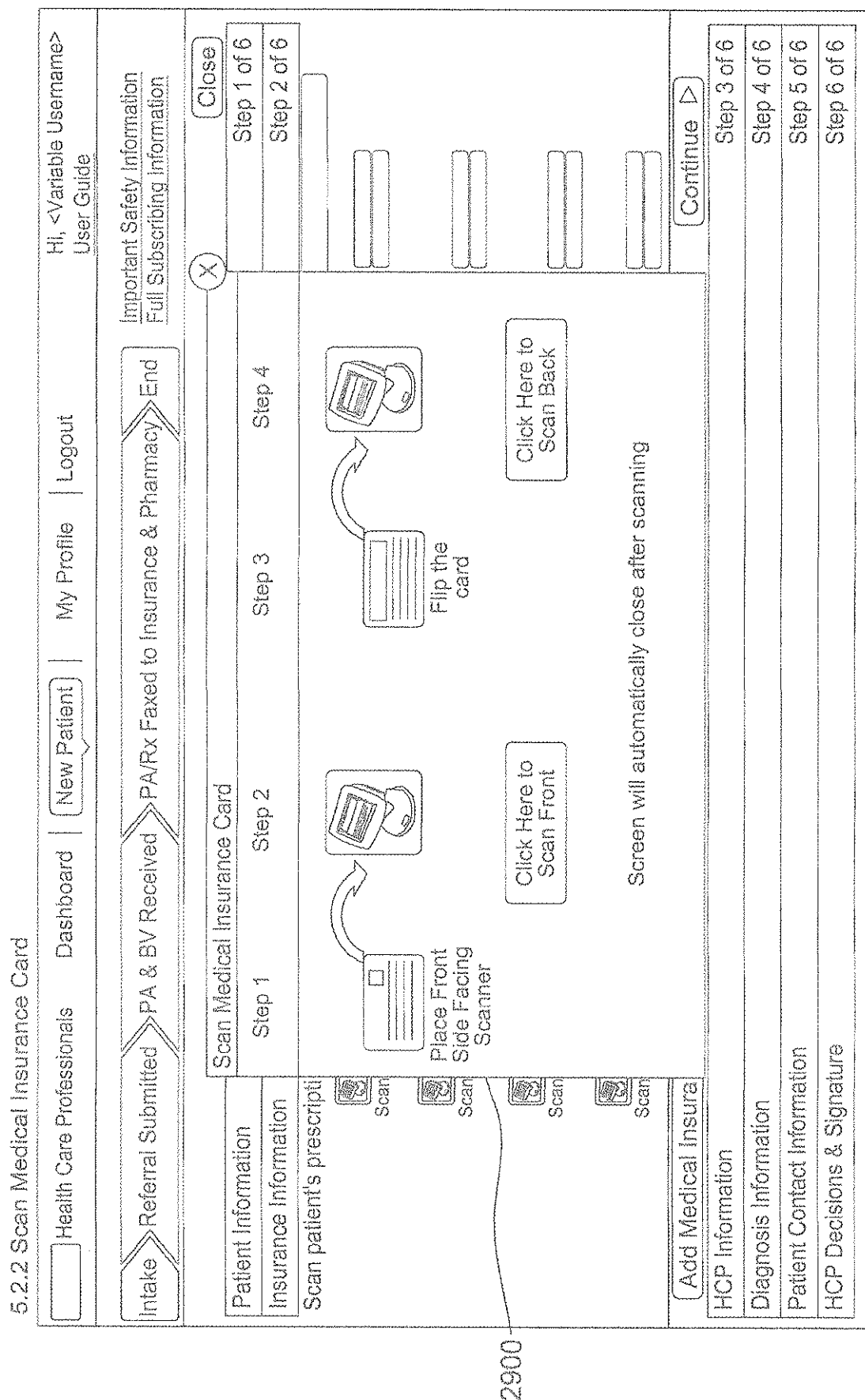
Step 4 of 6

Step 5 of 6

Step 6 of 6

FIG. 28

33/10



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5.3 HCP Information

Health Care Professionals

Dashboard

New Patient

My Profile

Logout

Hi, <Variable Username>
User Guide

Intake

Referral Submitted

PA & BV Received

PA/Rx Faxed to Insurance & Pharmacy

End

Important Safety Information

Full Subscribing Information

Close

Step 2 of 6

Step 3 of 6

Patient Information

HCP Information

Select Location of Service and HCP

Location of Service: -Select-

HCP Name: <Variable Name>

HCP Name

Specialty

Designation

State License Number

NPI Number

DEA Number

Office

Contact

Email

Continue

Step 4 of 6

Step 5 of 6

Step 6 of 6

Diagnosis Information

Patient Contact Information

HCP Decisions & Signature

FIG. 30

3000

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5.4 Diagnosis Information

Health Care Professionals | Dashboard | **New Patient** | My Profile | Logout | HI, <Variable Username> User Guide

Intake > Referral Submitted > PA & BV Received > PA/Rx Faxed to Insurance & Pharmacy > End

Important Safety Information
Full Subscribing Information

Close

Patient Information Step 2 of 6

HCP Information Step 3 of 6

Diagnosis Information Step 4 of 6

Select patient's diagnosis and dosing for DRUG(H)

INDICATIONS¹

* _____

* _____

* _____

* _____

SPECIALTY: ☒ -Select- Prescription: ☐ -Select-

3104

SAFETY CONSIDERATIONS¹

Serious Infections

* _____

Malignancies

* _____

Other Serious Adverse Reactions

* _____

Click here for Full Prescribing Information ~ 3102

Reference¹ _____

Continue >

Patient Contact Information Step 5 of 6

HCP Decisions & Signature Step 6 of 6

FIG. 31

3100

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3104

Rheumatology

HCP Information		Step 3 of 6	
Diagnosis Information		Step 4 of 6	
Select patient's diagnosis and dosing for <u>DRUG(H)</u>		Specialty: ☒ Rheumatology	Prescription: ☐ -Select- ☒ -Select-
Patient's Diagnosis		New Continuing	
☐ Rheumatoid Arthritis [RA] (714.0) ☐ Psoriatic Arthritis [PSA] (696.0) ☐ Other (Include Code)		☐ Ankylosing Spondylitis [AS] (720.0) ☐ Polyarticular Juvenile Idiopathic Arthritis [JIA]	
Dosing Mode	Rheumatoid Arthritis, Ankylosing Spondylitis, and Psoriatic Arthritis, Polyarticular JIA, weight is ≥ 30 kg (66 lbs.) for 4 years of age and older	Quantity (Pen/Syringe)	Refills
☐ ☒ -Select- ☒		☐ -Select- ☒	☐
Any Other Dosing			
☐ ☒ -Select- ☒	☒ ☒ SIG ☐	Quantity (Pen/Syringe)	Refills
☐ ☒ -Select- ☒		☐ ☒	☐

INDICATIONS¹

- Rheumatoid Arthritis: _____
- _____
- Juvenile Idiopathic ...: _____
- _____

SAFETY CONSIDERATIONS¹

- Serious Infections _____
- Malignancies _____
- Other Serious Adverse Reactions _____
- _____

Click here for Full Prescribing Information ~ 3102

Reference¹ _____

FIG. 32

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Rheumatology - Pen is selected		Intake Referral Submitted PA & BV Received PA/Rx Faxed to Insurance & Pharmacy End		Important Safety Information Full Subscribing Information	
Patient Information		Step 1 of 6			
Insurance Information		Step 2 of 6			
HCP Information		Step 3 of 6			
Diagnosis Information		Step 4 of 6			
Select patient's diagnosis and dosing for DRUG(H) Patient's Diagnosis				Specialty: Rheumatology Prescription: -New-	
☐ Rheumatoid Arthritis [RA] (714.0) ☐ Psoriatic Arthritis [PSA] (696.0) ☐ Other (Include Code)		☐ Ankylosing Spondylitis [AS] (720.0) ☐ Polyarticular Juvenile Idiopathic Arthritis [JIA] (714.30)			
Dosing Model: Rheumatoid Arthritis, Ankylosing Spondylitis, and Psoriatic Arthritis, Polyarticular JIA, weight is $\geq$ 30 kg (66 lbs.) for 4 years of age and older		DRUG(H) Pen 40 mg/0.8 mL NDC - 0074-4339-02		Quantity (Pen/Syringe) <input type="text" value="2"/> <input type="text" value="6"/>	
☐ Pen		40 mg SC inj. every other week		Refills <input type="text"/>	
☐ -Select-		Any Other Dosing		Refills <input type="text"/>	

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HEALTH CARE PROFESSIONALS		IMPORTANT SAFETY INFORMATION		FULL PRESCRIBING INFORMATION	
<p>HiLink</p> <p>DASHBOARD NEW PATIENT MY PROFILE HELP</p> <p>△ Hi, <Variable User Name> LOGOUT</p>		<p> <input type="button" value="PATIENT INFORMATION"/> <input type="button" value="INSURANCE INFORMATION"/> <input type="button" value="HCP INFORMATION"/> <input type="button" value="DIAGNOSIS INFORMATION"/> <input type="button" value="CLOSE"/> </p>			
<p>*denotes a required field</p> <p>Select patient's primary diagnosis and dosing for HUMIRA® (adalimumab).</p> <p>Patient's Primary Diagnosis*</p> <p> ☐ Crohn's Disease-Regional enteritis of small intestine (555.0) ☐ Crohn's Disease-Regional enteritis of small intestine with large intestine (555.2) ☐ Other (include Code) * </p> <p> ☐ Crohn's Disease-Regional enteritis of large intestine (555.1) ☐ Crohn's Disease-Regional enteritis of unspecified site (555.9) </p>					
<p>Prescription* <input type="button" value="--Select--"/></p> <p>Specialty* <input type="button" value="Gastroenterology"/></p>					
<p>☒ Starting Therapy for Moderate to Severe Crohn's Disease</p>		<p>Quantity (Pen/Syringe)</p> <p><input type="text" value="6"/></p>		<p>Refills</p> <p><input type="text" value="No"/></p>	
<p>☐ Crohn's Disease Starter Package HUMIRA® (adalimumab) Pen 40mg/0.8mL NDC-0074-4339-06</p>		<p> <input type="button" value="--Select--"/> <input type="button" value="--Select--"/> Two 40mg SC inj. Day 1, Two 40mg SC inj. Day 2, Two 40mg SC inj. Day 15 </p>			
<p>☐ Ongoing Therapy for Moderate to Severe Crohn's Disease</p>		<p>Quantity (Pen/Syringe)</p> <p><input type="button" value="--Select--"/></p>		<p>Refills</p> <p><input type="text" value="No"/></p>	
<p>☐ Any Other Dosing</p>		<p>Quantity (Pen/Syringe)</p> <p><input type="text" value="SC"/></p>		<p>Refills</p> <p><input type="text" value=""/></p>	

FIG. 33B-1

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INDICATIONS¹

- Rheumatoid Arthritis: HUMIRA is indicated, alone or in combination with methotrexate or other non-biologic DMARDs, for reducing signs and symptoms, inducing major clinical response, inhibiting the progression of structural damage, and improving physical function in adult patients with moderately to severely active rheumatoid arthritis.
- Juvenile Idiopathic Arthritis: HUMIRA is indicated, alone or in combination with methotrexate, for reducing signs and symptoms of moderately to severely active polyarticular juvenile idiopathic arthritis in pediatric patients 4 years of age and older.
- Psoriatic Arthritis: HUMIRA is indicated, alone or in combination with non-biologic DMARDs, for reducing signs and symptoms, inhibiting the progression of structural damage, and improving physical function in adult patients with active psoriatic arthritis.
- Ankylosing Spondylitis: HUMIRA is indicated for reducing signs and symptoms in adult patients with active ankylosing spondylitis.
- Crohn's Disease: HUMIRA is indicated for reducing signs and symptoms and inducing and maintaining clinical remission in adult patients with moderately to severely active Crohn's disease who have had an inadequate response to conventional therapy, and reducing signs and symptoms and inducing clinical remission in these patients if they have also lost response to or are intolerant to infliximab.

FIG. 33B-2

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5.4.2 Refer to Approved Indications

Insurance Information	Step 2 of 6		
HCP Information	Step 3 of 6		
Diagnosis Information	Step 4 of 6		

Select patient's diagnosis and dosing for DRUG(H) Specialty: Rheumatology Prescription: -Select-

Patient's Diagnosis

☐ Rheumatoid Arthritis [RA] (714.0) ☐ Ankylosing Spondylitis [AS] (720.0)
☐ Psoriatic Arthritis [PSA] (696.0) ☐ Polyarticular Juvenile Idiopathic Arthritis [JIA] (714.30)
☒ Other (Include Code)

Refer Approved Indications

Please refer to the DRUG(H) Prescribing information for approved indications

Click here for Full Prescribing Information

Ok

Dosing Mode	Quantity (Pen/Syringe)	Refills
☐ Rheumatoid Arthritis [RA] (714.0) ☐ Psoriatic Arthritis [PSA] (696.0) ☒ Other (Include Code)	-Select- <input type="button" value="v"/>	<input type="text"/>
☐ Juvenile Idiopathic Arthritis [JIA], weight is ≥ 3	-Select- <input type="button" value="v"/>	<input type="text"/>

INDICATIONS¹

☐ Rheumatoid Arthritis: _____
☐ Juvenile Idiopathic Arthritis: _____

SAFETY CONSIDERATIONS¹

Serious Infections _____

Malignancies _____

Other Serious Adverse Reactions _____

FIG. 34

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5.5 Patient Contact Information

Intake
Referral Submitted
PA & BV Received
PA/Rx Faxed to Insurance & Pharmacy
End

Important Safety Information
Full Subscribing Information

Close

Step 1 of 6
Patient Information

Step 2 of 6
Insurance Information

Step 3 of 6
HCP Information

Step 4 of 6
Diagnosis Information

Step 5 of 6
Patient Contact Information

To complete prescription, the patient's home phone number is required.

* denotes a required field

Best Phone Number to Reach Patient*

Alternative Phone Number to Reach Patient

Click here for Full Prescribing Information

Continue

HCP Decisions & Signature
Step 6 of 6

FIG. 35

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5.6 Welcome Page

Intake
Referral Submitted
PA & BV Received
PA/Rx Faxed to Insurance & Pharmacy
End

Important Safety Information
Full Subscribing Information

Hello, <Variable User Name>

Would you like to use the following screens to discuss optional services with your patient, <Variable Patient Name>?

Yes
Skip

FIG. 36

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5.6.2 Patient Welcome Page

Dear <Variable User Name>,

You have just been working with your Health Care Professional office to obtain a prescription. Within the next 2 business days, a pharmacy called <Pharmacy Name> is going to call you to discuss your prescription, explain your insurance coverage, and find out where you'd like to get your prescription filled. Please expect this important phone call.

We also want to make you aware of some optional product support services offered by the manufacturer of the product you have been prescribed. Many patients find these services helpful when beginning treatment. These services are offered by the manufacturer and not by your Health Care Professional and you do not need to use them to receive your prescription. All of these services are available at no additional charge to you.

If you are interested, please press "Get Started" and you'll be able to enroll in just a few minutes. If you are not interested at this time, please press "Not Right Now".

FIG. 37

3700

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5.8 myDRUG Information

Important Safety Information	Patient Instructions for Use of Pen	Patient Instructions for Use of Syringe	Full Prescribing Information	Medication Guide
<p>The <u>myDRUG</u> program provides a wide range of services to give you the care and support you deserve throughout treatment - all at no additional cost to you:</p> <p>Benefits include:</p> <ul style="list-style-type: none"> • Registered nurses who can show you how to perform an injection. • Ability to reach an on-call registered nurse, even after hours when your doctor's office may be closed • Pen or syringe disposal service. • Ongoing helpful information about <u>myDRUG</u>, our services, and your condition <p>Please click here for additional <u>Important Safety Information</u></p> <p>Click here for <u>Full Prescribing Information</u>, including the <u>Medication Guide</u> and discuss with your doctor.</p> <p>Would you like to enroll in <u>myDRUG</u>? An Email address is required. If you do not have an email address, call 1-800-xxxxxx for registration.</p> <div> <input type="button" value="No, Thank you"/> <input type="button" value="Yes, I want to enroll"/> </div>				

3800

3802

FIG. 38

45/110

5.9 myDRUG Consent

Important Safety Information	Patient Instructions for Use of Pen	Patient Instructions for Use of Syringe	Full Prescribing Information	Medication Guide
--	---	---	--	----------------------------------

myDRUG Consent

X

I am aware that my Health Care Professional will be releasing my health information to DRUGCO for the purpose of receiving information about my condition, DRUG(H), the myDRUG program and myDRUG services, and other DRUGCO treatments, products, and services.

The health information to be released will be limited to the following:

Name

Address

Telephone number

Email Address

Diagnosis

Date of Birth

Gender

I understand that the information I have provided will be used only DRUGCO and its contracted...

Please click here for additional [Important Safety Information](#)

Click here for [Full Prescribing Information](#), including the [Medication Guide](#) and discuss with your doctor.

Agree

Decline

3900

FIG. 39

SUBSTITUTE SHEET (RULE 26)

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Home	Important Safety Information	Patient Instructions For Use	Full Prescribing Information	Medication Guide	Close
 myHUMIRA Treatment Tools <div data-bbox="300 324 379 492" style="float: right; text-align: right;"> HUMIRA® adalimumab </div>					
To receive the treatment tools you selected, please provide us with your information *=mandatory field					
<div style="display: flex; justify-content: space-between;"> <div style="width: 48%;"> <p>I am aware that my Health Care Provider will be releasing my health information to Abbott for the purpose of receiving marketing information about my condition, HUMIRA (adalimumab), the myHUMIRA program and myHUMIRA services, and other Abbott treatments, products and services.</p> <p>The health information to be released will be limited to the following:</p> <p>Name <input type="text" value="Smith"/></p> <p>Address <input type="text" value="JSmith@email.com"/></p> <p>Telephone number <input type="text"/></p> <p>Email Address <input type="text" value="JSmith@email.com"/></p> <p>Diagnosis <input type="text"/></p> <p>Date of Birth <input type="text"/></p> <p>Gender ☒ Male ☐ Female</p> </div> <div style="width: 48%;"> <p>I understand that the information I've provided will be used only by HUMIRA and its contracted third parties to mail (and email) me helpful information on rheumatoid arthritis, Crohn's disease and/or plaque psoriasis and related treatments, products and services, and for marketing and informational purposes. HUMIRA will not sell or transfer my name or contact information to any third party their marketing use. To be removed from our mailing list or to request a copy of this information, contact 800.888.6260.</p> <p>I understand that the information I have provided will be used only by Abbott and its contracted third parties to contact me by mail, email and phone with helpful information about my condition, HUMIRA (adalimumab), the myHUMIRA program, and other Abbott treatments, products and services. Abbott will not sell or transfer my name or contact information to any third party for their marketing use. To be removed from our mailing list or to receive a copy of this information, please contact 800.888.6260. I understand that information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer protected by HIPAA.</p> <p>I understand that I will not be denied services if I decline to enroll in the myHUMIRA program.</p> <div data-bbox="1220 380 1316 638" style="text-align: center; border: 1px solid black; padding: 10px; margin-top: 20px;"> Agree </div> </div> </div>					

FIG. 39B

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5.10 myDRUG Sign-up

Important Safety Information	Patient Instructions for Use of Pen	Patient Instructions for Use of Syringe	Full Prescribing Information	Medication Guide
<div> <div>myDRUG Sign-up</div> <div> <div>Review and add information.</div> <div> <div>Name*: <input type="text"/></div> <div>Gender*: ☐ Male ☐ Female</div> <div>Date of Birth*: <input type="text"/></div> <div>Address*: <input type="text"/></div> <div>City*: <input type="text"/></div> <div>State*: <input type="text"/></div> <div>Zip*: <input type="text"/></div> <div>Phone Number*: <input type="text"/></div> <div>Diagnosis*: <input type="text"/></div> <div>Email*: <input type="text"/></div> <div>Confirm Email*: <input type="text"/></div> </div> </div> <div> <div>Please click here for additional Important Safety Information</div> <div>Click here for Full Prescribing Information, including the Medication Guide and discuss with your doctor.</div> <div>I understand that the information I have provided will be used only DRUGCO and its contracted...</div> <div> <div>Skip registration</div> <div>Submit</div> </div> </div> </div>				

4002

4000

FIG. 40

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5.12 HCP Decisions & Signature

Health Care Professionals	Dashboard	New Patient	My Profile	Logout	Hi, <Variable Username> User Guide
---	---------------------------	-----------------------------	----------------------------	------------------------	---

Intake Referral Submitted PA & BV Received PA/Rx Faxed to Insurance & Pharmacy End	Important Safety Information Full Subscribing Information
--	--

Close

Patient Information	Step 1 of 6
Insurance Information	Step 2 of 6
HCP Information	Step 3 of 6
Diagnosis Information	Step 4 of 6
Patient Contact Information	Step 5 of 6
HCP Decisions & Signature	Step 6 of 6

A. Confirm	
HCP Name <Variable HCP Name> Location <Variable Location> <Variable City, State, Zip Code>	Specialty <Variable Specialty> NPI Number <Variable NPI Number> Contact <Variable Contact>
Designation <Variable Designation> DEA Number <Variable DEA Number> Email <Variable Email Address>	
B. Complete Drug Allergies	
C. Choose	
☐ Dispense as written/Do not substitute ☐ Substitution permitted/Brand exchange permitted	☐ Hold prescription & run a benefit verification only ☐ Nursing Services (RN) to provide subcutaneous injection training including administration by Nurse (RN)
D. Signature	View Rx Document for <Variable Patient Name>

Attach Signature Click here for Full Prescribing Information .	Submit for Referral
---	-------------------------------------

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5.12.1 Signature Authentication

	Health Care Professionals Dashboard New Patient My Profile Logout	Hi, <Variable Username> User Guide
--	---	---------------------------------------

Intake >> Referral Submitted >> PA & BV Received >> PA/Rx Faxed to Insurance & Pharmacy >> End	Close
--	-----------------------

Patient Information

Insurance Information

HCP Information

Diagnosis Information

Patient Contact Information

HCP Decisions & Signature

A. Confirm
HCP Name <Variable HCP Name>
Location <Variable Location>
<Variable City, State, Zip>

B. Complete Drug Allergies _____

C. Choose
☐ Dispense as written/Do not substitute
☐ Substitution permitted/Brand exchange permitted

D. Signature

Signature Authentication

Enter your login credentials to insert HCP's signature

User Name:

Password:

[Submit](#)

Designation <Variable Designation>
DEA Number <Variable DEA Number>
Email <Variable Email Address>

[Attach Signature](#)

☐ Hold prescription & run a benefit verification only
☐ Nursing Services (RN) to provide subcutaneous injection training including administration by Nurse (RN)

[View Rx Document for <Variable Patient Name>](#)

[Submit for Referral](#)

Click here for Full Prescribing Information.

0000

24

5.12.2 PS Referral Form

50/110

4300

RHEUMATOLOGY																					
DRUG REFERRAL AND PRESCRIPTION FORM FOR QUESTIONS, PLEASE CALL (888) XXX-XXXX																					
PATIENT AND PRESCRIBER INFORMATION	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 50%;">PATIENT INFORMATION</th> <th style="width: 50%;">PRESCRIBER INFORMATION ☐ MD ☐ DO ☐ Other:</th> </tr> <tr> <td>First Name: _____ MI: _____</td> <td>Prescriber Name: _____</td> </tr> <tr> <td>Last Name: _____</td> <td>Specialty: ☐ Rheum ☐ Other</td> </tr> <tr> <td>DOB: _____ Sex: ☐ M ☐ F</td> <td>NPI/Provider #: _____ State License #: _____</td> </tr> <tr> <td>Address: _____</td> <td>Office Name: _____ Contact: _____</td> </tr> <tr> <td>City/State/Zip: _____</td> <td>Address: _____</td> </tr> <tr> <td>Primary Phone: _____</td> <td>City/State/Zip: _____</td> </tr> <tr> <td>Alternate Phone: _____</td> <td>Phone: _____</td> </tr> <tr> <td>Drug Allergies: _____</td> <td>Fax: _____</td> </tr> </table>	PATIENT INFORMATION	PRESCRIBER INFORMATION ☐ MD ☐ DO ☐ Other:	First Name: _____ MI: _____	Prescriber Name: _____	Last Name: _____	Specialty: ☐ Rheum ☐ Other	DOB: _____ Sex: ☐ M ☐ F	NPI/Provider #: _____ State License #: _____	Address: _____	Office Name: _____ Contact: _____	City/State/Zip: _____	Address: _____	Primary Phone: _____	City/State/Zip: _____	Alternate Phone: _____	Phone: _____	Drug Allergies: _____	Fax: _____		
PATIENT INFORMATION	PRESCRIBER INFORMATION ☐ MD ☐ DO ☐ Other:																				
First Name: _____ MI: _____	Prescriber Name: _____																				
Last Name: _____	Specialty: ☐ Rheum ☐ Other																				
DOB: _____ Sex: ☐ M ☐ F	NPI/Provider #: _____ State License #: _____																				
Address: _____	Office Name: _____ Contact: _____																				
City/State/Zip: _____	Address: _____																				
Primary Phone: _____	City/State/Zip: _____																				
Alternate Phone: _____	Phone: _____																				
Drug Allergies: _____	Fax: _____																				
INSURANCE INFORMATION	<p>Fax a copy of the front and back of prescription insurance card(s) or fill in the information below</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2">Primary Insurance:</td> <td colspan="2">Secondary Insurance:</td> </tr> <tr> <td colspan="2">Phone: _____</td> <td colspan="2">Phone: _____</td> </tr> <tr> <td>Cardholder ID #: _____</td> <td>Group #: _____</td> <td>Cardholder ID #: _____</td> <td>Group #: _____</td> </tr> <tr> <td>PCN: _____</td> <td>BIN: _____</td> <td>PCN: _____</td> <td>BIN: _____</td> </tr> <tr> <td colspan="2">Policyholder Name: _____</td> <td colspan="2">Policyholder Name: _____</td> </tr> </table>	Primary Insurance:		Secondary Insurance:		Phone: _____		Phone: _____		Cardholder ID #: _____	Group #: _____	Cardholder ID #: _____	Group #: _____	PCN: _____	BIN: _____	PCN: _____	BIN: _____	Policyholder Name: _____		Policyholder Name: _____	
Primary Insurance:		Secondary Insurance:																			
Phone: _____		Phone: _____																			
Cardholder ID #: _____	Group #: _____	Cardholder ID #: _____	Group #: _____																		
PCN: _____	BIN: _____	PCN: _____	BIN: _____																		
Policyholder Name: _____		Policyholder Name: _____																			
INJECTION TRAINING	<p>Complete ONLY if you desire to have <u>DRUG(H)</u> Nursing Services train patients</p> <p>☐ <u>DRUG(H)</u> Nursing Services (RN) to provide SC injection training for <u>DRUG(H)</u>, including administration by Nurse (RN)</p> <p style="text-align: center;">Order valid for 90 days</p>																				
CLINICAL AND PRESCRIPTION INFORMATION	<p>PATIENT'S DIAGNOSIS</p> <p>☐ Rheumatoid Arthritis (714.0) ☐ Psoriatic Arthritis (696.0) ☐ Polyarticular Juvenile idiopathic Arthritis [JIA] (714.30)</p> <p>☐ Ankylosing Spondylitis (720.0) ☐ Other (include code): _____</p> <p>PRESCRIPTION ☐ New ☐ Continuing</p> <p>Rheumatoid Arthritis, ...</p> <p>☐ <u>DRUG(H)</u> Pen 40 mg/0.8 mL 40 mg SC inj. every other week ☐ #2 pens ☐ #6 pens Refills _____</p> <p>Polyarticular JIA if 15 kg (33 lbs) to <30 kg (66 lbs) only ...</p> <p>☐ <u>DRUG(H)</u> Pre-filled Syringe... 20 mg SC inj. every other week ☐ #2 pens ☐ #6 pens Refills _____</p> <p>Other</p> <p>☐ <u>DRUG(H)</u> _____ SIG: _____ Qty: _____ Refills _____</p> <p>If you wish to prescribe a non-biologic DRUG2 in combination with <u>DRUG(H)</u>...</p>																				
<p>PRESCRIBER SIGNATURE: PRESCRIBER SIGNATURE IS REQUIRED TO VALIDATE PRESCRIPTIONS</p> <p>☐ I do not want to prescribe <u>DRUG(H)</u> at this time, but please verify drug coverage</p> <p>☐ Dispense as written/Do not substitute</p> <p>☐ Substitutions permitted/Brand exchange permitted</p> <p style="text-align: center;">For states requiring...</p> <p>This information...</p> <p>Please see important Safety Information, including BOXED WARNING on Serious Infections and Malignancy, on next page. Please see full Prescribing Information provided and/or visit www.ourwebsite.com</p>																					

FIG. 43

6.0 Fill PA Form

Health Care Professionals | Dashboard | New Patient | My Profile | Logout | Hi, <Variable Username> | User Guide

Intake > Referral Submitted > PA & BV Received > PA/Rx Faxed to Insurance & Pharmacy > End

Important Safety Information
Full Subscribing Information

Close

PA Forms

☒ <Variable PA Form Name> 4406 4408 4414
Fill Sign Fax

Intake Details

Patient Name: <Variable Patient Name> Referral 238

Drug: DRUG(H)

Diagnosis: <Variable Specialty>

Insurance: <Variable Insurance Card>

Physician: <Variable HCP Name>

Documents Add New

<Variable Rx Document for Patient.pdf>
Rx Document

<Variable PA Form Name>

Please fill out the following form. You can save data typed into this form.

Print Download Save

Highlight Existing Fields

<Variable PA Form>

4400 4404 4402 51/110

FIG. 44

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6.1.2 PA Fill

HiLink

DASHBOARD NEW PATIENT MY PROFILE HELP

Hi, <Variable User Name> | LOGOUT

HEALTH CARE PROFESSIONALS		IMPORTANT SAFETY INFORMATION		FULL PRESCRIBING INFORMATION	
<div> <div> BEST SUMMARY </div> <div> PRIOR AUTHORIZATION (1) </div> <div> PRESCRIPTION </div> </div>		<div> PATIENT DETAILS </div> <div> PATIENT DOCUMENTS </div>			
Please save form before signing it.					
<Variable PA Form Name> was sent to <Variable Insurance Company> on <Date> at <Time>					
<div> <div>FILL</div> <div>SUBMIT FOR SIGNATURE</div> <div>SIGN</div> <div>NEXT</div> </div>		<div> EDIT </div>			
<div> <div> <Variable PA Form Name> </div> </div>					

FIG. 44B

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6.4.1 Intake Details - Patient Information

Health Care Professionals

Dashboard

New Patient

My Profile

Logout

Hi, <Variable Username>

User Guide

Intake

Referral Submitted

PA & BV Received

PA/Rx Faxed to Insurance & Pharmacy

End

Important Safety Information

Full Subscribing Information

PA Forms

☒ <Variable

Fill

Sign

Intake Details

Patient Name:

Drug:

Diagnosis:

Insurance:

Physician: <Variable HCP Name>

Patient Information

<Variable Identification Card image>

Name:

Gender: ☐ Male ☐ Female

Date of Birth:

Address:

City:

State: -Select-

Zip:

Close

X

Documents

Add New

<Variable Rx Document for Patient.pdf>

Rx Document

954

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5000

PATIENT INFORMATION		STEP 1 OF 4	
Use edit to update the patient's information.			
<div> <div><Variable Other's Locate Images></div> <div> <div>*denotes a required field</div> <div>EDIT</div> </div> </div>			
Name*	<input type="text"/>	☐	<input type="text"/>
Gender*	☐ Male ☒ Female		
Date of Birth*	<input type="text"/>		
	mm/dd/yyyy		
Address*	<input type="text"/>		
	<input type="text"/>		
City*	<input type="text"/>		
State*	<input type="text"/> <input type="button" value="v"/> <input type="text"/>	Zip*	<input type="text"/>
Drug Allergies <input type="text"/>			
Preferred Phone Number*	<input type="text"/>	<input type="text"/>	<input type="button" value="v"/> <input type="text"/>
Secondary Phone Number	<input type="text"/>	<input type="text"/>	<input type="button" value="v"/> <input type="text"/>
If you have an active Rx window open, please refresh that page after saving to include the updated information. If you have an active PA form window open, please refresh that page after saving to include the updated information.			
		CANCEL	SAVE

55/110

INSURANCE INFORMATION		STEP 2 OF 4
<p>Use edit to update the insurance information.</p> <p style="text-align: center; margin: 20px 0;"><Variable Insurance Card Images></p> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>Prescription Plan Card</p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <div style="display: flex; justify-content: space-between;"> <div style="width: 40%;"> <p>Insurance Company Name</p> <p>Insurance Company Phone Number</p> <p>Policyholder Name</p> <p>Policyholder ID</p> <p>Rx BIN</p> <p>Rx GRP</p> </div> <div style="width: 60%;"> <p><input type="text"/></p> <p><input type="text"/></p> <p><input type="text"/></p> <p><input type="text"/></p> <p><input type="text"/></p> <p><input type="text"/></p> </div> </div> </div> </div> <div style="width: 50%; margin-top: 10px;"> <p><input type="text"/></p> <p><input type="text"/></p> <p><input type="text"/></p> <p><input type="text"/></p> <p><input type="text"/></p> <p><input type="text"/></p> </div> </div> <div style="text-align: right; margin-top: 10px;"> <input type="button" value="EDIT"/> </div>		
<div style="display: flex; justify-content: space-between; align-items: center;"> <div style="width: 45%;"> <p><input type="button" value="ADD INSURANCE CARD"/></p> <p style="font-size: small; margin-top: 10px;">If you have an active Rx window open, please refresh that page after saving to include the updated information.</p> <p style="font-size: small;">If you have an active PA form window open, please refresh that page after saving to include the updated information.</p> </div> <div style="width: 50%; text-align: right;"> <input type="button" value="CANCEL"/> <input type="button" value="SAVE"/> </div> </div>		

FIG. 45B-2

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HCP INFORMATION

STEP 3 OF 4

Use edit to change the Location or HCP Location and HCP details can be updated by the Practice Admin or the HCP in the 'My Profile' section.

Location of Service

HCP Name

HCP Name

Specialty

Designation

State License Number

NPI Number

DEA Number

Office

Contact

E-Mail

If you have an active Rx window open, please refresh that page after saving to include the updated information.
If you have an active PA form window open, please refresh that page after saving to include the updated information.

FIG. 45B-3

DIAGNOSIS INFORMATION

STEP 4 OF 4

EDIT

Use edit to update the patient's diagnosis information.

*denotes a required field

Select patient's primary diagnosis and dosing for HUMIRA® (adalimumab).

Patient's Primary Diagnosis*

☒ <Variable Diagnosis based on Specialty>

☐ <Variable Diagnosis based on Specialty>

☐ Other (Include Code)

Prescription*

Specialty*

Dosing Mode	<Variable Diagnosis>	Quantity (Pen/Syringe)	Refills
<div>☐ <input type="text"/></div>	<div><Variable Product Variable Dosing Mode Variable NDC></div>	<div><input type="text"/></div>	<div><input type="text"/></div>

Dosing Mode	<Variable Diagnosis>	Quantity (Pen/Syringe)	Refills
<div>☐ <input type="text"/></div>		<div>--Select-- <input type="text"/></div>	<div><input type="text"/></div>

Any Other Dosing			
Dosing Mode	Quantity (Pen/Syringe)	Refills	
<div>☐ <input type="text"/></div>	<div><input type="text"/></div>	<div><input type="text"/></div>	<div>SIC <input type="text"/></div>

FIG. 45C-1

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INDICATIONS¹

- Rheumatoid Arthritis: HUMIRA is indicated, alone or in combination with methotrexate or other non-biologic DMARDs, for reducing signs and symptoms, inducing major clinical response, inhibiting the progression of structural damage, and improving physical function in adult patients with moderately to severely active rheumatoid arthritis.
- Juvenile Idiopathic Arthritis: HUMIRA is indicated, alone or in combination with methotrexate, for reducing signs and symptoms of moderately to severely active polyarticular juvenile idiopathic arthritis in pediatric patients 4 years of age and older.
- Psoriatic Arthritis: HUMIRA is indicated, alone or in combination with non-biologic DMARDs, for reducing signs and symptoms, inhibiting the progression of structural damage, and improving physical function in adult patients with active psoriatic arthritis.
- Ankylosing Spondylitis: HUMIRA is indicated for reducing signs and symptoms in adult patients with active ankylosing spondylitis.
- Crohn's Disease: HUMIRA is indicated for reducing signs and symptoms and inducing and maintaining clinical remission in adult patients with moderately to severely active Crohn's disease who have had an inadequate response to conventional therapy, and reducing signs and symptoms and inducing clinical remission in these patients if they have also lost response to or are intolerant to infliximab.
- Plaque Psoriasis: HUMIRA is indicated for the treatment of adult patients with moderate to severe chronic plaque psoriasis who are candidates for systemic therapy or phototherapy, and when other systemic therapies are medically less appropriate. HUMIRA should only be administered to patients who will be closely monitored and have regular follow-up visits with a physician.

FIG. 45C-2

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SAFETY CONSIDERATIONS¹**Serious Infections**

Patients treated with HUMIRA are at increased risk for developing serious infections that may lead to hospitalization or death. These infections include active tuberculosis (TB), reactivation of latent TB, invasive fungal infections, and bacterial, viral and other infections due to opportunistic pathogens. Most patients who developed these infections were taking concomitant immunosuppressants such as methotrexate or corticosteroids.

Malignancies

Lymphoma, including a rare type of T-cell lymphoma, and other malignancies, some fatal, have been reported in patients treated with TNF blockers, including HUMIRA.

Other Serious Adverse Reactions

Patients treated with HUMIRA also may be at risk for other serious adverse reactions, including anaphylaxis, hepatitis B virus reactivation, demyelinating disease, cytopenia, pancytopenia, heart failure, and a lupus-like syndrome.

[Click here for full Prescribers Information.](#)

Reference: 1. HUMIRA Injection [package insert]. North Chicago, IL: Abbott Laboratories

If you have an active Rx window open, please refresh that page after saving to include the updated information.

If you have an active PA form window open, please refresh that page after saving to include the updated information.

SAVE

CANCEL

CLOSE

FIG. 45C-3

6.5 Add Documents

Health Care Professionals

Dashboard

New Patient

My Profile

Logout

Hi, <Variable Username>
User Guide

Intake

Referral Submitted

PA & BV Received

PA/Rx Faxed to Insurance & Pharmacy

End

Important Safety Information

Full Subscribing Information

PA Forms

☒ <Variable PA Form Name>

Fill

Sign

Fax

Intake Details

Referral 238

Patient Name: <Variable Patient Name>

Drug: DRUG(H)

Diagnosis: <Variable Specialty>

Insurance: <Variable Insurance Card>

Physician: <Variable HCP Name>

Documents

Add New

<Variable Rx Document for Patient.pdf>

Rx Document

Add Document

Document Name:

Link:

Browse

Save

Cancel

Close

4600

60/110

FIG. 46

61/110

6.4 Patient Documents

HiLink

DASHBOARD NEW PATIENT MY PROFILE HELP

Hi, <Variable User Name>

HEALTH CARE PROFESSIONALS
IMPORTANT SAFETY INFORMATION
FULL PRESCRIBING INFORMATION

PATIENT DOCUMENTS FOR <VARIABLE PATIENT NAME>

Please upload any documents from your computer.

Document Name

File

Browse...

CANCEL

UPLOAD

PA Forms	Rx Documents	Other Documents
<Variable PA Form Document Name>	<Variable Rx Document Name>	<Variable Document Name>
		<Variable Document Name>
		<Variable Document Name>

FIG. 46B

6.2 Fax Documents

Health Care Professionals | Dashboard | New Patient | My Profile | Logout | Hi, <Variable Username> User Guide

Intake > Referral Submitted > PA & BV Received > PA/Rx Faxed to Insurance & Pharmacy > End

Important Safety Information
Full Subscribing Information

Close

PA Forms

☒ <Variable PA Form Name>

Intake Details [Referral 238]

Patient Name: <Variable Patient Name>
Drug: DRUG(H)
Diagnosis: <Variable Specialty>
Insurance: <Variable Insurance Card>
Physician: <Variable HCP Name>

Documents Add New

<Variable Rx Document for Patient.pdf>
Rx Document

Fax Documents

Select Additional Documents for Insurance

☐ <Variable Document>
☐ <Variable Document>

Insurance Carrier <Variable Insurance Carrier>
Fax Number:

Prior Authorization, Rx, and any documentation you loaded will be faxed to

Insurance Carrier <Variable Insurance Carrier>
Fax Number: <Variable Fax Number>

4700 62/110

4702

FIG. 47

63/110

6.4 Patient Documents

Link

DASHBOARD NEW PATIENT MY PROFILE HELP

Hi, <Variable User Name> | LOGOUT

HEALTH CARE PROFESSIONALS

IMPORTANT SAFETY INFORMATION FULL PRESCRIBING INFORMATION

BENEFIT SUMMARY PRIOR AUTHORIZATION (4) PRESCRIPTION

PATIENT DETAILS PATIENT DOCUMENTS

ADD DOCUMENTS

Please upload any documents from your computer that you would like to send with the Prior Authorization Form.

Document Name

File

Browse..

UPLOAD

Select any additional documents you would like to send.

☒ <Variable Document Name>

The documents will be faxed to: <Variable Insurance Company Name>

Fax Number: <Variable Fax Number>

CANCEL SEND

FIG. 47B

64/110

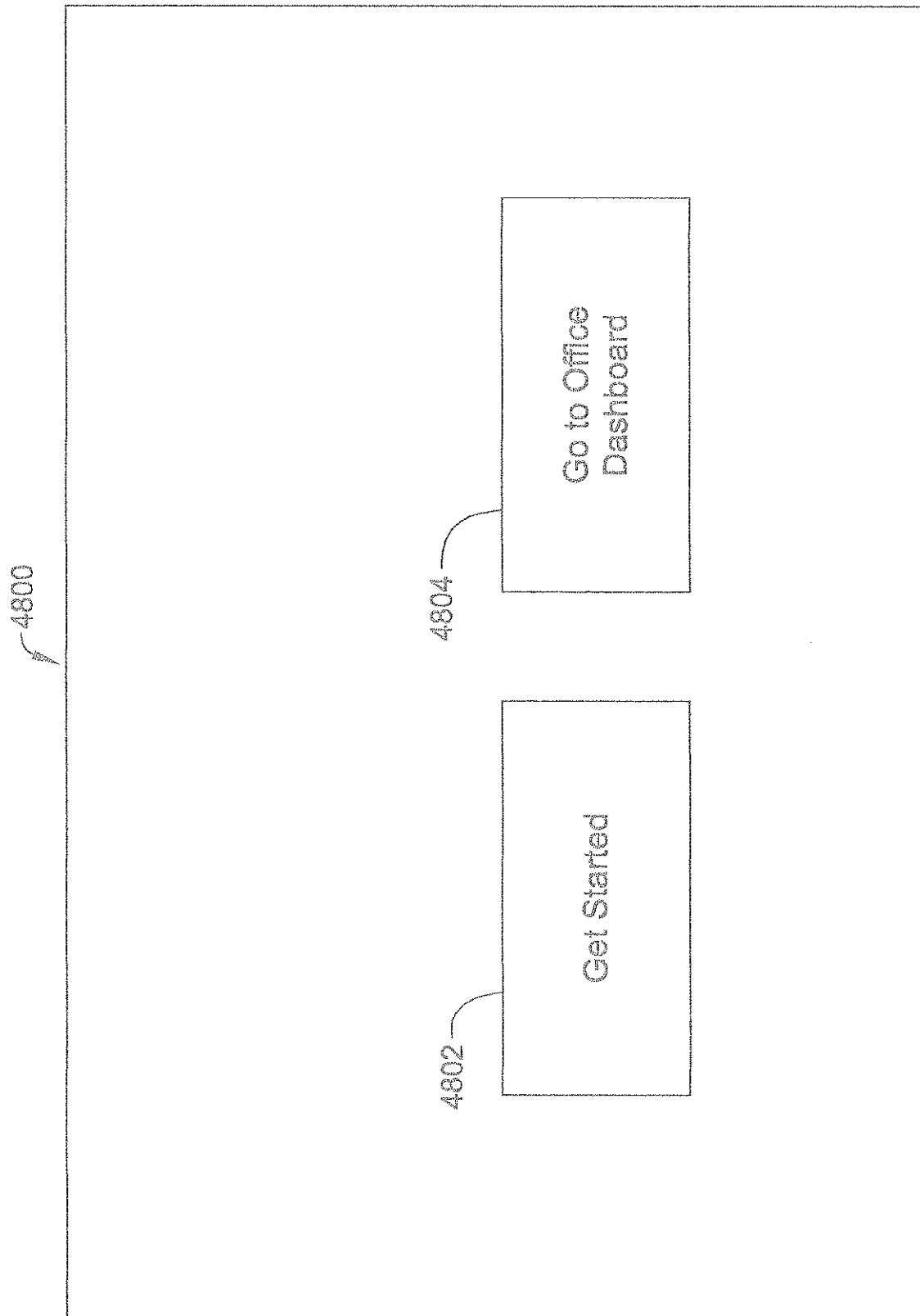


FIG. 48

65/110

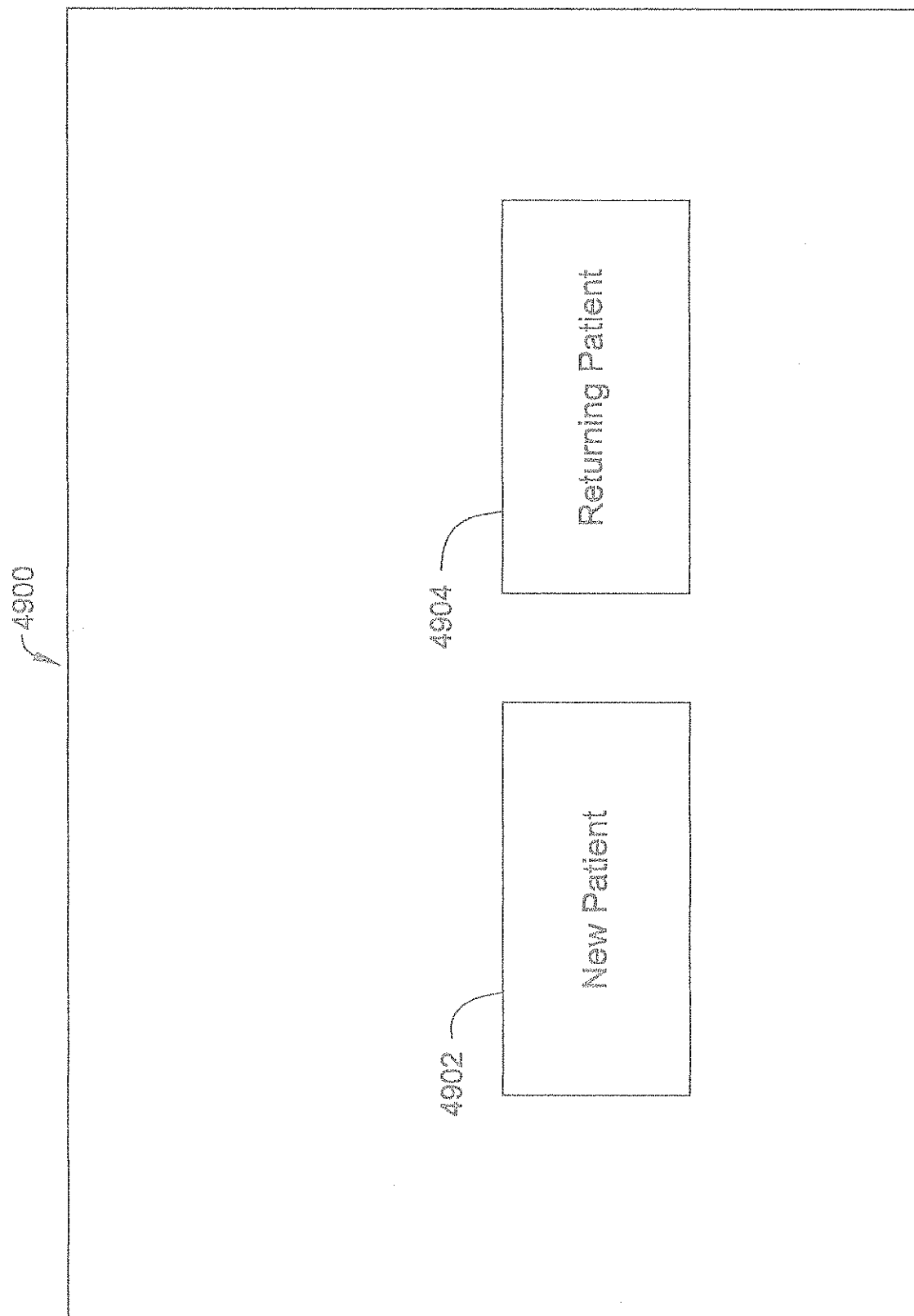


FIG. 49

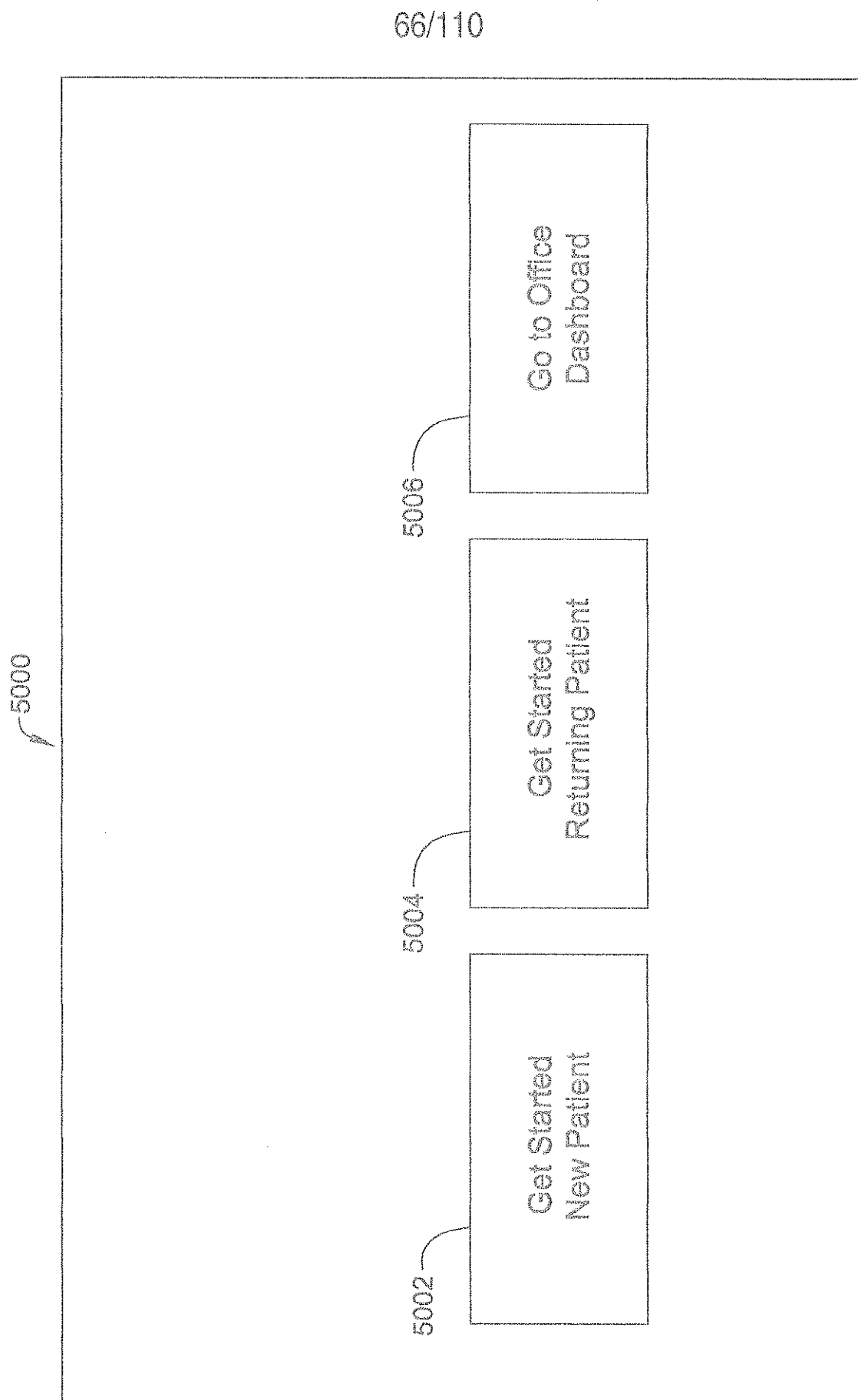


FIG. 50

67/110

5100

5102 Patient Information:		5104 Insurance Information:		5106 Diagnosis Information:		5108 Injection Training/Support		5110 Consent	
Date:		Case Number:		Case Number:		Case Number:		Case Number:	
First Name:		Last Name:		Last Name:		Last Name:		Last Name:	
Sex:	☐ Male ☐ Female	Age:		Age:		Age:		Age:	
DOB:									
Address:									
City:									
State:									
Zip Code:									
Home Phone:		Office Phone:		Office Phone:		Office Phone:		Office Phone:	
Submit for BV									

FIG. 51

68/110

5100

5108

Patient Information:			Insurance Information:			Diagnosis Information:			Injection Training/Support			Consent		
☐ <u>DRUG(H)</u> Nursing Services (RN) to provide SC injection training for <u>DRUG(H)</u> ☐ <u>DRUG(H)</u> Nursing Services (RN) to provide SC injection training for <u>DRUG(H)</u> , including administration by Nurse (RN)														
HPP Card Information														
RxBIN #: <input type="text"/> RxPCN #: <input type="text"/> RxGroup: <input type="text"/> RxID: <input type="text"/> Suf: <input type="text"/>														
Submit for BV														

FIG. 51A

69/110

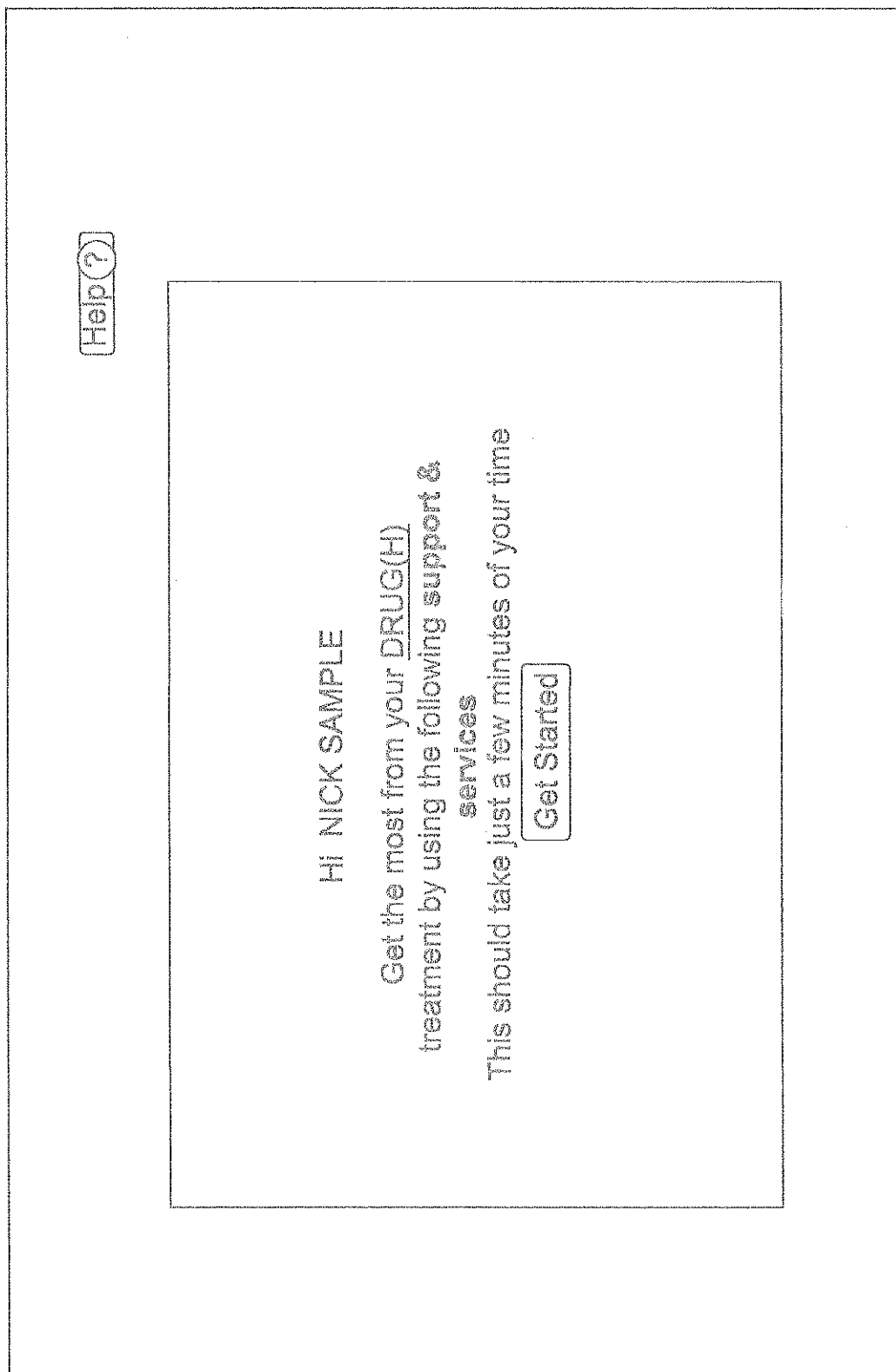


FIG. 52

70/110

[Help ?](#)

[① OOP Solutions](#)

[② Injection Training](#)

[③ myDRUG Program](#)

Many patients are concerned about affording their medications. Regardless of your current status - employed, unemployed, insured, or uninsured - DRUGCO offers guidance and support to help you access the treatment your doctor has prescribed. Make your prescription more affordable by opting for Out of Pocket solutions.

Benefits

- Includes 12 months of co-pay savings and covers DRUG(H) plus two additional medications.
- Save up to \$50 toward your co-pay
- plus up to \$100 of the cost of other medications

No, Thank you

Yes, I'm Interested

Our representative will contact you

Your Progress

FIG. 53

71/110

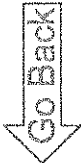
[Help?](#)

① OOP Solutions
② Injection Training
③ myDRUG Program

It's normal to feel uneasy about self-injecting. myDRUG nurses can train you for FREE in person, wherever it's most convenient for you - your home, doctor's office, or one of many clinics nationwide

Please choose ONE option

☐ I'd like a nurse to train me over a call
☐ I'd like a nurse to train me at my house
☐ No Thank you, I will get my training at prescriber office.



Go Back

Continue

Your Progress

FIG. 54

72/110

[Help \(?\)](#)

[① OOP Solutions](#)

[② Injection Training](#)

[③ myDRUG Program](#)

By registering with the myDRUG program you can get the following services:

- Injection DVD: Step-by-step video to help you get comfortable with self-injecting Practice DRUG Pen: Allows you to practice self-injecting
- Travel pack: Makes traveling with DRUG more convenient - and comes with a reusable ice pack
- Treatment information: Helps you understand what to expect when starting DRUG

[Go Back](#)

[No, Thank you](#)

[Yes, Register me](#)

[Your Progress](#)

FIG. 55

73/110

Help?

Your Contact Information

In order to offer these services, we need the best contact number to reach you

Preferred Contact No.

Email ID (in case we can't reach you by phone)

Go Back

Continue

Your Progress

FIG. 56

74/110

[Help?](#)

Your Authorization

In order to offer these services, HIPPA requires your written consent for the same. Please confirm the below details before signing

☒ Interested in Out of Pocket Solutions
☒ Interested in myDRUG program

Patient Signature

Click to sign

By signing, you agree to the [Terms & Conditions of myDRUG program](#)

Confirmation of Signature

Click to sign

Staff Signature

or

Attach Signature

FIG. 57

75/110

Help?

Physician Staff Authorization

User Name:

Password:

Submit

Your Authorization

In order to
same. Pl
✓ Inter
✓ Inter
Patient S
By signing y
Confirma
Staff Sign

Your Progress

Go Back

Print Copy

Finish

FIG. 58

76/110

[Help?](#)

Your Authorization

In order to offer these services, HIPPA requires your written consent for the same. Please confirm the below details before signing

☒ Interested in Out of Pocket Solutions
☒ Interested in myDRUG program

Patient Signature *Mick*

By signing, you agree to the Terms & Conditions of myDRUG program

Confirmation of Signature *Mick* or Attach Signature

Staff Signature

Go Back
Print Copy
Finish

Your Progress |||||

FIG. 59

77/110

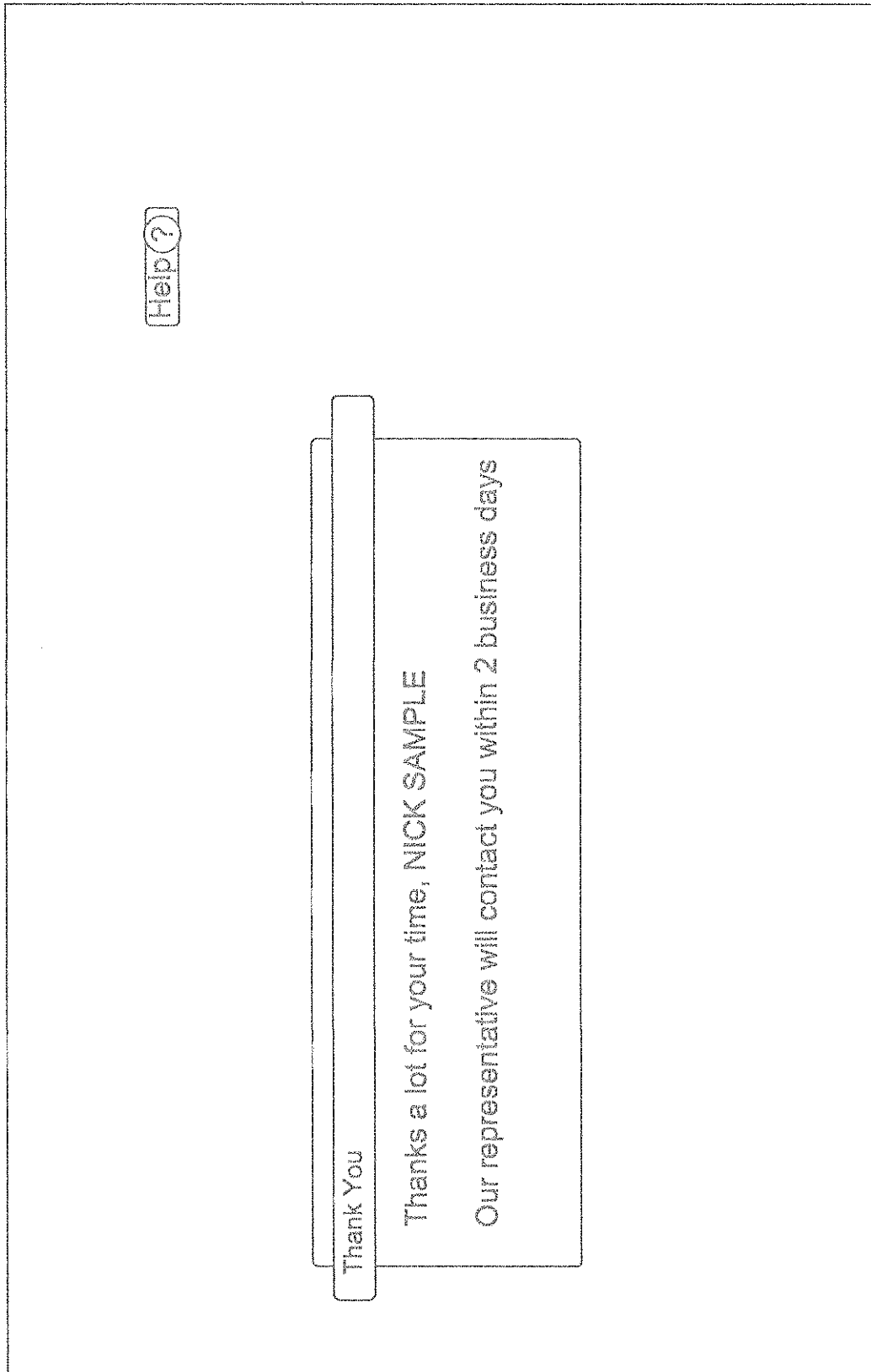


FIG. 60

5100

5112

5120

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Patient Information: Insurance Information: Diagnosis Information: Injection Training/Support Patient Consent Physician Consent

Patient Certification and Authorization for Disclosure of Information
 I request and authorize the sharing of any information regarding my health, treatment, and coverage that...

For Eligible Patient Assistance Patients Only:
 I understand that any assistance in the form of product at no cost is contingent upon my ability to meet the
 eligibility criteria for the PAP as determined by ...

Home Phone #:
 Mobile Phone #:
 Office Phone #:
 Home
 Consent As: ☐ Print ☐ Email
 Email Address:
 Patient's Name: Signature: Date:

Submit for BV

FIG. 61

5100
5114

Patient Information:

Insurance Information:

Diagnosis Information:

Injection Training/Support

Patient Consent

Physician Consent

☐ Staff authorized to sign on behalf of doctor

Staff Name:

Location:

For whom:

5122

Physician Certification:

Physician Signature (no stamps): _____ Date: _____

By signing this form, I represent that I have obtained all necessary Federal and state authorizations and consents from my patient to allow me to release health information to ...

Submit for BV

5130

FIG. 62

80/110

5100

= X

Register New Patient
Case 12345
Dashboard
New Patient
Resources
My Profile
Search Name

Patient Information NICK SAMPLE Modify

Insurance Information BCBC POS Modify

Diagnosis Information Rheumatology Modify

Physician Information

Location of Service: Tallahassee, FL v

Physician Name: John Caring v

Signature Required for
Creating Prescription
Sending a Nurse for DRUG(H) training

Physician Name: John Caring

Specialty: Dermatology

Designation: MD

Office: 123 ABC STREET

Contact: 123-4567

Email: johncaring@abc.com

Physician Signature:
Attached

Remove

By signing, I agree to the [Terms & Conditions](#) of this program

Submit for Benefit Summary

81/110






5100

Dashboard

New Patient

Resources

My Profile

Search Name

Register New Patient

Case 12345

Confirmation

Case 12345 has been submitted successfully

Patient Name: NICK SAMPLE

Diagnosis: Rheumatology

Insurance: Insurance Co.

Physician: John Carling

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6500

6502

Patient Information:
Insurance Information:
Diagnosis Information:
Injection Training/Support
Benefits Verification
Consent

Deductible (Individual):
Deductible (Family):
Additional Information: PHARMACY is a specialty pharmacy. Please fax prescription to
866-XXX-XXXX
Lifetime Maximum:
Benefit Cap: 200
Retail Co-pay for Amevive: retail
Out of Pocket:

Select Pharmacy:

PA Template:
No Documents Attached
Add Document
6504

Submit to Physician Office for PA
6506

FIG. 65

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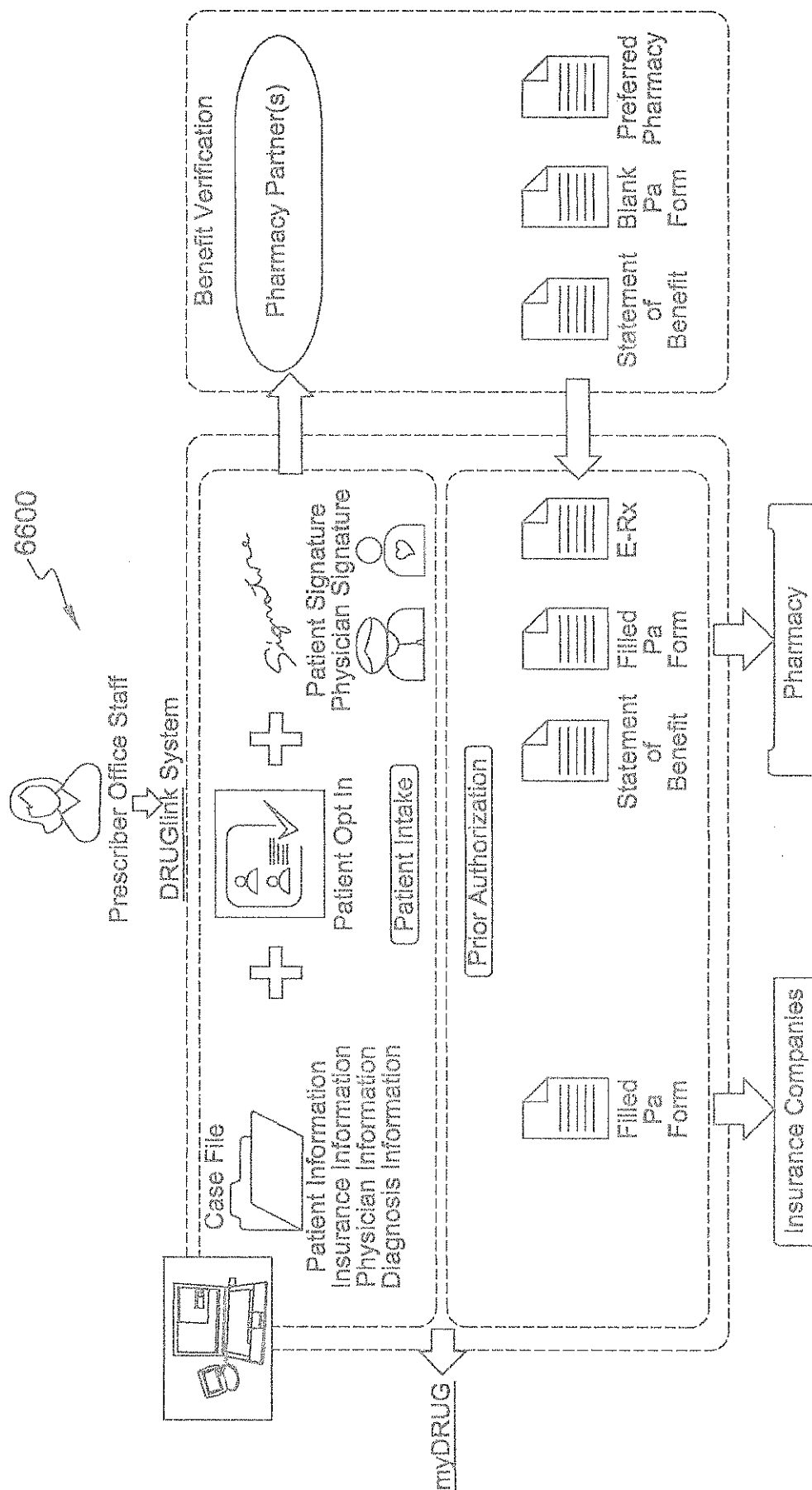


FIG. 66

84/110

6700

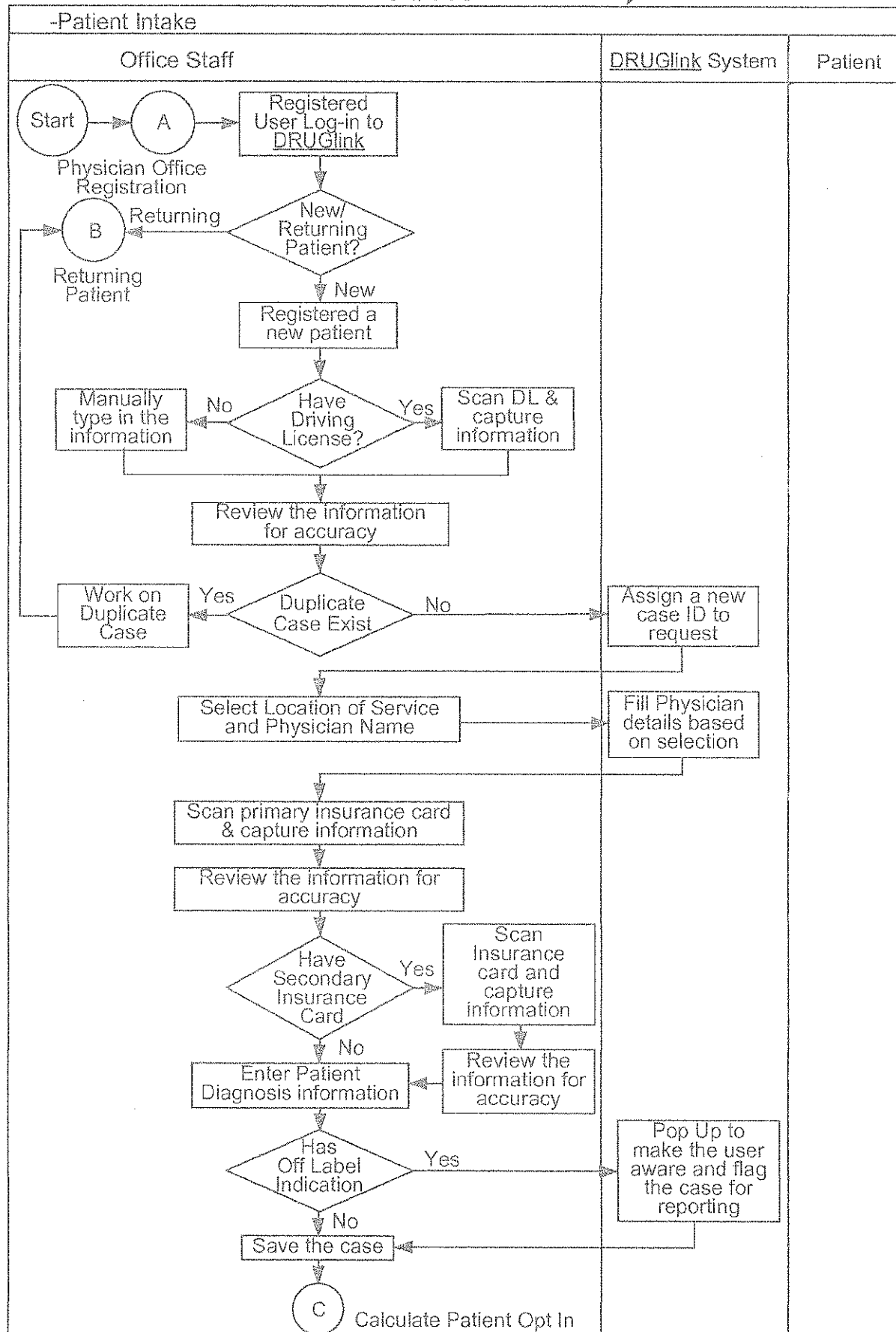


FIG. 67

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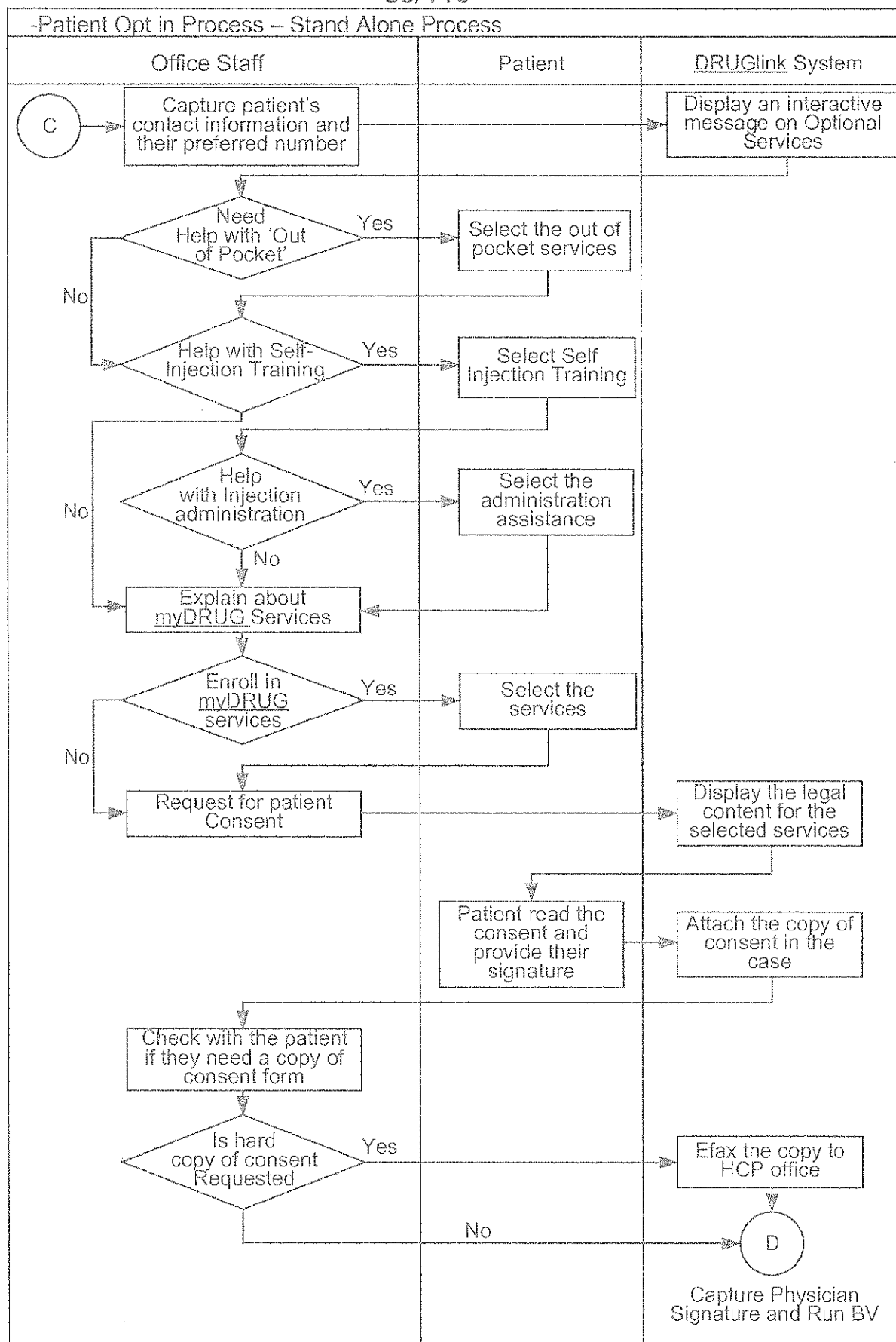


FIG. 68

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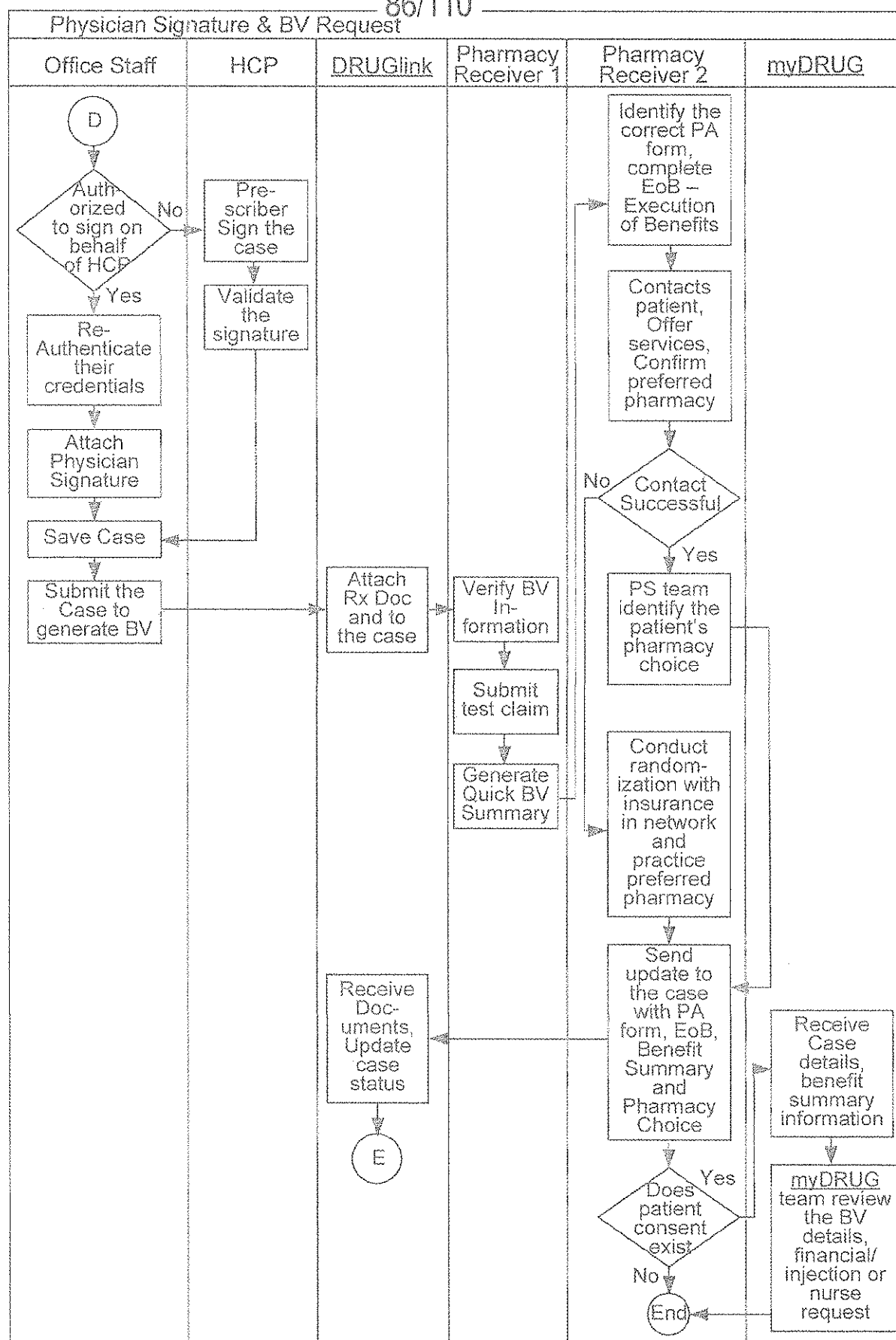


FIG. 69

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7000

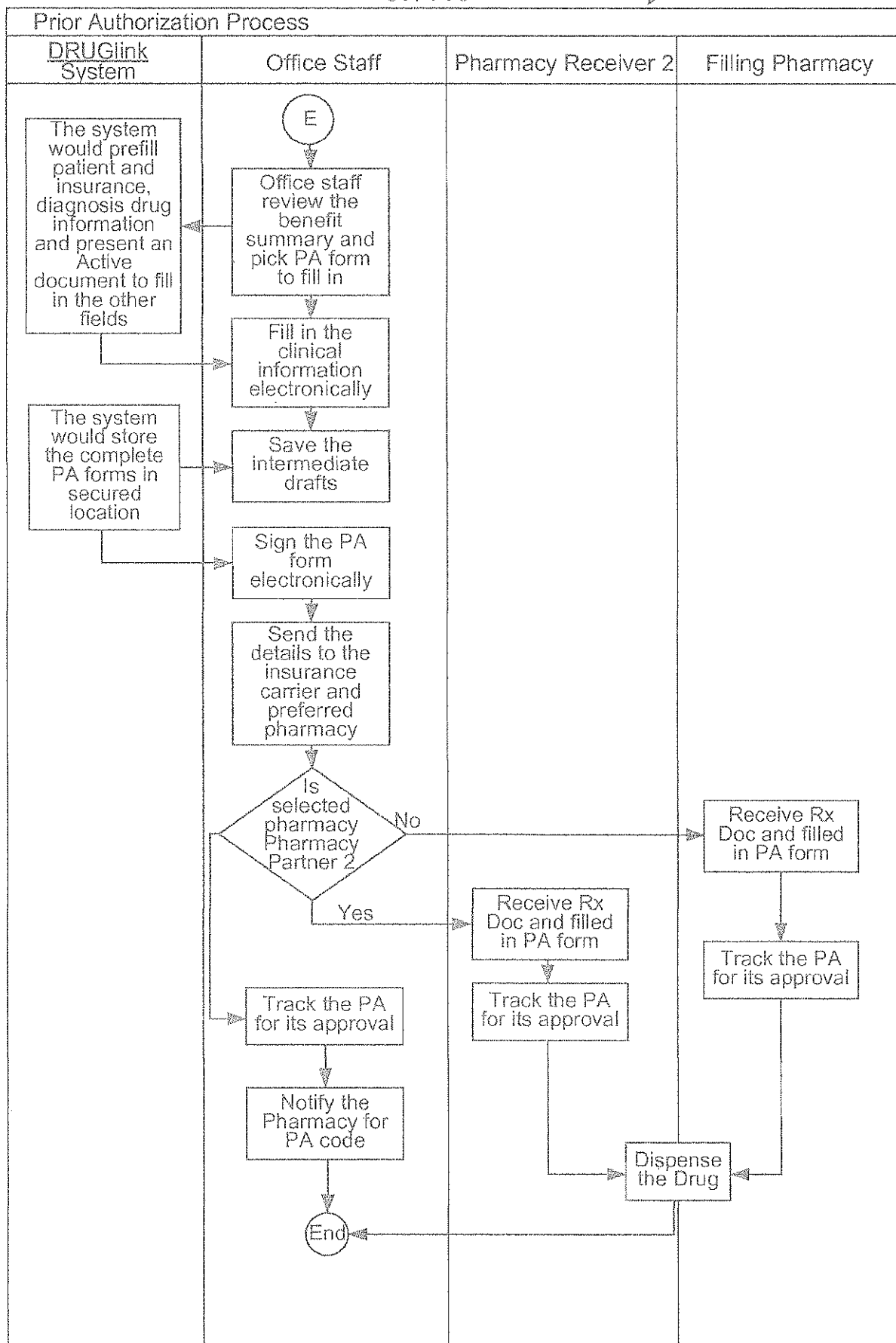


FIG. 70

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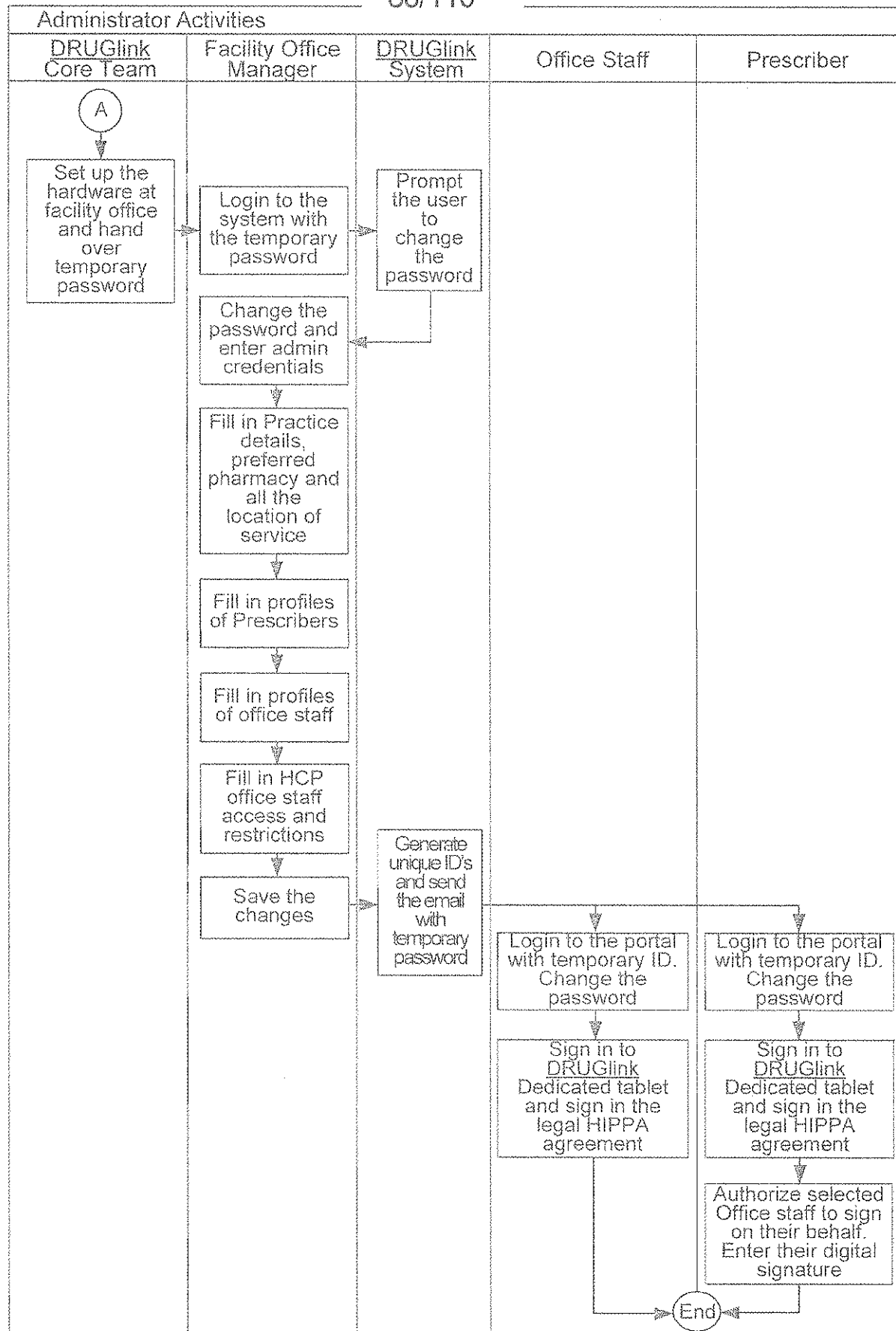


FIG. 71

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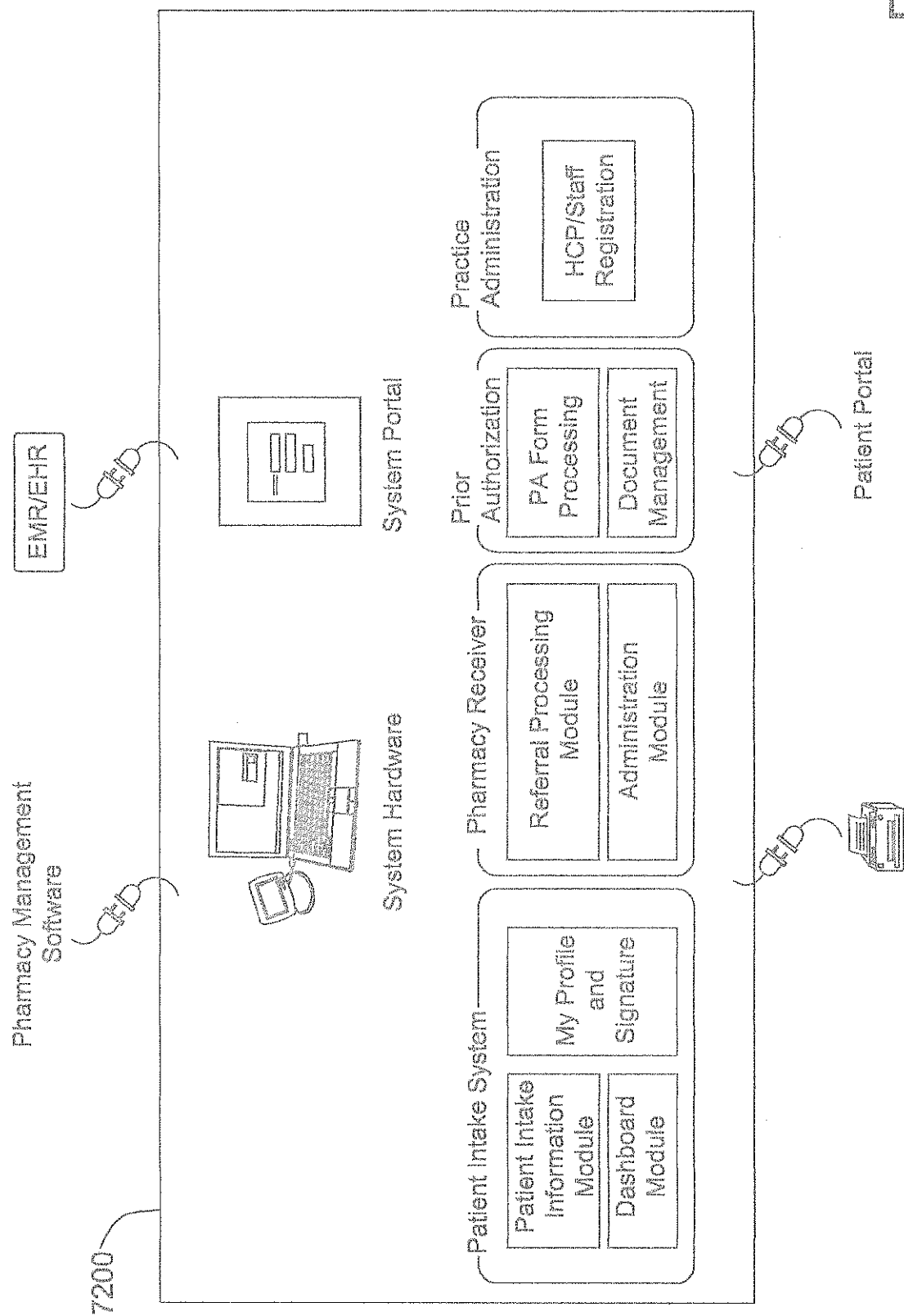


FIG. 72

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<p>Contact Information Please provide the following information about yourself.</p>	
<p>Registrant's Contact Type:</p>	<p>Specialty:</p>
<p>First Name:</p>	<p>NPI Provider #:</p>
<p>Last Name:</p>	<p>State License #:</p>
<p>Email Address:</p>	<p>Ext.:</p>
<p>Confirm Email Address:</p>	
<p>Phone Number:</p>	
<p>Best Time to Contact:</p>	
<p>Office Information Please provide the following information for your PRIMARY office location.</p>	
<p>Office Name:</p>	<p>Zip:</p>
<p>Address 1:</p>	<p>Ext.:</p>
<p>Address 2:</p>	<p>Ext.:</p>
<p>City:</p>	
<p>State:</p>	
<p>Office Phone:</p>	
<p>Office Fax:</p>	
<p>Tax ID:</p>	
<p>Login Information</p>	
<p>User Name:</p>	
<p>Start Screen:</p>	
<p>Email:</p>	
<p>New Password:</p>	
<p>Confirm Password:</p>	
<p>Email Notifications:</p>	
<p>Email Notifications: ☐ BV Request</p>	
<p>☐ Print PA</p>	
<p>☐ Register Patient</p>	
<p><input type="button" value="Submit"/></p>	

FIG. 73

608

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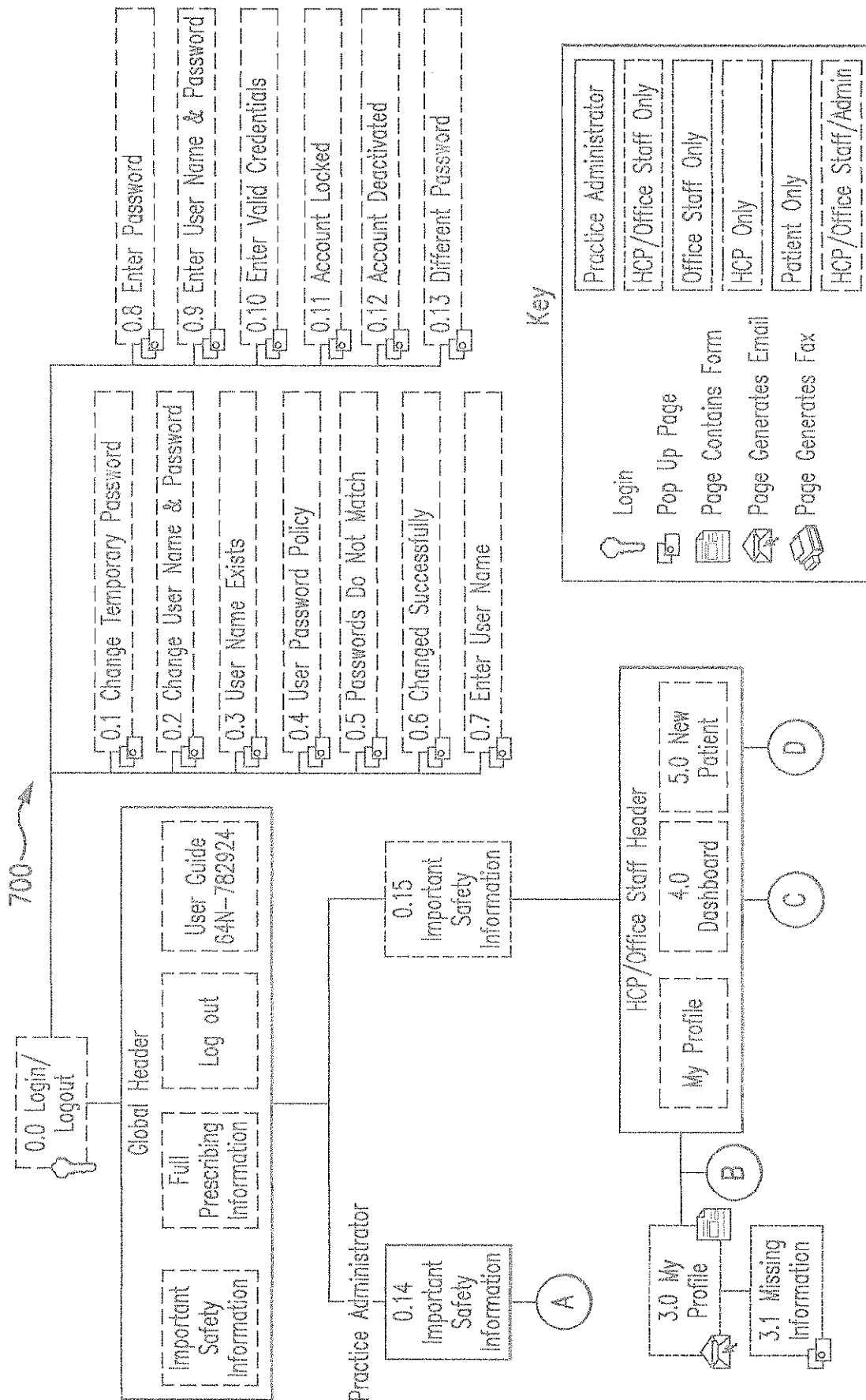


FIG. 74A

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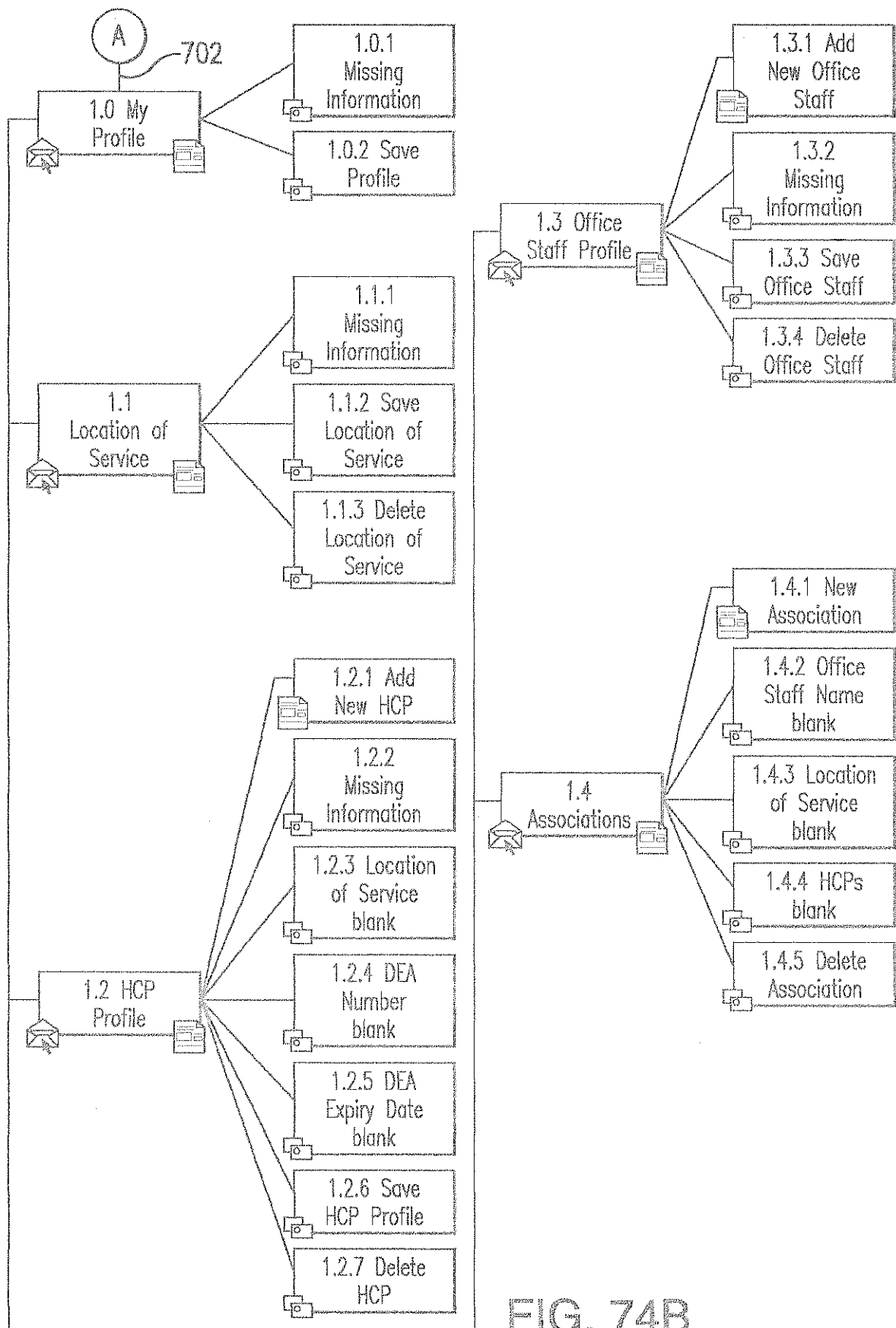


FIG. 74B

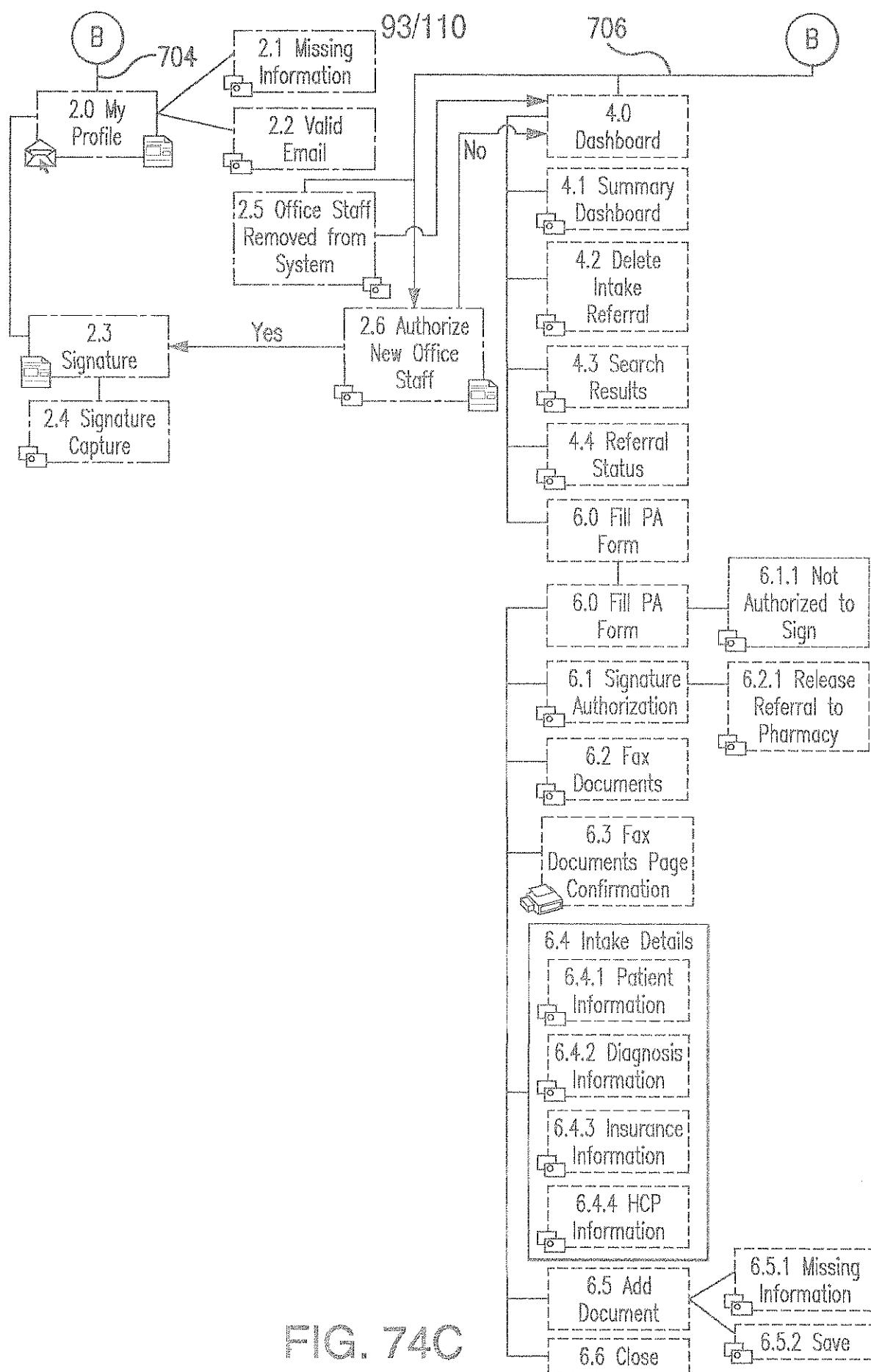


FIG. 74C

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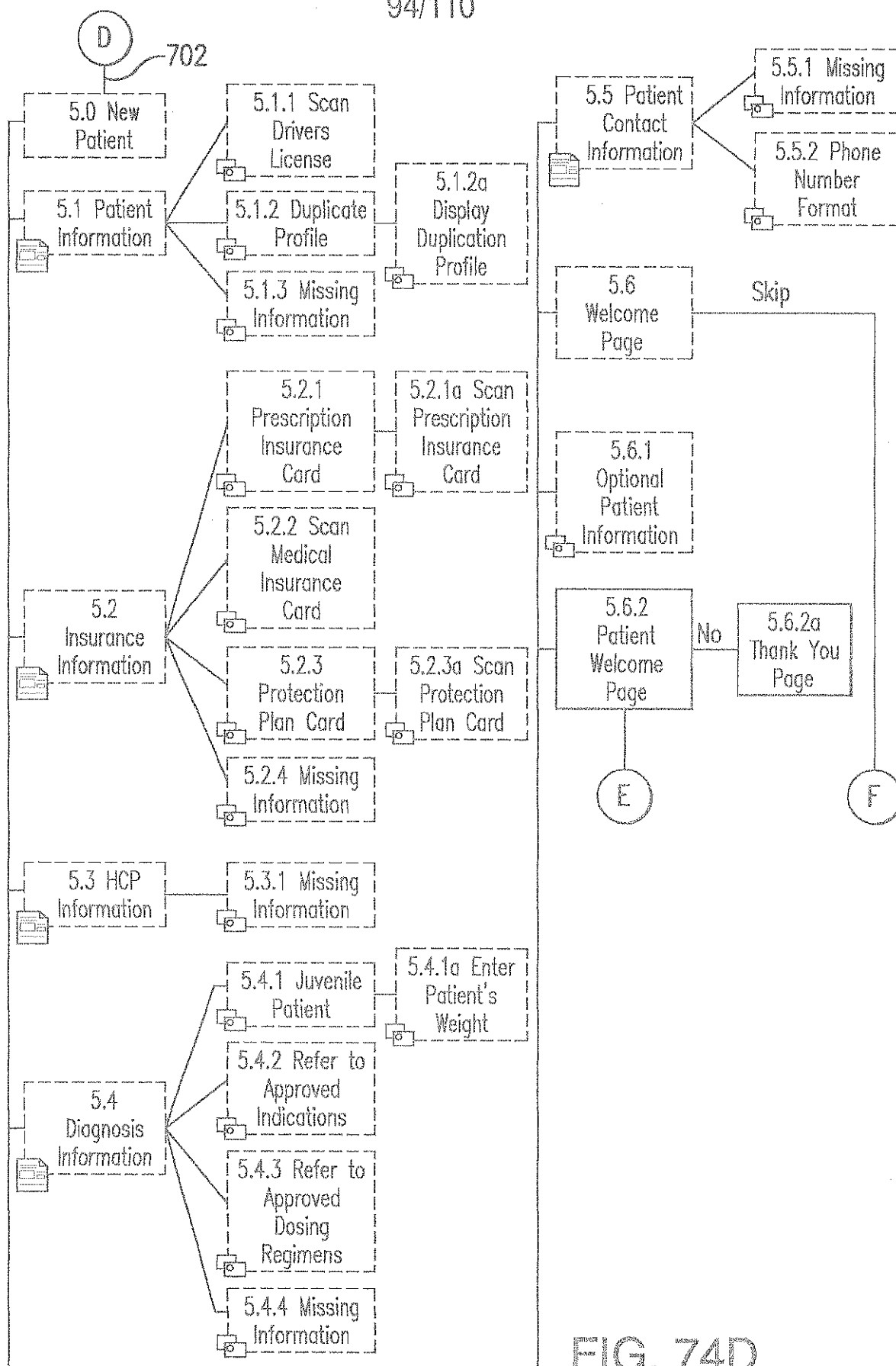


FIG. 74D

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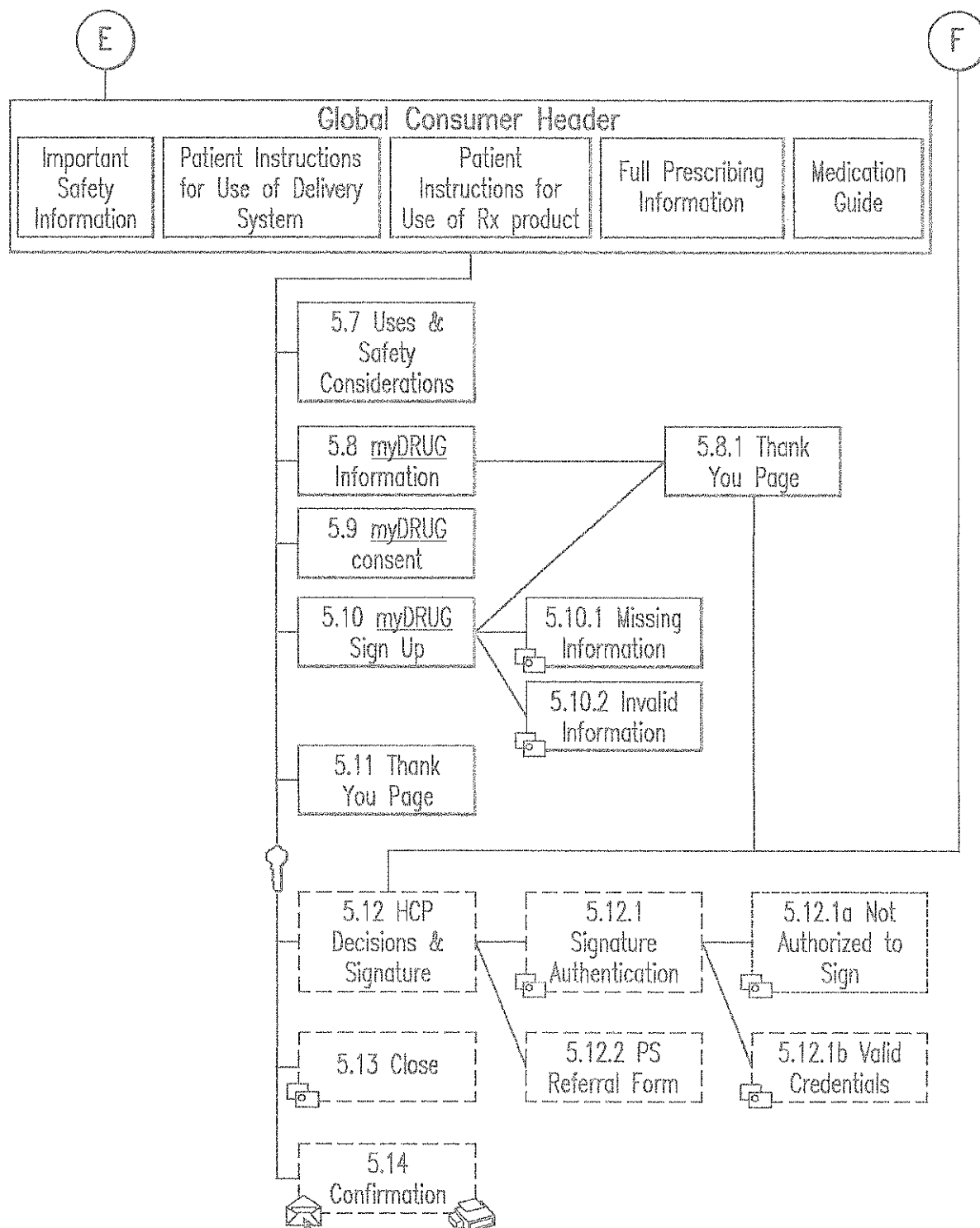
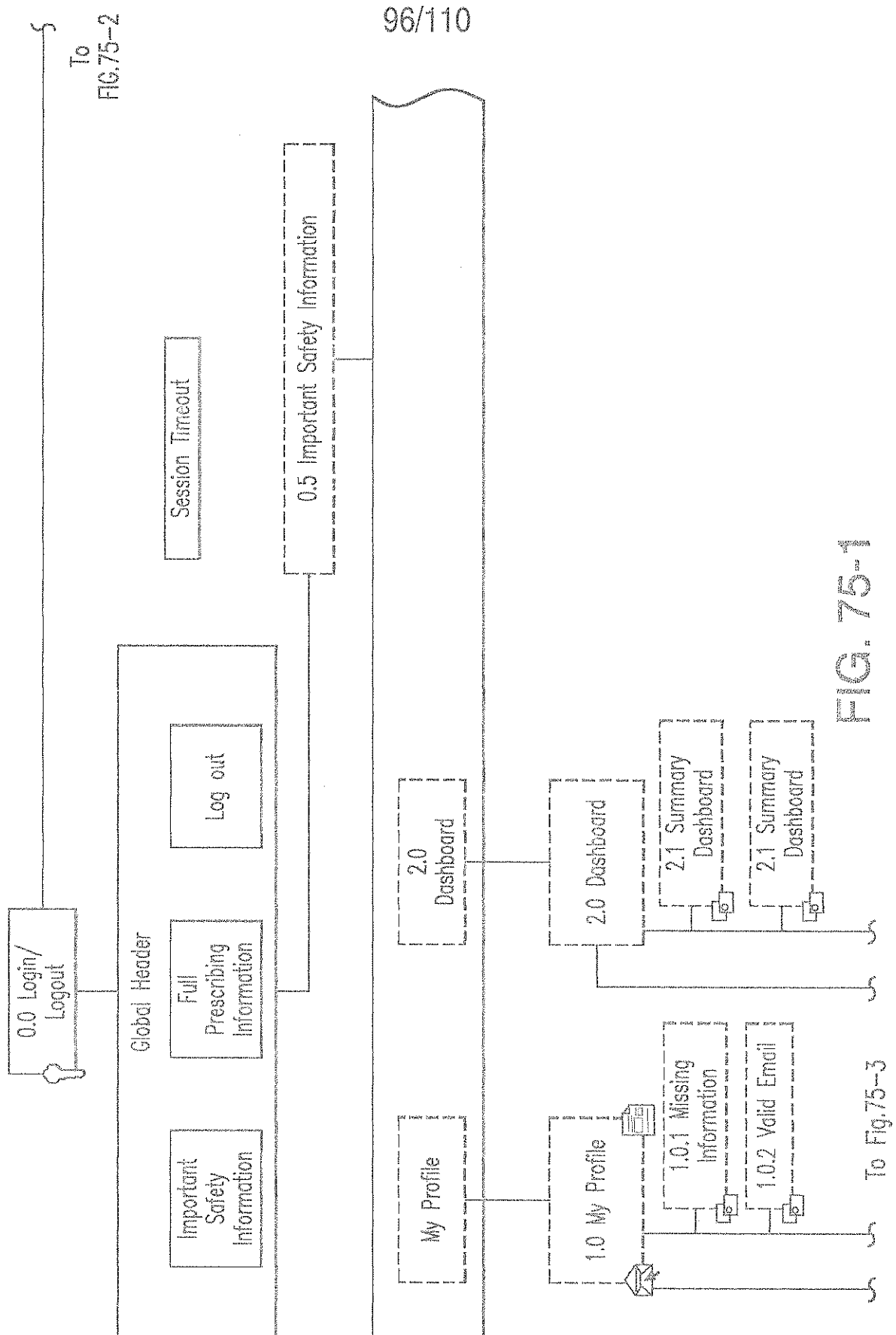
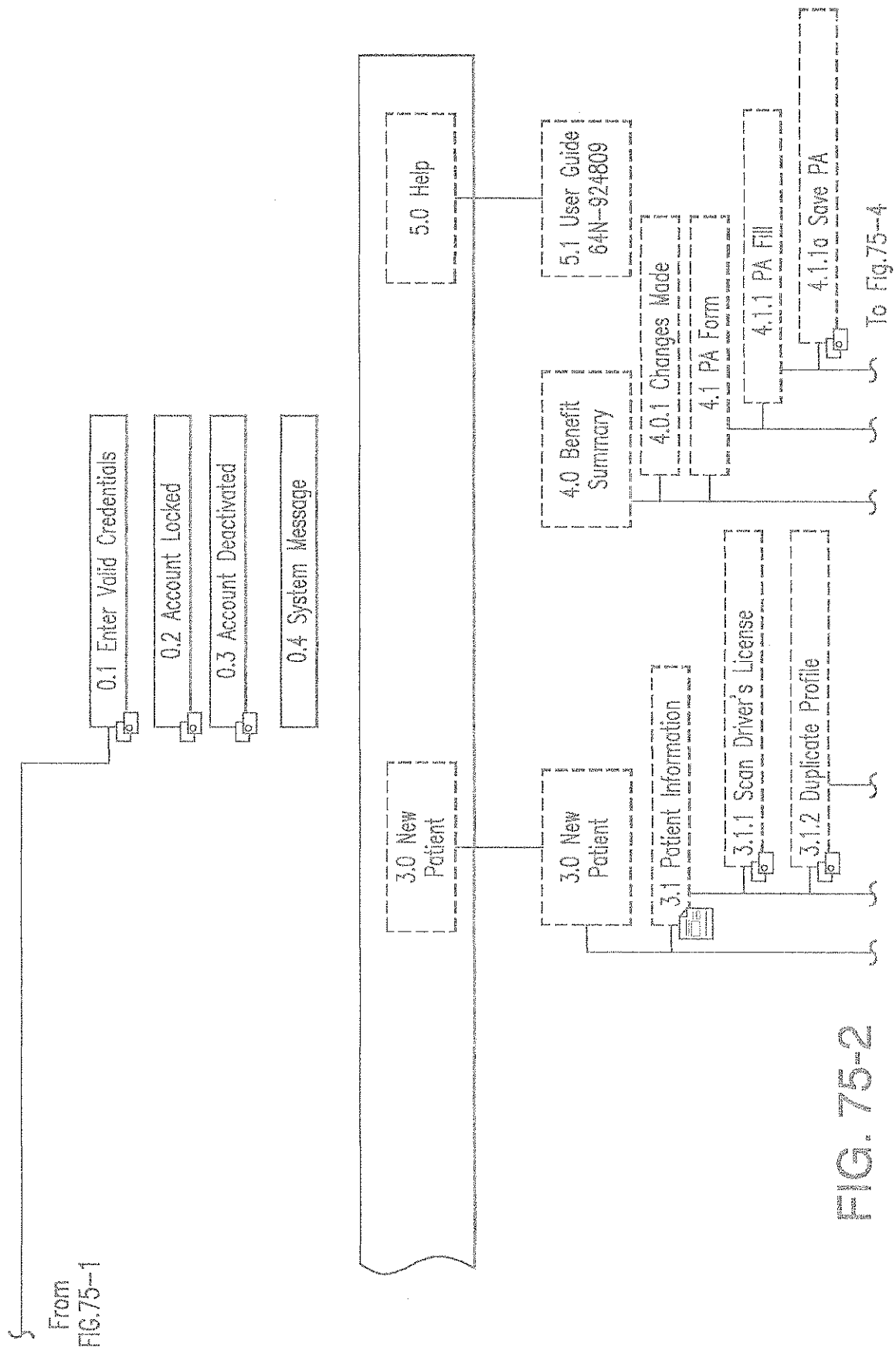


FIG. 74E



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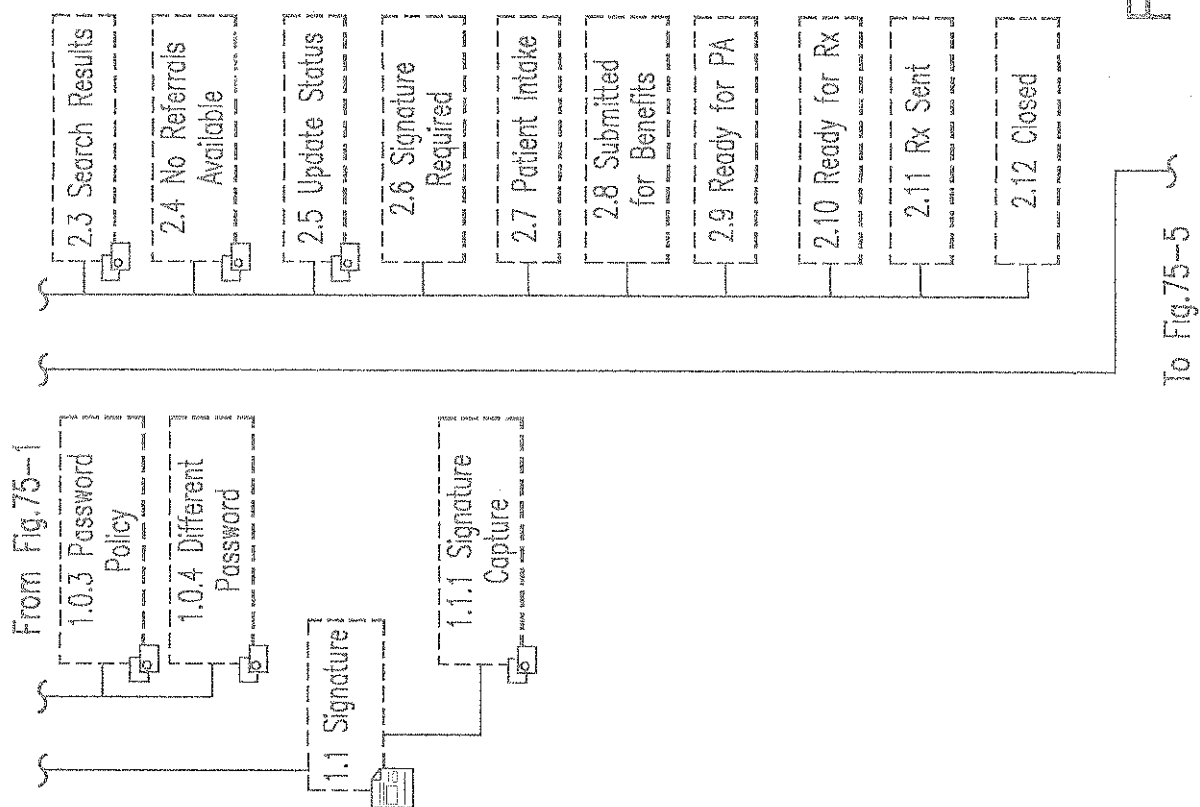
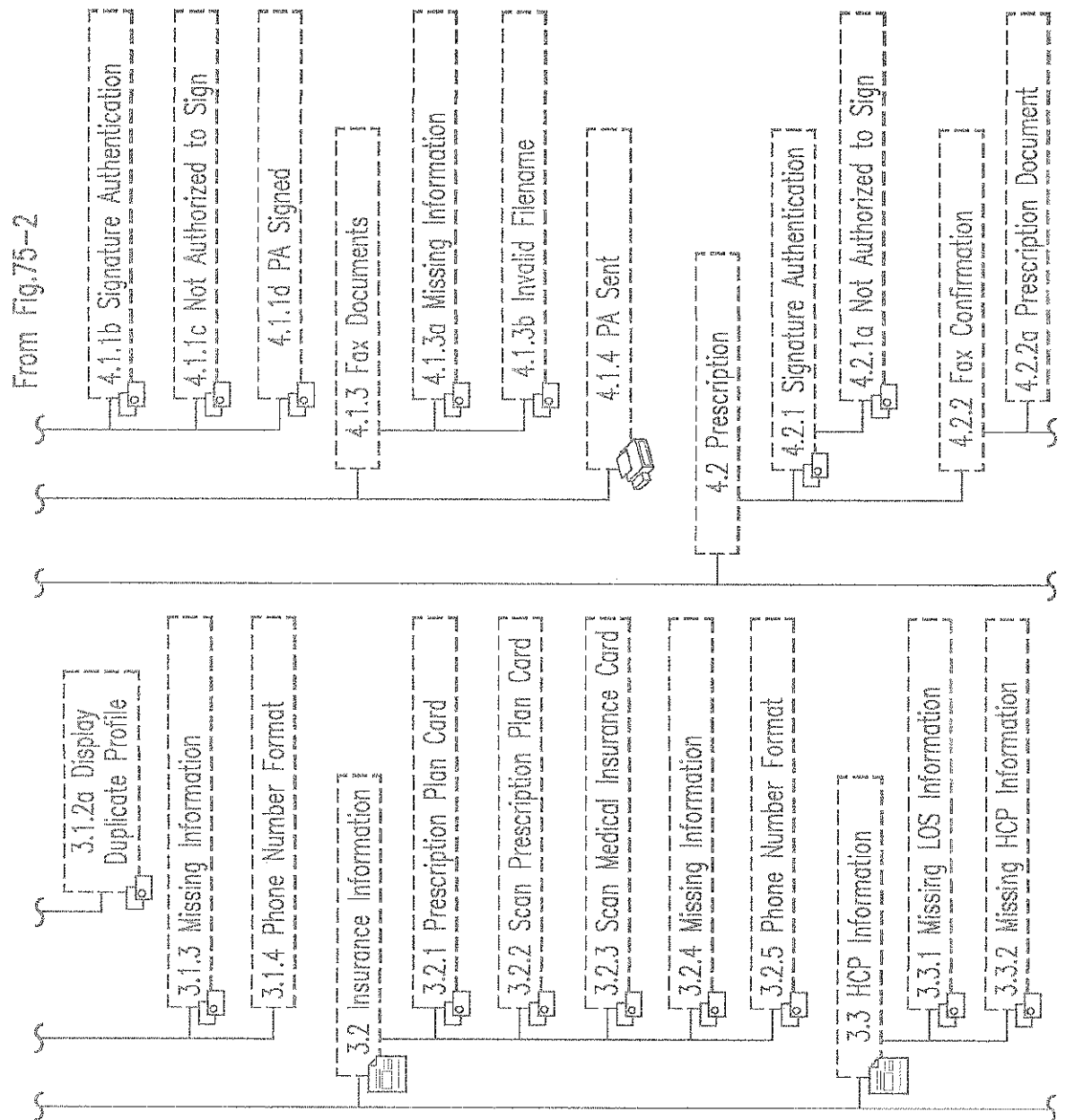


FIG. 75-3

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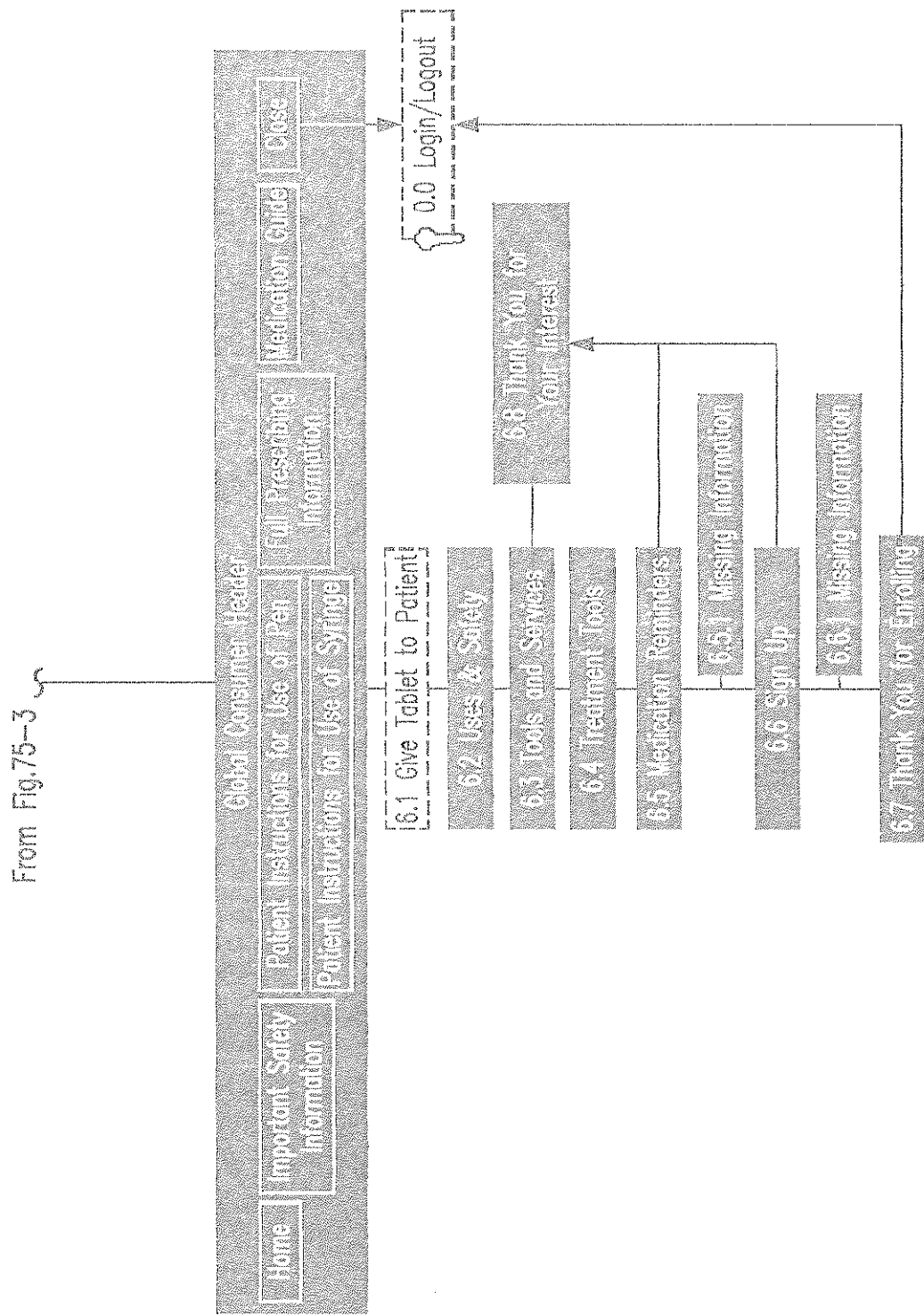
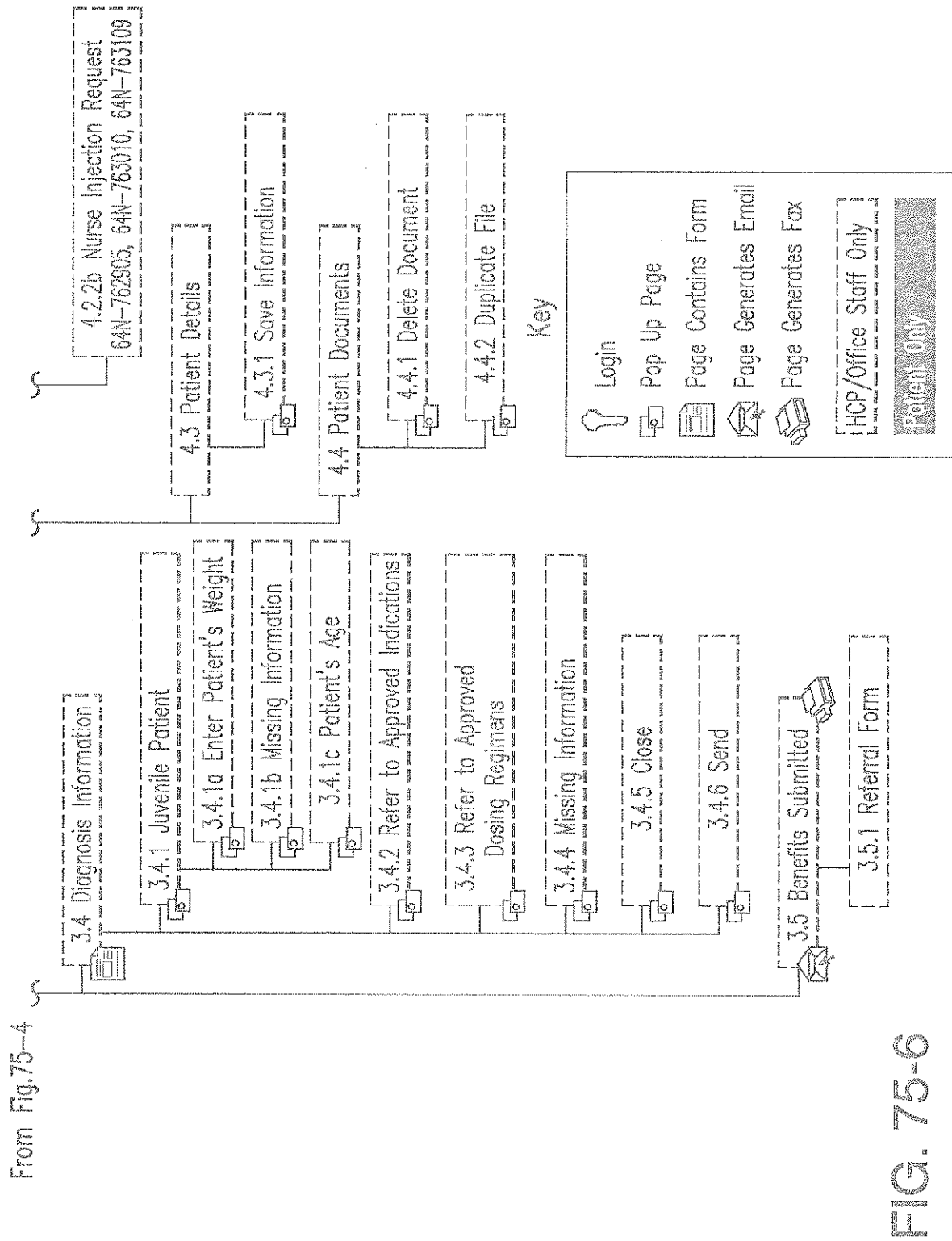


FIG. 75-5

101/110



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6.2 Rx


[DASHBOARD](#)
[NEW PATIENT](#)
[MY PROFILE](#)
[HELP](#)

 Hi, <Variable User Name> | [LOGOUT](#)

HEALTH CARE PROFESSIONALS		IMPORTANT SAFETY INFORMATION		FULL PRESCRIBING INFORMATION	
BENEFIT SUMMARY > PRIOR AUTHORIZATION (#) PRESCRIPTION		PATIENT DETAILS		PATIENT DOCUMENTS	
Confirm Details Edit					
Patient Details		Health Care Professional Details		Pharmacy Details	
<Variable Patient Name>		<Variable HCP Name>		<Variable Pharmacy Name>	
<Variable Street Address>		<Variable Street Address>		<Variable Street Address>	
<Variable City> <Variable State> <Var. Zip>		<Variable City> <Variable State> <Var. Zip>		<Variable City> <Variable State> <Var. Zip>	
<Variable Phone Number>		<Variable Phone>		<Variable Phone>	
<Variable DOB> <Variable Weight> <Allergies>		<Variable Phone>		<Variable Fax>	
Drug and Dosing					
Dosing Mode		<Variable Diagnosis & Therapy>		Quantity (Per/Syringe)	
<Variable Product Name Dosing Mode, mg/mL NDC>		<Variable SIG>		Refills	

FIG. 76-1

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<p>Ship To</p> <p>☐ Patient ☐ Health Care Professional</p> <p>Nurse Injection Training</p> <p>Would you like to order Nurse Injection Training for your patient? ☐ Yes ☐ No</p> <p>☐ The Nurse is to provide subcutaneous injection training.</p> <p>☐ The Nurse is to provide subcutaneous injection training, including administration by the nurse.</p> <p>Create Prescription</p> <p>☒ Dispense as written/Do not Substitute</p> <p>☐ Substitution permitted d/Brand exchange permitted</p> <p>Click here for full Prescribing Information.</p>	<p><input type="button" value="SIGN"/></p> <p><input type="button" value="SUBMIT FOR SIGNATURE"/></p> <p><input type="button" value="SEND"/></p>
---	--

FIG. 76-2

104/110

CHANGES MADE TO PATIENT DETAILS	[X] CLOSE
Pharmacy Solutions has updated Patient details. Review the changes and accept or reject them.	<input type="button" value="REJECT ALL"/> <input type="button" value="ACCEPT ALL"/>
PATIENT INFORMATION	
<Variable field name> was changed from <Original Value> to <New Value>	<input type="button" value="REJECT ALL"/> <input type="button" value="ACCEPT ALL"/>
INSURANCE INFORMATION	
<Variable field name> was changed from <Original Value> to <New Value>	<input type="button" value="REJECT ALL"/> <input type="button" value="ACCEPT ALL"/>

FIG. 77

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HUMIRA® (adalimumab) Nursing Services Request Form Rheumatology

To
FIG.78-1

Patient Information

Name: <u>Shannon Sword</u>	
Sex (circle one): ☒ F ☐ M	Date of Birth: <u>2/25/1985</u>
Address: <u>17689 W Running Creek Ct</u>	
City: <u>Gurnee</u>	State: <u>IL</u> Zip: <u>60031</u>
Day Phone: <u>1234567890</u>	Evening: _____
Alternate Phone Number: _____	
Primary Language: _____	
Email Address: _____	
Personal Representative: _____ Relationship: _____	

Patient's Diagnosis	
☐ Rheumatoid Arthritis (714.0)	☐ Ankylosing Spondylitis (720.0) ☒ Date of Diagnosis: <u>10-08-2012</u>
☒ Psoriatic Arthritis (696.0)	☐ Polyarticular Juvenile Idiopathic Arthritis [JIA] (714.30)

Request for Nurse Injection Training (order valid for one year)	
☐ The Nurse (RN) is to provide subcutaneous injection training for HUMIRA	
☒ The Nurse (RN) is to provide subcutaneous injection training for HUMIRA, including administration by the Nurse (RN)	
☐ Follow up calls only*. _____	Start Date: _____
*Series of five (5) calls to foster patient confidence with self-injection topics such as storage and site care	
HUMIRA Nursing Order (this is not a prescription) (circle one):	
New to HUMIRA ☐	Restart on HUMIRA ☐ Continuing on HUMIRA ☒
Drug Allergies: <u>Codeine</u>	
Pharmacy: <u>WALGREENS</u>	

Physician Signature (no Stamps): <u>Codeine</u>	Date: <u>10/8/2012</u>
---	------------------------

Please see Important Safety Information, including BOXED WARNING on Serious Infections and Malignancy, on next page.

Please see full Prescribing information provided or visit www.rxabbott.com/pdf/humira.pdf.

FIG. 78-1

From
FIG.78-2

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Please sign and fax this form to 866-980-1066
For questions, please call 800-448-6472

Physician Information

Physician Name: <u>Crazy Santhosh</u>	(circle one):	☒ MD	☐ DO	☐ Other:
Office Name: <u>TCT</u>				
Address: <u>Gandhi Nagar Bhuj</u>				
City: <u>Bhopal</u>	State: <u>NV</u>	Zip: <u>383058</u>		
State License #: <u>1234567890 1234567890 1234567890</u>	NPI #: <u>1234567890 1234567890 123456</u>			
Email Address: <u>santhoshkumar.perumal@abbott.com</u>				
Office Contact: <u>Crazy Santhosh</u>				
Phone: <u>4805280528</u>		Fax: <u>093583058</u>		

Disease Therapies (this is not a prescription)

Rheumatoid Arthritis, Ankylosing Spondylitis, Psoriatic Arthritis, and Polyarticular JIA if ≥ 30 kg (66 lbs)

☒ HUMIRA Pen 40 mg/0.8 mL 40mg SC inj. every other week, #2 pens Refills: 2

☐ HUMIRA Prefilled Syringe 40 mg/0.8 mL 40mg SC inj. every other week, #2 syringes Refills:

Polyarticular JIA if 15 kg (33 lbs) to <30 kg (66 lbs) only

☐ HUMIRA Prefilled Syringe 20 mg/0.4 mL 20 mg SC inj. every other week, #2 syringes Refills:

OTHER

☐ HUMIRA Sig: Qty: Refills:

HUMIRA is indicated, alone or in combination with methotrexate or other non-biologic DMARDs, for reducing signs and symptoms, inducing major clinical response, inhibiting the progression of structural damage, and improving physical function in adult patients with moderately to severely active rheumatoid arthritis. HUMIRA is indicated, alone or in combination with methotrexate, for reducing signs and symptoms of moderately to severely active polyarticular juvenile idiopathic arthritis in pediatric patients 4 years of age and older. HUMIRA is indicated, alone or in combination with non-biologic DMARDs, for reducing signs and symptoms, inhibiting the progression of structural damage, and improving physical function in adult patients with active psoriatic arthritis. HUMIRA is indicated for reducing signs and symptoms in adult patients with active ankylosing spondylitis.

Serious Infections

Patients treated with HUMIRA are at increased risk for developing serious infections that may lead to hospitalization or death. These infections include active tuberculosis (TB), reactivation of latent TB, invasive fungal infections, and bacterial, viral, and other infections due to opportunistic pathogens. Most patients who developed these infections were taking concomitant immunosuppressants such as methotrexate or corticosteroids.

Malignancies

Lymphoma, including a rare type of T-cell lymphoma, and other malignancies, some fatal, have been reported in patients treated with TNF blockers, including HUMIRA.

Other Serious Adverse Reactions

Patients treated with HUMIRA also may be at risk for other serious adverse reactions, including anaphylaxis, hepatitis B virus reactivation, demyelinating disease, cytopenias, pancytopenia, heart failure, and a lupus-like syndrome.

FIG. 78-2

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pharmacy SOLUTIONS

Hi, Shannon Pharmacy Solutions
User Guide

Referral In Progress

Referral Processed | Logout

Search for Patient

Practice Name	HCP Name	HCP State	Patient Name	myHUMIRA Enrollment	Created Date	Time Since Last Update
<u>Formal Testing</u>	Crazy Santhosh	Illinois	Michael Moore	No	Oct 08 2012, 18:08	0 days ago
<u>Formal Testing</u>	Crazy Santhosh	Illinois	Shannon Sward	No	Oct 08 2012, 17:34	0 days ago
<u>Formal</u>	VTP HCP	Louisiana	MOUNA DEa	No	Oct 05 2012, 06:54	1 days ago
<u>Formal</u>	VTP TWO	Louisiana	Jerry rich	No	Oct 05 2012, 03:30	1 days ago
<u>V Care</u>	HCPone Validation	New Mexico	Referral Four	No	Oct 05 2012, 02:22	1 days ago
<u>V Care</u>	HCPone Validation	New Mexico	Referral Three	No	Oct 05 2012, 02:18	1 days ago
<u>V Care</u>	HCPone Validation	New Mexico	Referral Two	No	Oct 05 2012, 02:16	1 days ago
<u>V Care</u>	HCPone Validation	New Mexico	Referral One	No	Oct 05 2012, 02:12	1 days ago
<u>QA Formal</u>	HCP Two VTP SixtyFour	Nevada	Patient Two	No	Oct 05 2012, 01:29	1 days ago
<u>QA Formal</u>	HCP One VTP SixtyFour	California	Patient One	No	Oct 05 2012, 00:54	1 days ago
<u>Formal Testing</u>	Crazy Santhosh	Maine	Abcdefghijklmnopqrstuvwxyz Abcdefghijklm Abcdefghijklmnopqrstuvwxyz Abcdefghijkl m	No	Oct 04 2012, 16:24	2 days ago

Sham Swords

DOCTOR_MADAM

Kansas

Susan Jones

No

Oct 04 2012, 12:42

2 days ago

FIG. 79

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		Hi, Shannon Pharmacy Solutions User Guide	
pharmacy SOLUTIONS		Referral In Progress Referral Processed Logout	
<div style="display: flex; justify-content: space-between; align-items: center;"> <div> Send Close </div> <div> Notify Missing PA Form </div> </div>			
<div style="border: 1px solid black; padding: 5px;"> <u>Referral Summary</u> Referral ID 19380 Patient Name <u>Shannon Sword</u> Diagnosis <u>Rheumatology</u> Insurance <u>Prescription Card</u> HCP <u>Crazy Santhosh</u> Enrolled in <u>No</u> myHUMIRA </div>		<div style="border: 1px solid black; padding: 5px;"> <u>PA Form</u> <div style="display: flex; justify-content: space-between;"> <div> PA Required <input type="text" value="Yes"/> Specialty <input type="text" value="Rheumatology"/> PA Document <input type="text" value="Aetna - All - 1.0"/> Insurance Carrier <input type="text" value="Aetna"/> Therapy State <input type="text" value="Ongoing Therapy"/> Fax Number <input type="text" value="1234567890"/> </div> <div> Attach to Referral Cancel </div> </div> </div>	
<div style="border: 1px solid black; padding: 5px;"> <u>PA Forms</u> </div>		<div style="border: 1px solid black; padding: 5px;"> <u>Pharmacy</u> </div>	
<div style="border: 1px solid black; padding: 5px;"> <u>Documents</u> Add New BV Request Shannon Sword 10/08/2012.pdf </div>			

FIG. 80

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Pharmacy SOLUTIONS

Referral In Progress

Referral Processed

Logout

Hi, Shannon Pharmacy Solutions
User Guide

Referral Summary
 Referral ID 19380
 Patient Name Shannon Sword
 Diagnosis Rheumatology
 Insurance Prescription Card
 HCP Crazy Santhosh
 Enrolled in No
 myHUMIRA
 PA Forms
☒ Aetna_PS, RA, PSA_1.0 - Starting Therapy ☒

Documents
 Add New
 BV Request Shannon Sword 10/08/2012.pdf

Enter Pharmacy Details
 Fulfilling Pharmacy - Pharmacy Solutions [No]

Pharmacy Name Walgreens
 State Select

City
 Zip

Send Close

Pharmacy Name	Address	City	State	Zip
☐ Walgreens	200 field dr	fsafs	Michigan	32432432
☐ WALGREENS	PO BOX 1020	BEAVERTON	Oregon	97075
☐ WALGREENS	4323 CHICAGO AVE	MINNEAPOLIS	Minnesota	55407
☒ WALGREENS	P.O. BOX 628001	ORLANDO	Florida	32862
☐ WALGREENS	2220 S INTERSTATE 35	ROUND ROCK	Texas	78681
☐ WALGREENS	3715 MECHANICSVILLE TP KE	RICHMOND	Virginia	23223
☐ WALGREENS	8633 W CHARLESTON BLVD.	LAS VEGAS	Nevada	89117
☐ WALGREENS	9775 SW GEMINI DR.	BEAVERTON	Oregon	970078
☐ WALGREENS	2323 L ST	OMAHA	Nebraska	68107
☐ WALGREENS FOR HLTH PARTNERS	1143 HIGHLAND DR.	ANN ARBOR	Michigan	48108

>

FIG. 81-1

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*denotes a required field

Pharmacy Name*	WALGREENS		
Address*	P.O. BOX 628001		
	ALTERNATE P# 888-782-8443		
City*	ORLANDO		
State*	FL		
Zip*	32862		
Phone Number*	8007490009	Extn	
Fax Number*	8666176685		

Add Cancel

FIG. 81-2