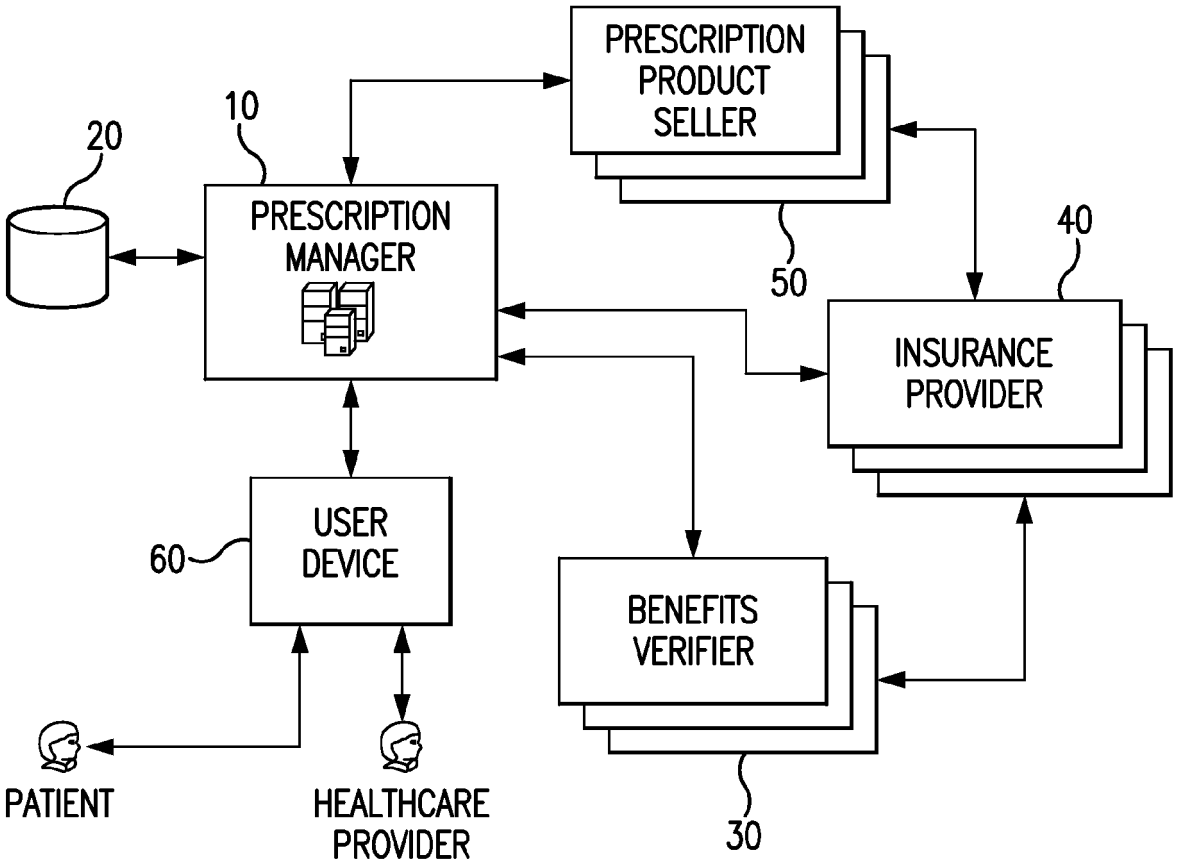

PRESCRIPTION PRODUCT SELLER
10
20
PRESCRIPTION MANAGER
50
40
INSURANCE PROVIDER
USER DEVICE
60
BENEFITS VERIFIER
PATIENT
HEALTHCARE PROVIDER
30

FIG. 1

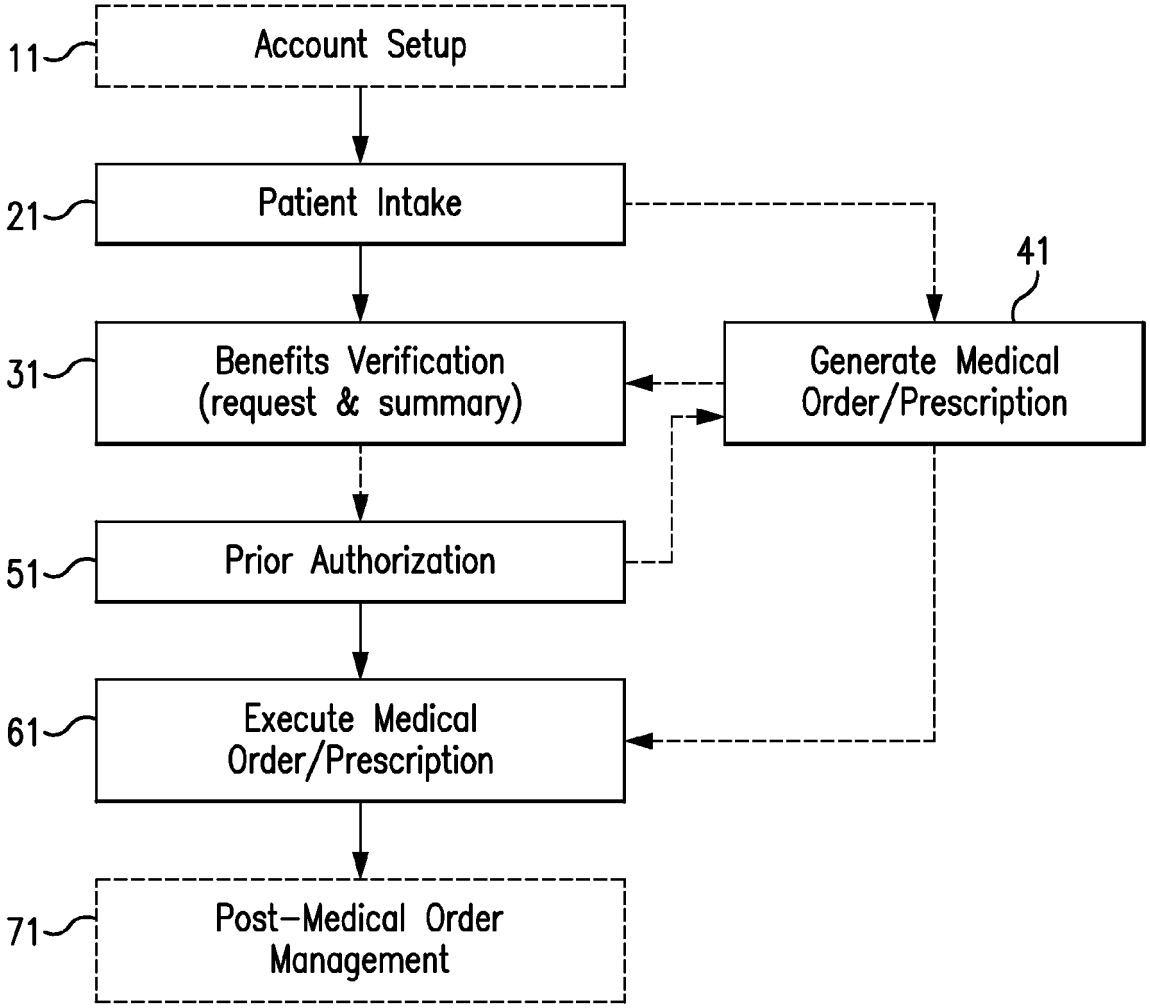

11
Account Setup
21
Patient Intake
41
31
Benefits Verification
(request & summary)
Generate Medical
Order/Prescription
51
Prior Authorization
61
Execute Medical
Order/Prescription
71
Post-Medical Order
Management

FIG. 2

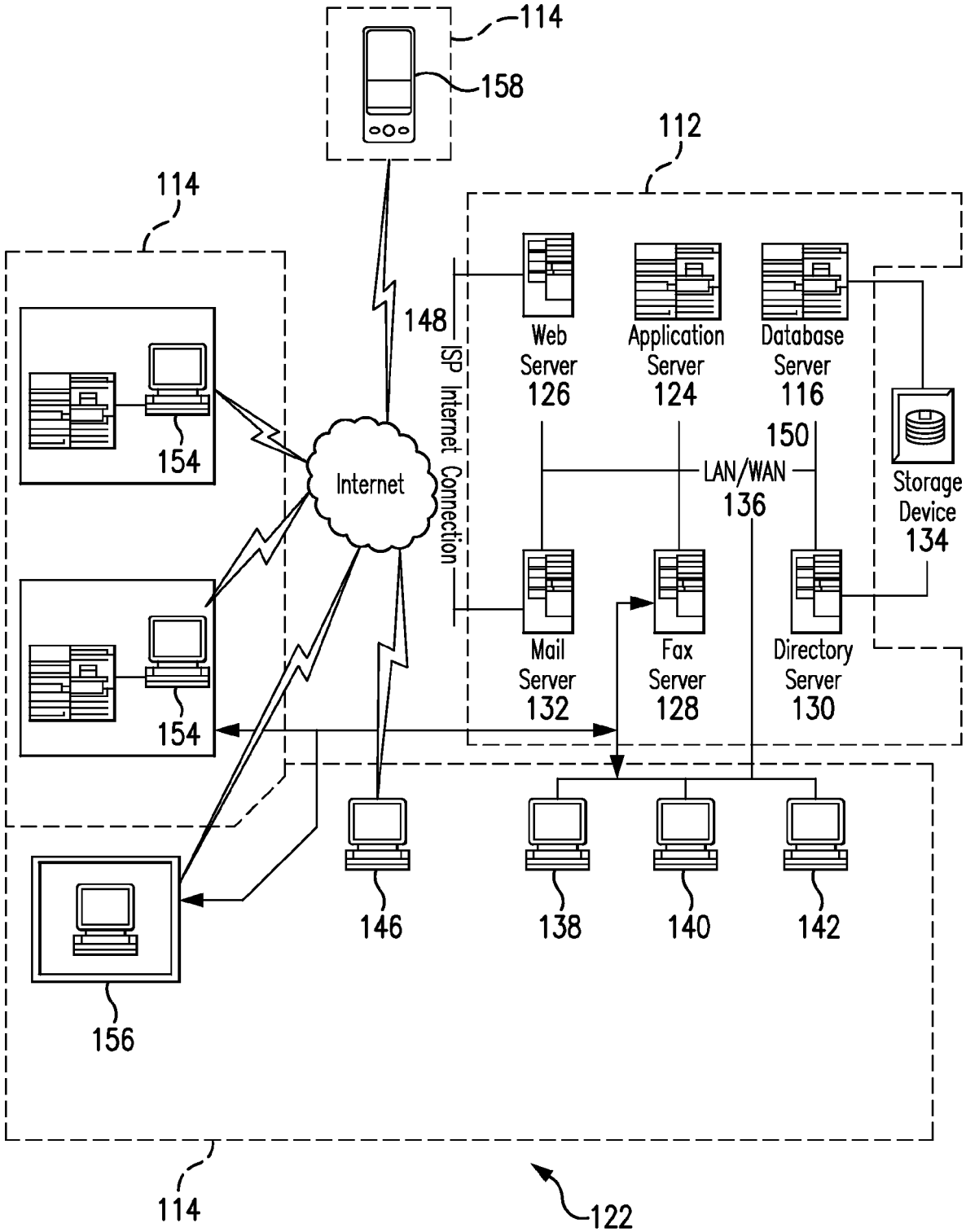

114
158
112
114
148
ISP Internet Connection
Web Server 126
Application Server 124
Database Server 116
150
LAN/WAN 136
Storage Device 134
Internet
154
154
Mail Server 132
Fax Server 128
Directory Server 130
146
138
140
142
156
114
122

FIG. 3A

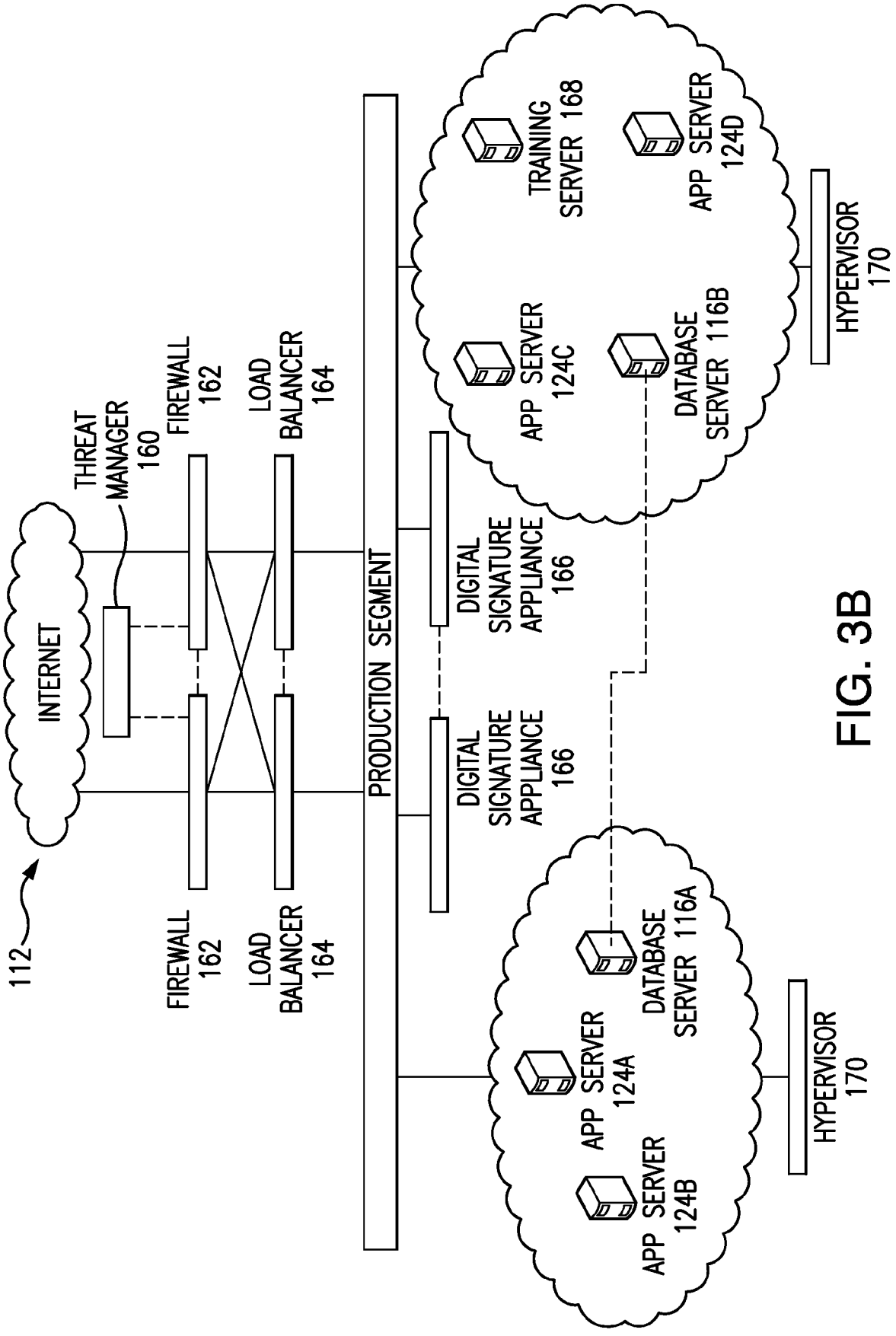

INTERNET
112
THREAT MANAGER 160
FIREWALL 162
LOAD BALANCER 164
FIREWALL 162
LOAD BALANCER 164
PRODUCTION SEGMENT
DIGITAL SIGNATURE APPLIANCE 166
DIGITAL SIGNATURE APPLIANCE 166
TRAINING SERVER 168
APP SERVER 124D
APP SERVER 124C
DATABASE SERVER 116B
HYPERVISOR 170
APP SERVER 124A
APP SERVER 124B
DATABASE SERVER 116A
HYPERVISOR 170

FIG. 3B

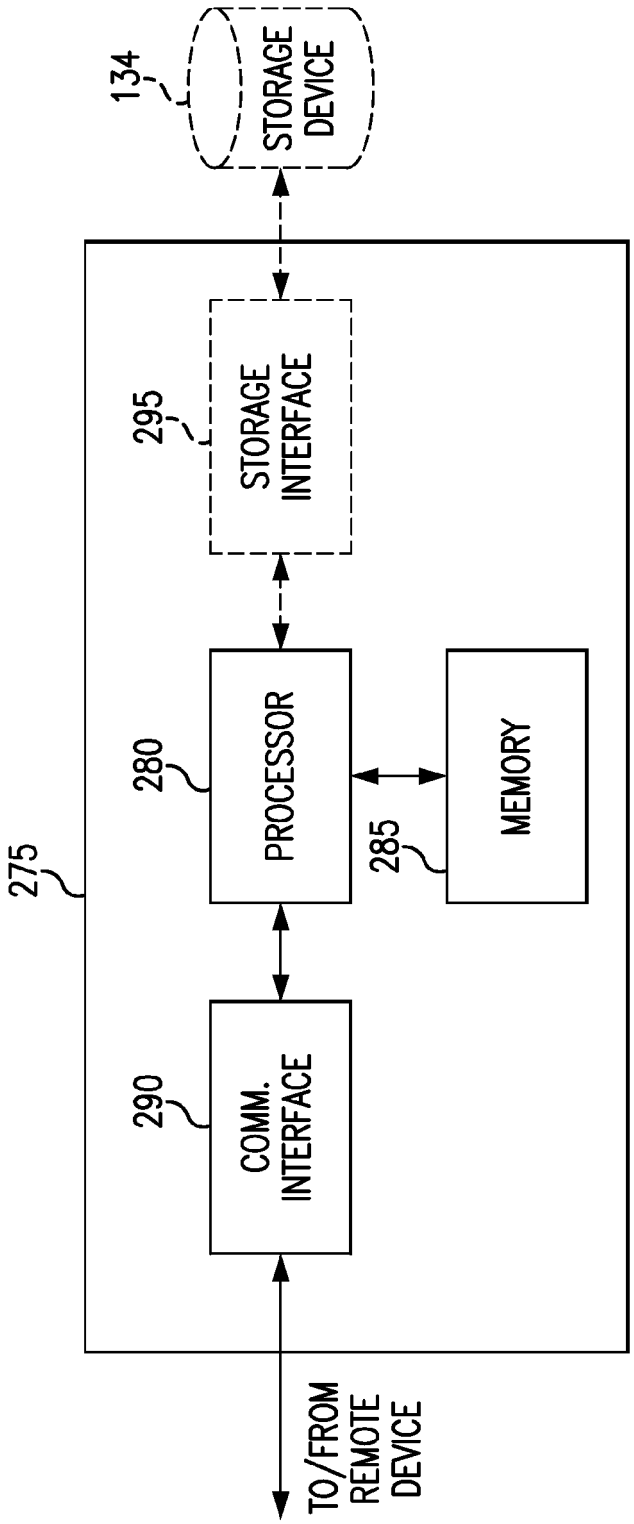

134
STORAGE DEVICE
295
STORAGE INTERFACE
280
PROCESSOR
285
MEMORY
275
290
COMM. INTERFACE
TO/FROM REMOTE DEVICE

FIG. 3C

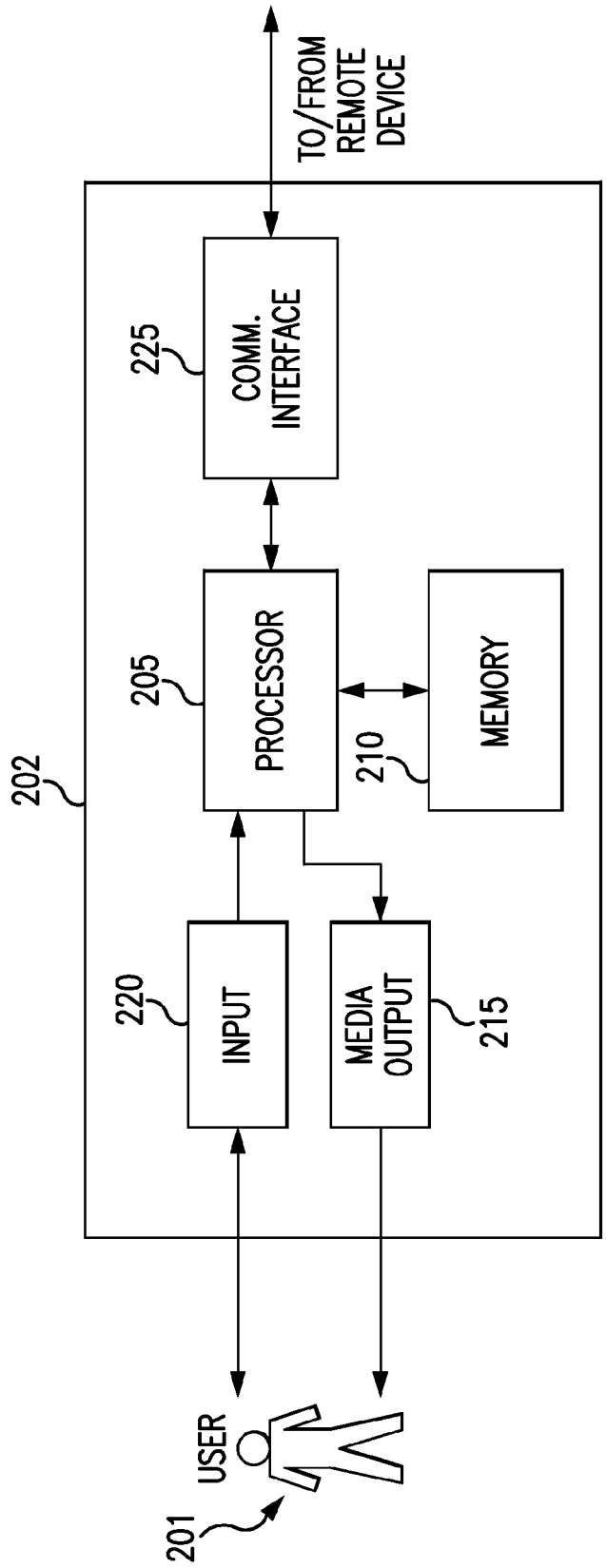

TO/FROM REMOTE DEVICE
225
COMM. INTERFACE
205
PROCESSOR
210
MEMORY
202
220
INPUT
MEDIA OUTPUT
215
USER
201

FIG. 4

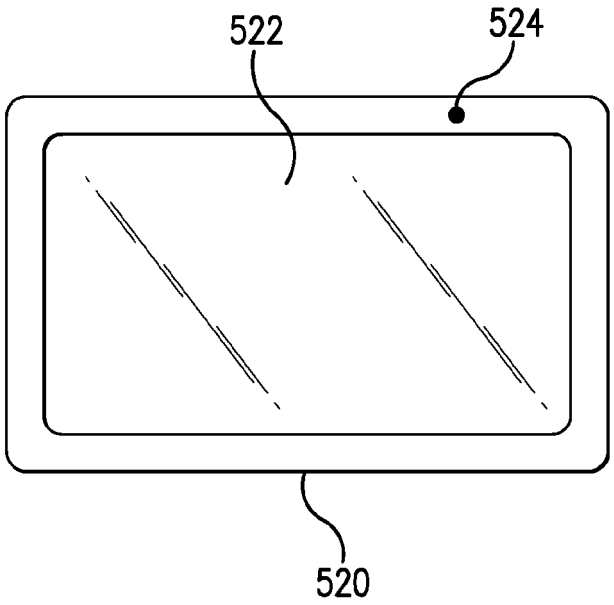


FIG. 5A

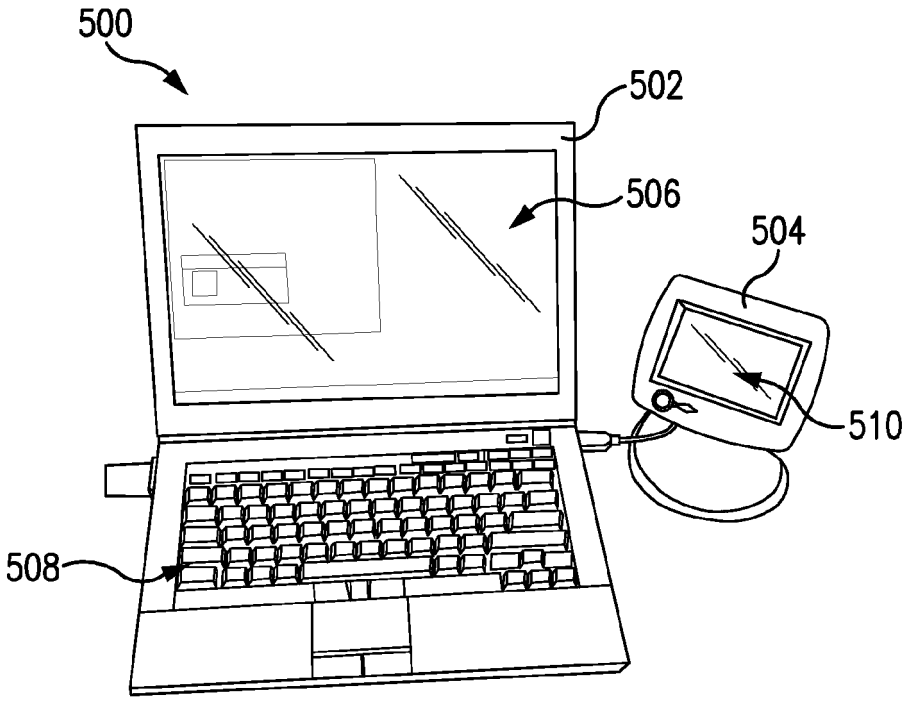


FIG. 5B

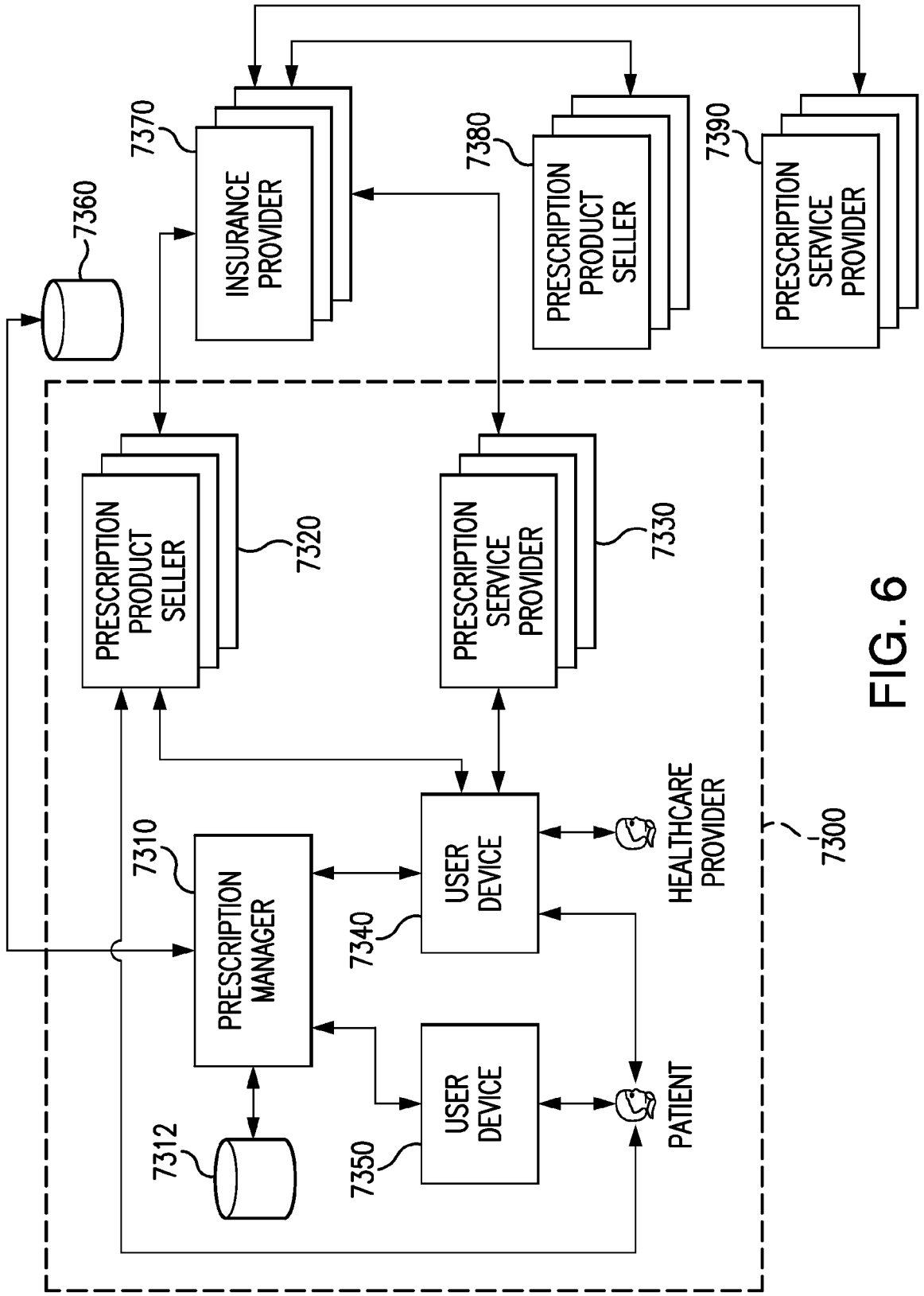

7370
INSURANCE PROVIDER
7380
PRESCRIPTION PRODUCT SELLER
7390
PRESCRIPTION SERVICE PROVIDER
7360
7320
PRESCRIPTION PRODUCT SELLER
7330
PRESCRIPTION SERVICE PROVIDER
7310
PRESCRIPTION MANAGER
7340
USER DEVICE
HEALTHCARE PROVIDER
7300
7312
7350
USER DEVICE
PATIENT

FIG. 6

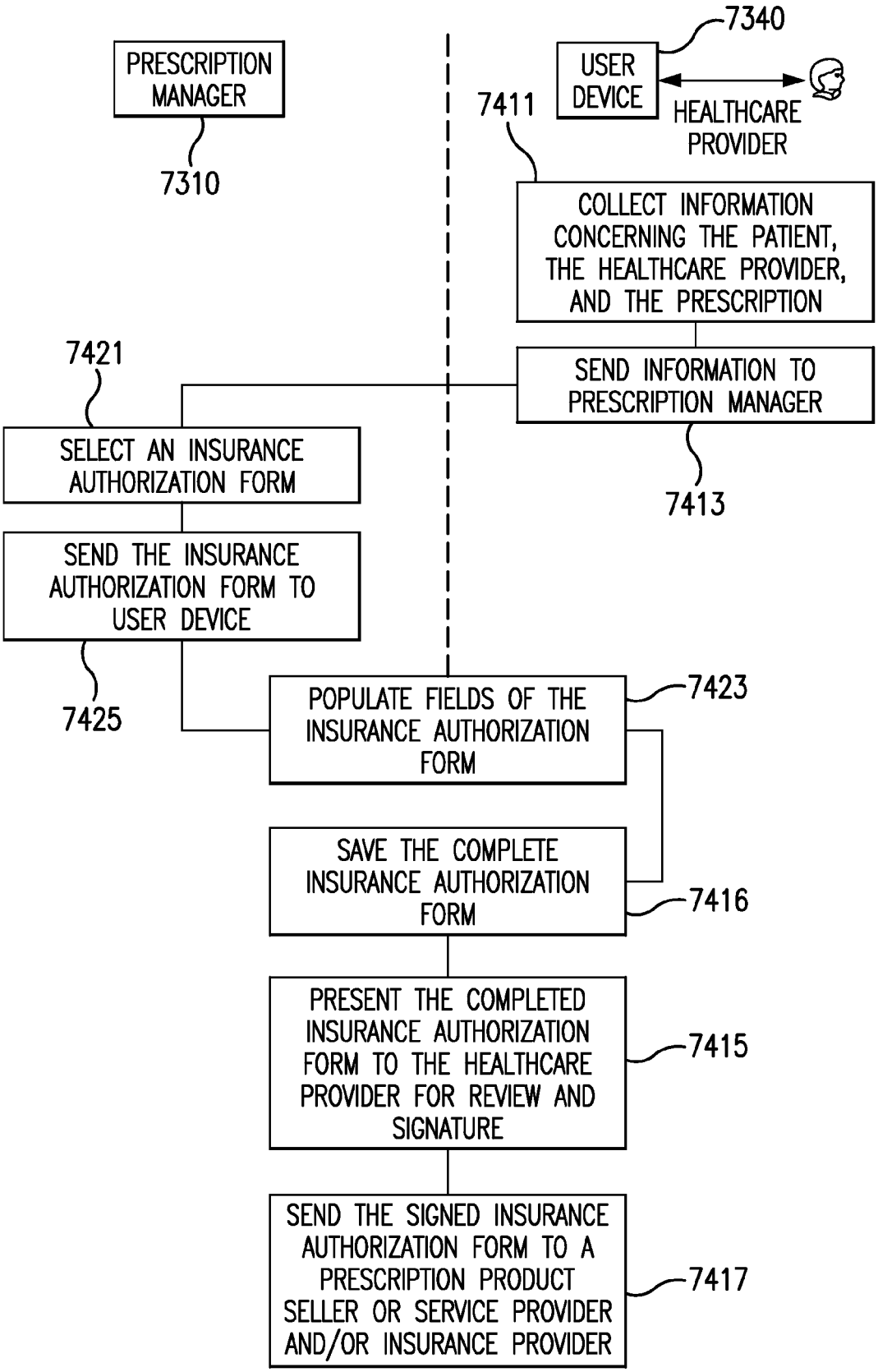

PRESCRIPTION MANAGER
7310
7340
USER DEVICE
HEALTHCARE PROVIDER
7411
COLLECT INFORMATION CONCERNING THE PATIENT, THE HEALTHCARE PROVIDER, AND THE PRESCRIPTION
SEND INFORMATION TO PRESCRIPTION MANAGER
7413
7421
SELECT AN INSURANCE AUTHORIZATION FORM
SEND THE INSURANCE AUTHORIZATION FORM TO USER DEVICE
7425
POPULATE FIELDS OF THE INSURANCE AUTHORIZATION FORM
7423
SAVE THE COMPLETE INSURANCE AUTHORIZATION FORM
7416
PRESENT THE COMPLETED INSURANCE AUTHORIZATION FORM TO THE HEALTHCARE PROVIDER FOR REVIEW AND SIGNATURE
7415
SEND THE SIGNED INSURANCE AUTHORIZATION FORM TO A PRESCRIPTION PRODUCT SELLER OR SERVICE PROVIDER AND/OR INSURANCE PROVIDER
7417

FIG. 7

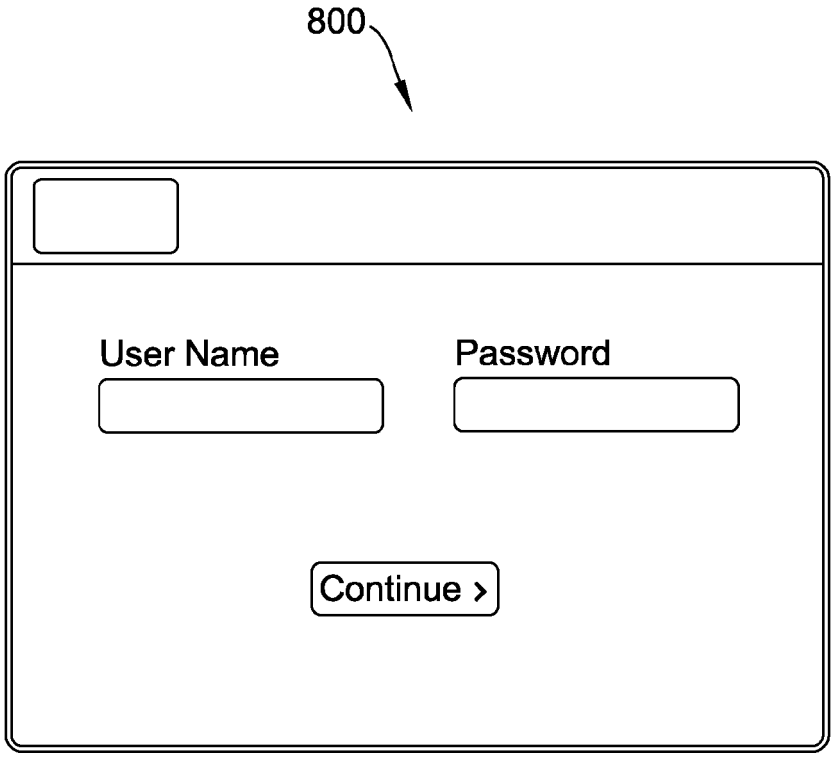
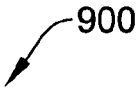


FIG. 8

FIG. 9



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

- ———

INDICATIONS[1]

- ———
- ———
- ———

Click here for Full Prescribing Information

Reference[1] ———

Continue

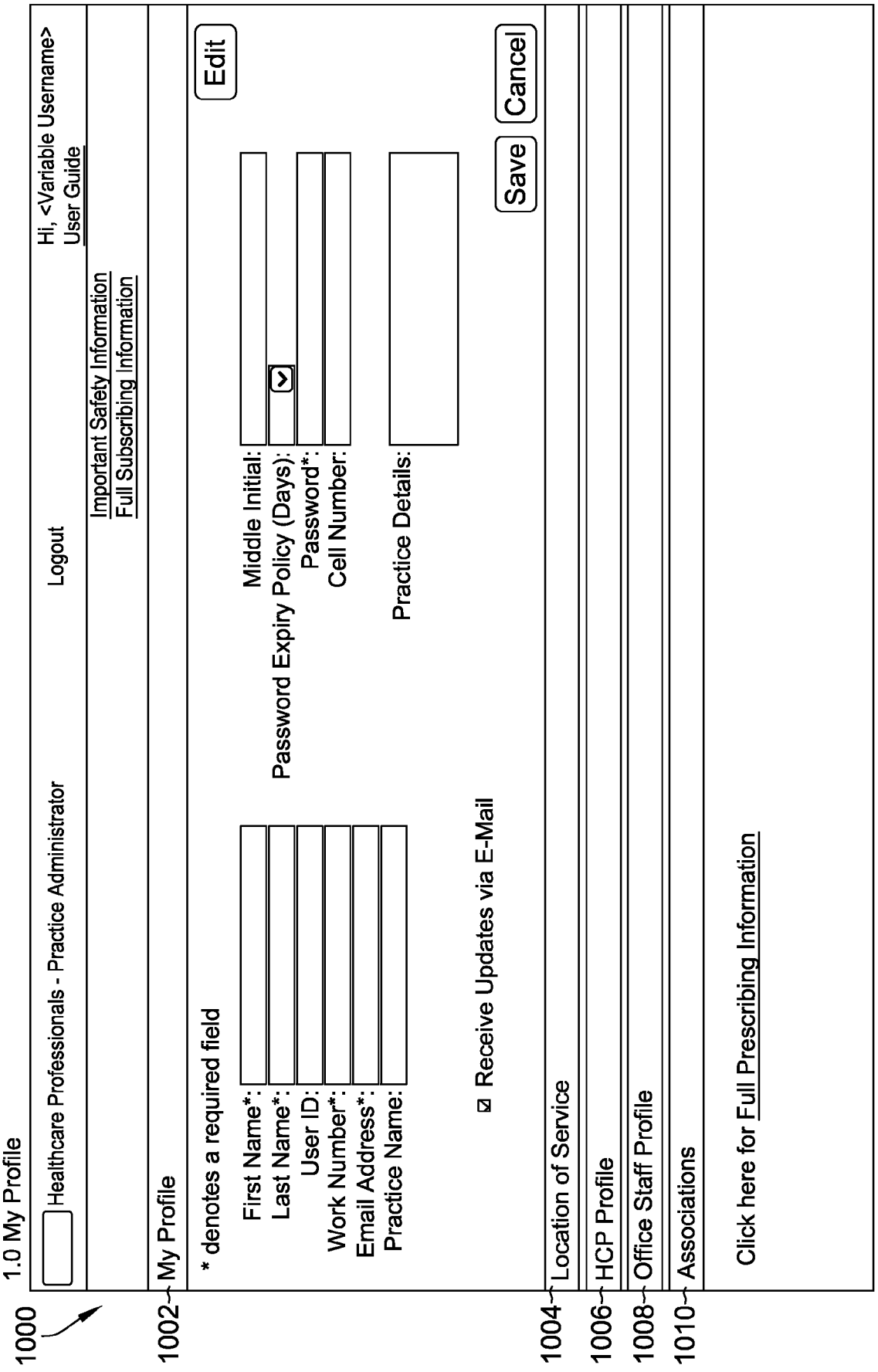

1000
1.0 My Profile
Healthcare Professionals - Practice Administrator
Logout
Hi, <Variable Username>
User Guide
Important Safety Information
Full Subscribing Information
1002
My Profile
* denotes a required field
Edit
First Name*:
Last Name*:
User ID:
Work Number*:
Email Address*:
Practice Name:
Middle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

FIG. 10

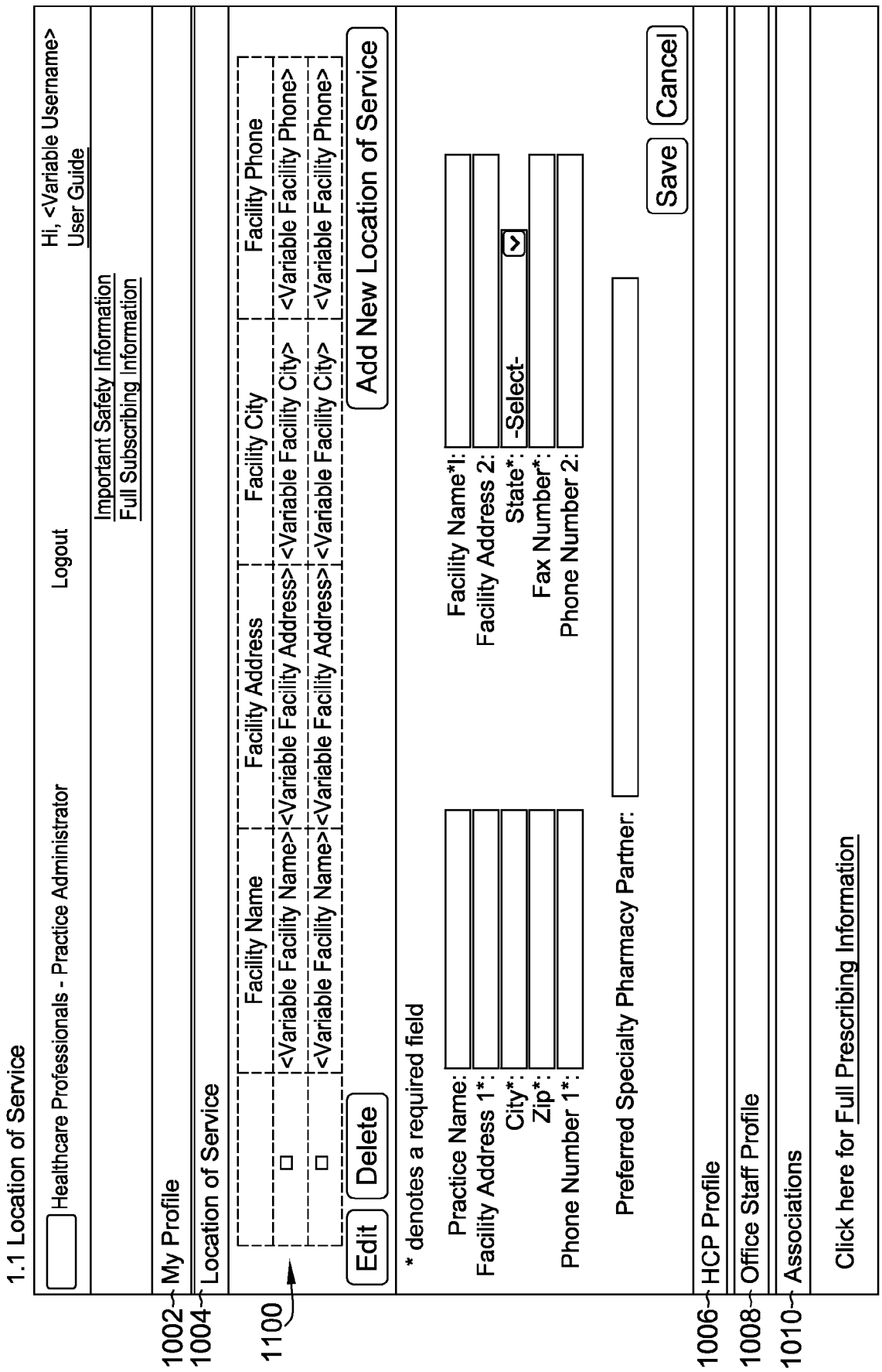

1.1 Location of Service
Healthcare Professionals - Practice Administrator
Logout
Hi, <Variable Username>
User Guide
Important Safety Information
Full Subscribing Information
1002 My Profile
1004 Location of Service
1100
Facility Name
Facility Address
Facility City
Facility Phone
<Variable Facility Name>
<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*l:
Facility Address 2:
State*:
-Select-
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

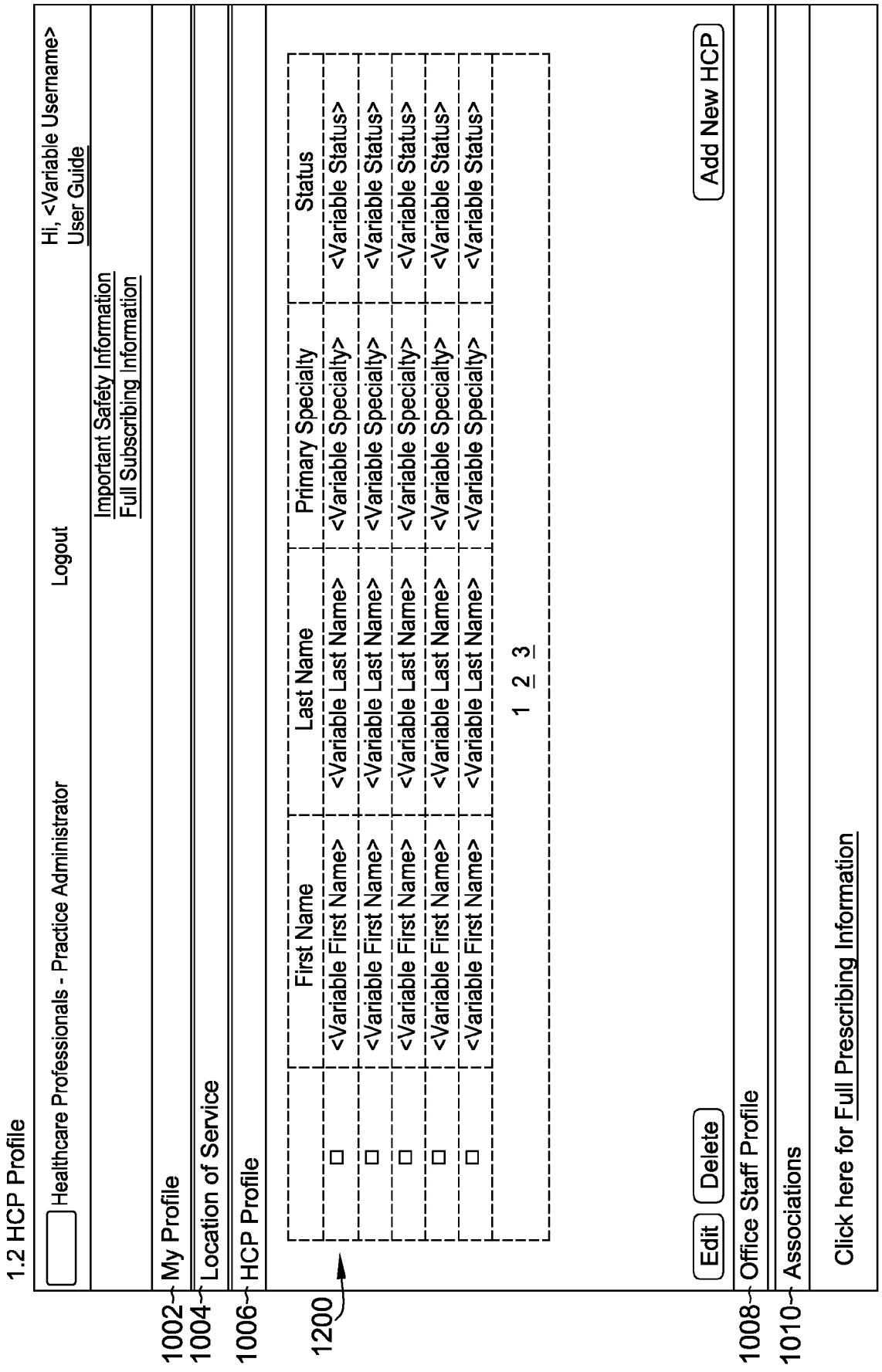

1.2 HCP Profile
Healthcare Professionals - Practice Administrator
Logout
Hi, <Variable Username>
User Guide
Important Safety Information
Full Subscribing Information
My Profile
Location of Service
HCP Profile
First Name
Last Name
Primary Specialty
Status
<Variable First Name>
<Variable Last Name>
<Variable Specialty>
<Variable Status>
1 2 3
Edit
Delete
Add New HCP
Office Staff Profile
Associations
Click here for Full Prescribing Information
1002
1004
1006
1200
1008
1010

FIG. 12

SUBSTITUTE SHEET (RULE 26)

1.2.1 Add New HCP

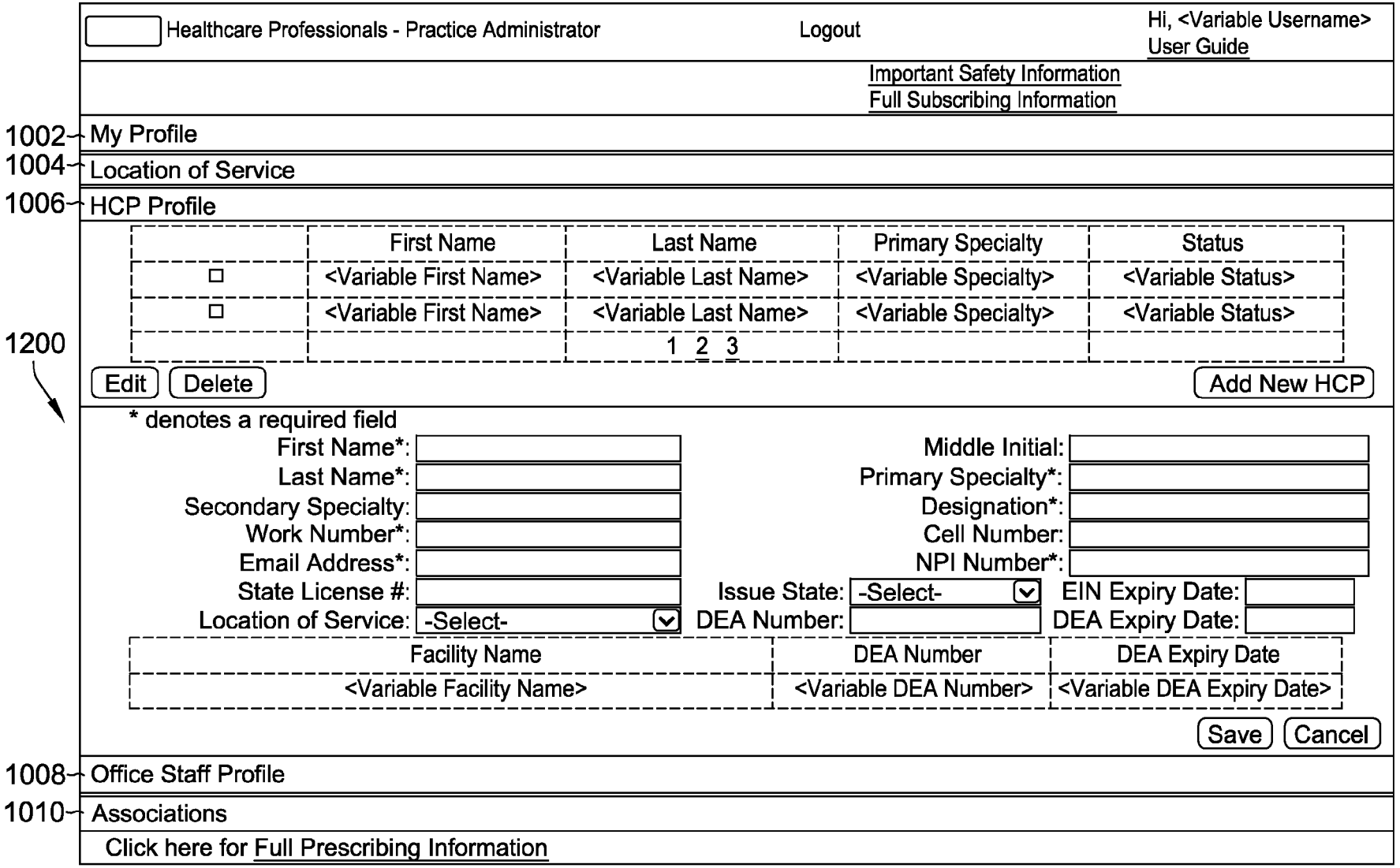


FIG. 13

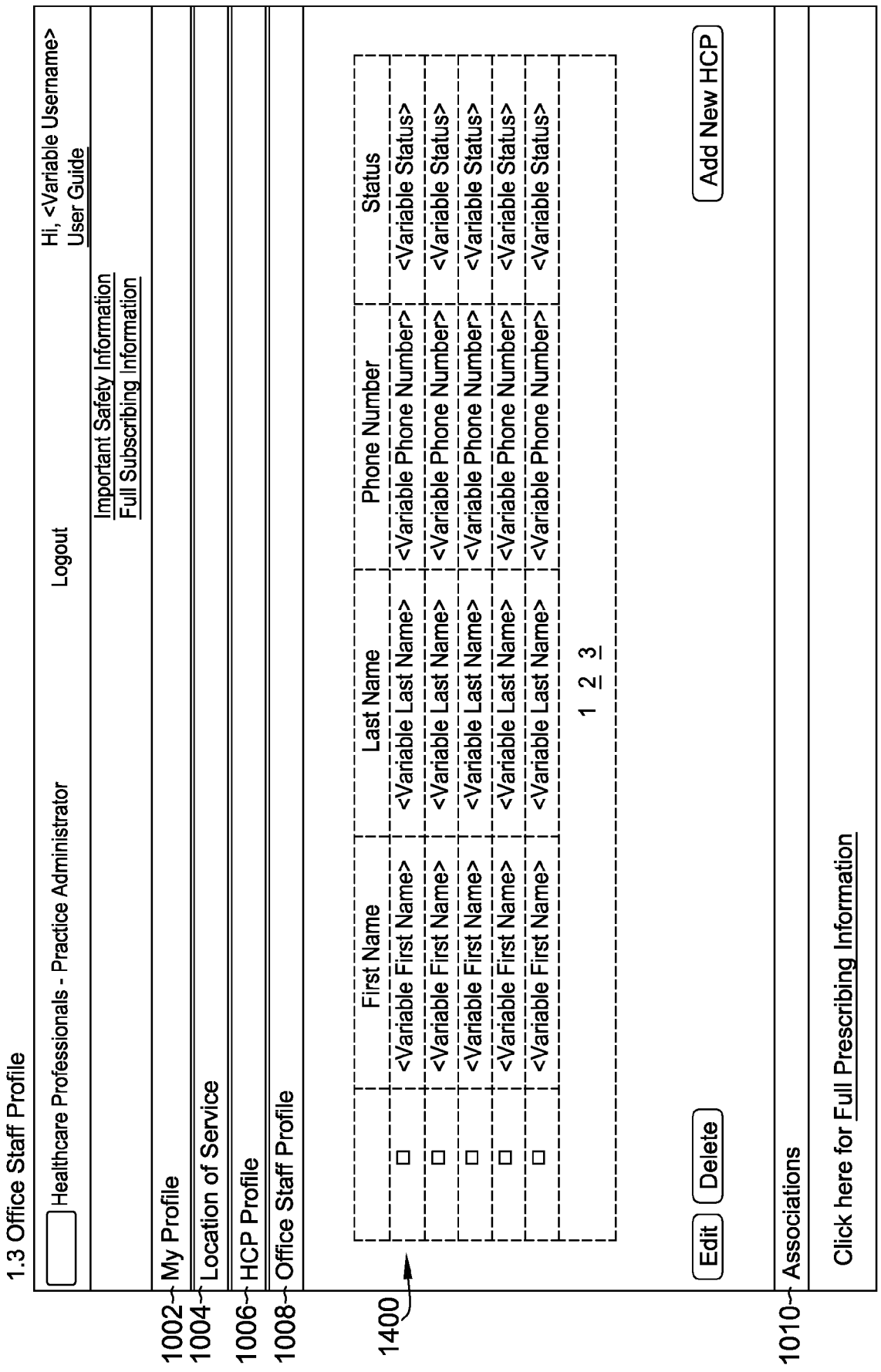

1.3 Office Staff Profile
Healthcare Professionals - Practice Administrator
Logout
Hi, <Variable Username>
User Guide
Important Safety Information
Full Subscribing Information
1002 My Profile
1004 Location of Service
1006 HCP Profile
1008 Office Staff Profile
1400
First Name
Last Name
Phone Number
Status
<Variable First Name>
<Variable Last Name>
<Variable Phone Number>
<Variable Status>
1 2 3
Edit
Delete
Add New HCP
1010 Associations
Click here for Full Prescribing Information

FIG. 14

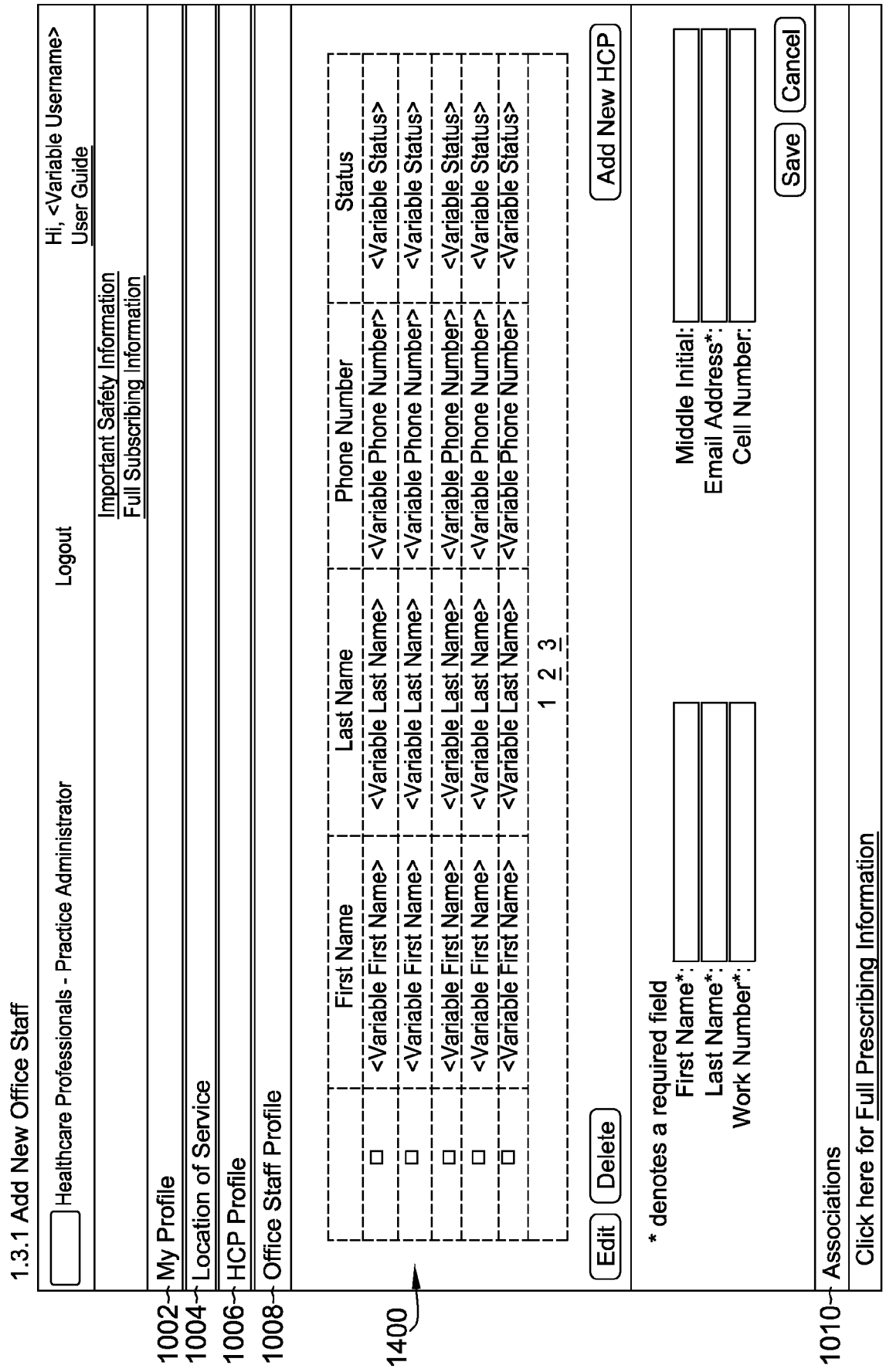

1.3.1 Add New Office Staff
Healthcare Professionals - Practice Administrator
Logout
Hi, <Variable Username>
User Guide
Important Safety Information
Full Subscribing Information
1002 My Profile
1004 Location of Service
1006 HCP Profile
1008 Office Staff Profile
1400
First Name
Last Name
Phone Number
Status
<Variable First Name>
<Variable Last Name>
<Variable Phone Number>
<Variable Status>
1 2 3
Edit
Delete
Add New HCP
* denotes a required field
First Name*:
Last Name*:
Work Number*:
Middle Initial:
Email Address*:
Cell Number:
Save
Cancel
1010 Associations
Click here for Full Prescribing Information

FIG. 15

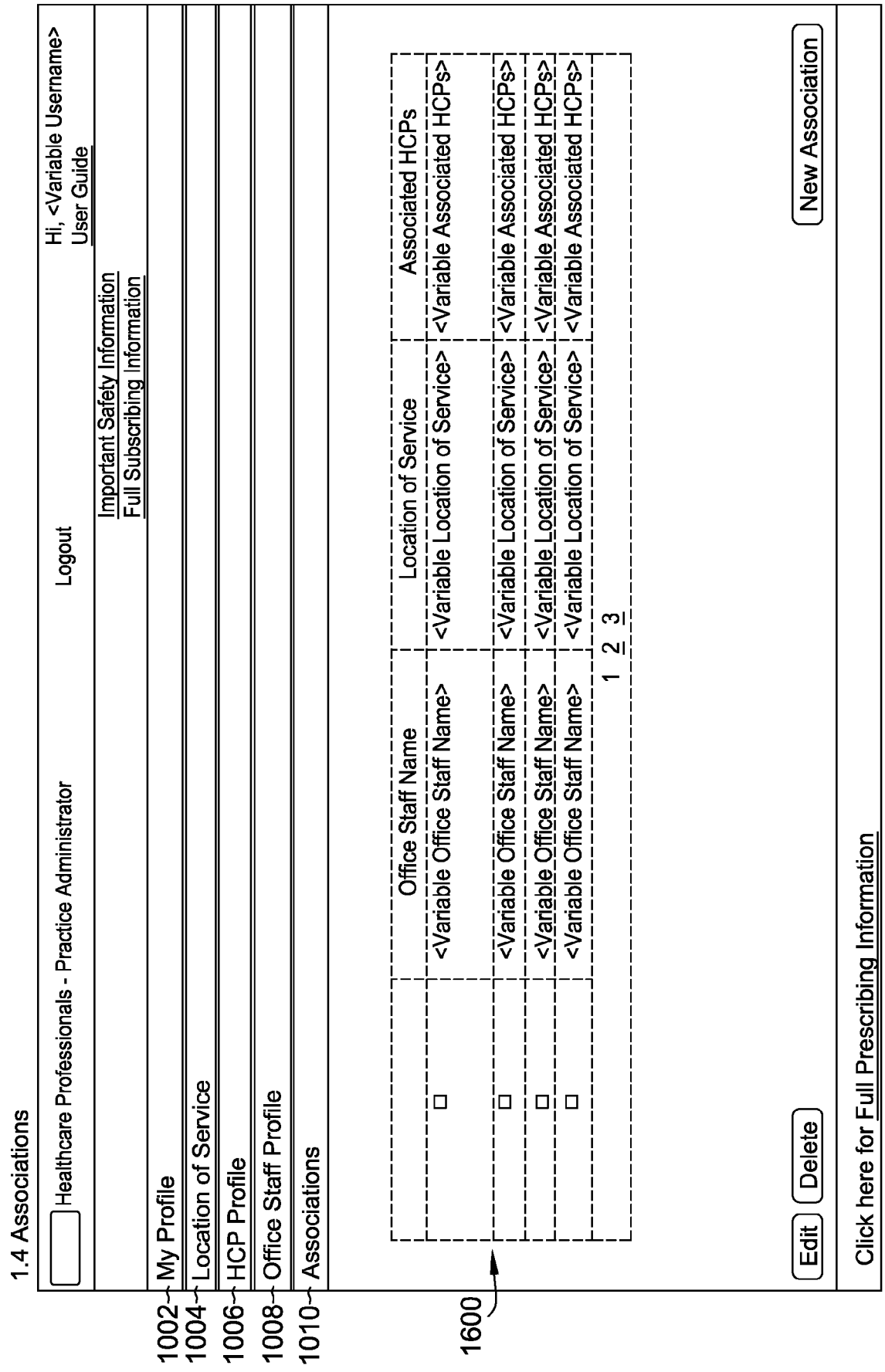

1.4 Associations
Healthcare Professionals - Practice Administrator
Logout
Hi, <Variable Username>
User Guide
Important Safety Information
Full Subscribing Information
My Profile
Location of Service
HCP Profile
Office Staff Profile
Associations
1002
1004
1006
1008
1010
1600
Office Staff Name
Location of Service
Associated HCPs
<Variable Office Staff Name>
<Variable Location of Service>
<Variable Associated HCPs>
1 2 3
Edit
Delete
New Association
Click here for Full Prescribing Information

FIG. 16

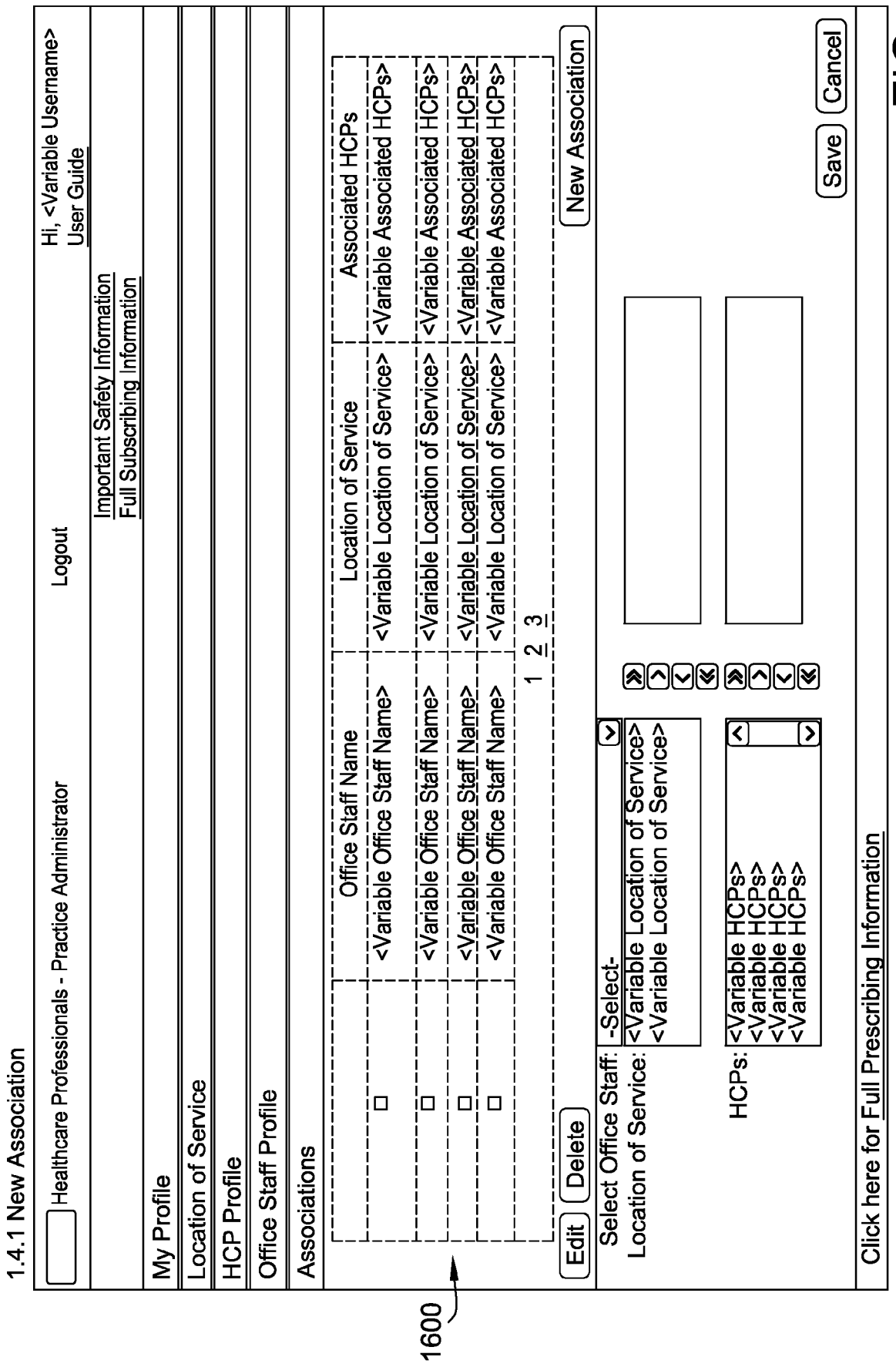

1.4.1 New Association
Healthcare Professionals - Practice Administrator
Logout
Hi, <Variable Username>
User Guide
Important Safety Information
Full Subscribing Information
My Profile
Location of Service
HCP Profile
Office Staff Profile
Associations
Office Staff Name
Location of Service
Associated HCPs
<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-
Location of Service:
<Variable Location of Service>
<Variable Location of Service>
HCPs:
<Variable HCPs>
<Variable HCPs>
<Variable HCPs>
<Variable HCPs>
Save
Cancel
Click here for Full Prescribing Information
1600

FIG. 17

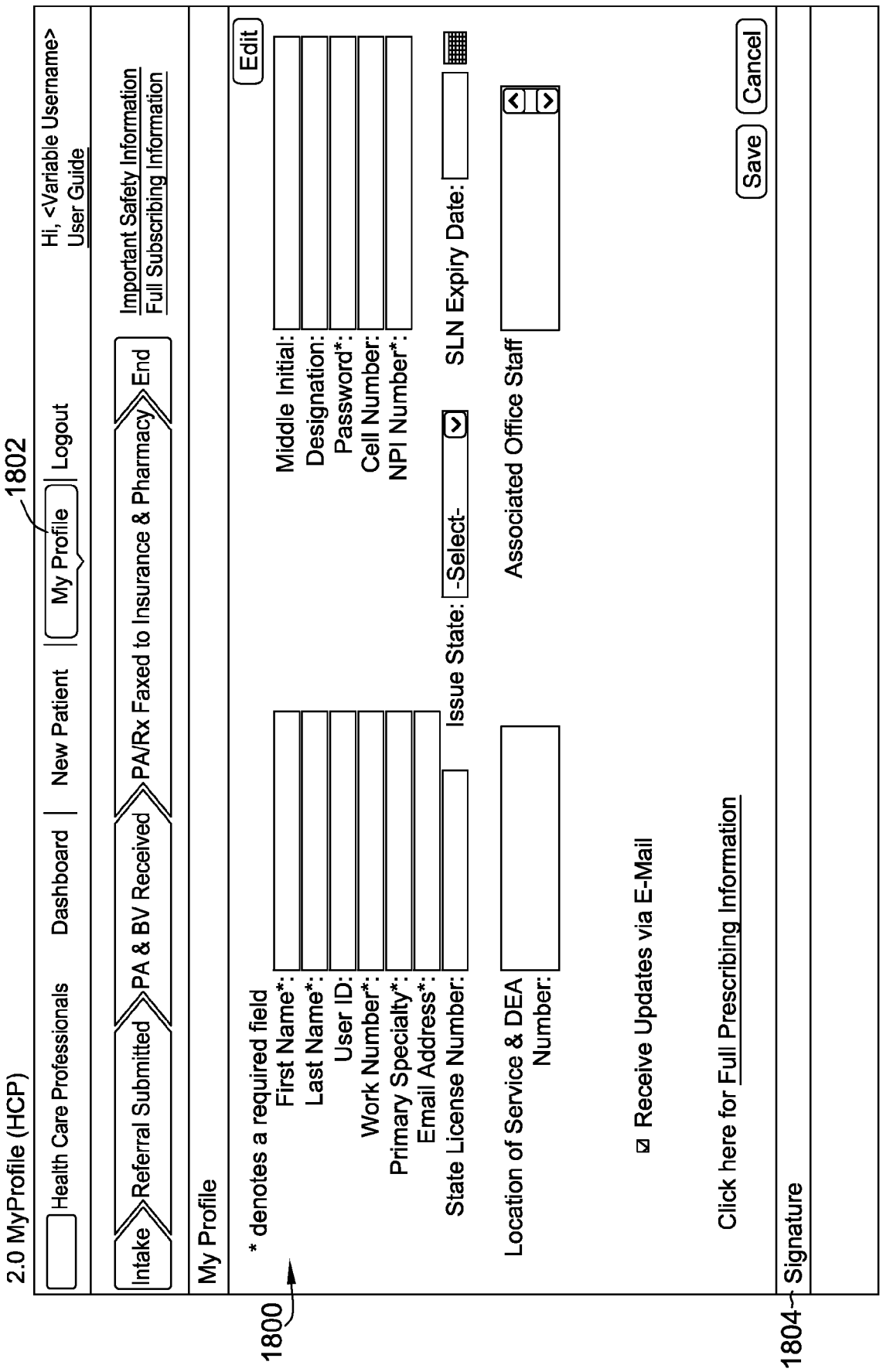

2.0 MyProfile (HCP)
Health Care Professionals
Dashboard
New Patient
My Profile
Logout
Hi, <Variable Username>
User Guide
Intake
Referral Submitted
PA & BV Received
PA/Rx Faxed to Insurance & Pharmacy
End
Important Safety Information
Full Subscribing Information
My Profile
Edit
* denotes a required field
First Name*:
Last Name*:
User ID:
Work Number*:
Primary Specialty*:
Email Address*:
State License Number:
Issue State:
-Select-
Middle Initial:
Designation:
Password*:
Cell Number:
NPI Number*:
SLN Expiry Date:
Location of Service & DEA Number:
Associated Office Staff
Receive Updates via E-Mail
Click here for Full Prescribing Information
Save
Cancel
Signature
1800
1802
1804

FIG. 18

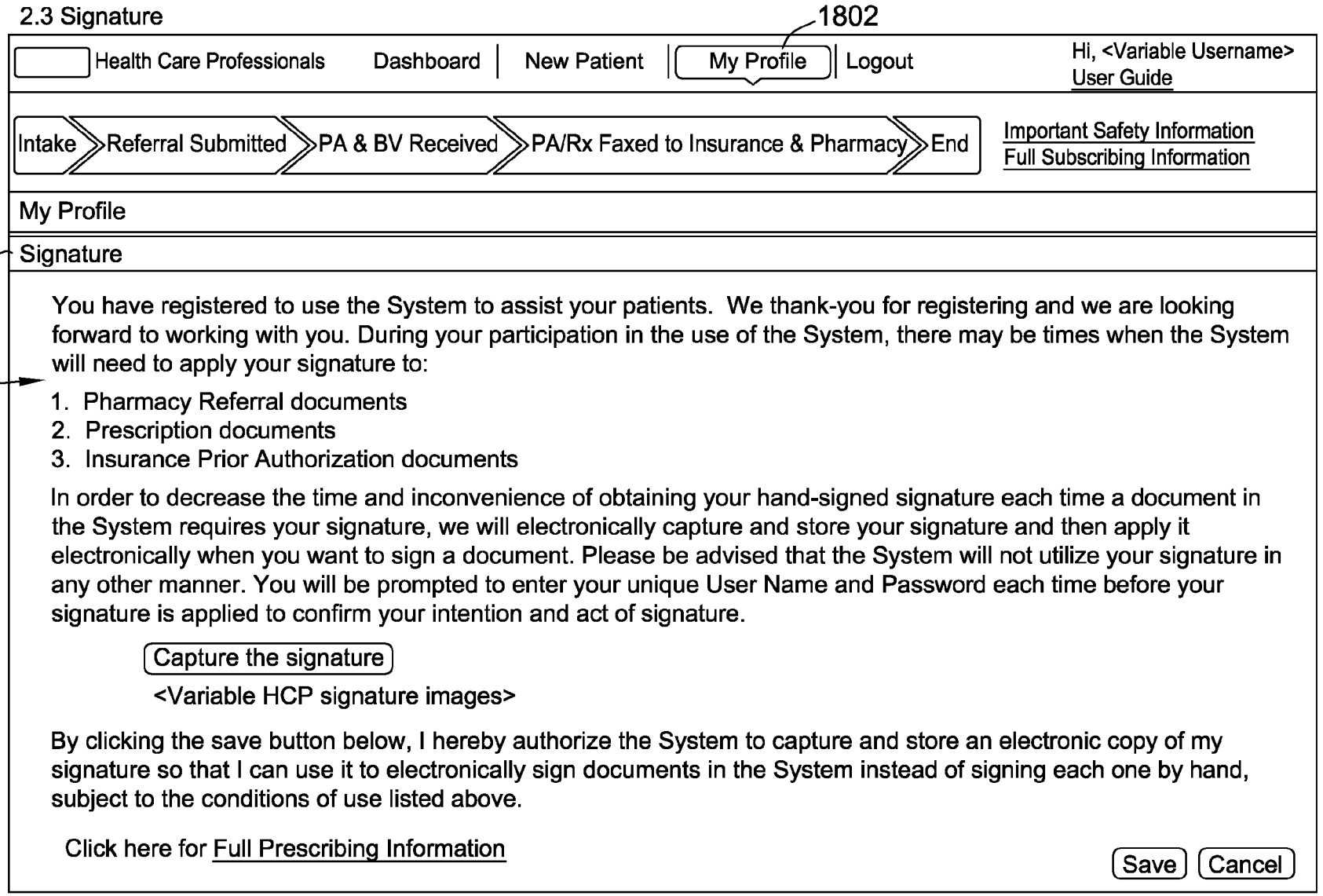

2.3 Signature
1802
Health Care Professionals
Dashboard
New Patient
My Profile
Logout
Hi, <Variable Username>
User Guide
Intake
Referral Submitted
PA & BV Received
PA/Rx Faxed to Insurance & Pharmacy
End
Important Safety Information
Full Subscribing Information
My Profile
1804
Signature
1900
You have 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

2.4 Signature Capture
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
Signature
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
the System requires your signature, we will electror
when you want to sign a document. Please be advi
You will be prompted to enter your unique User Na
confirm your intention and act of signature.
Capture the signature
<Variable HCP signature images>
Capture the Signature
Capture
Clear
Ok
signature each time a document in
apture and then apply it electronically
your signature in any other manner.
before your signature is applied to
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
2000

FIG. 20

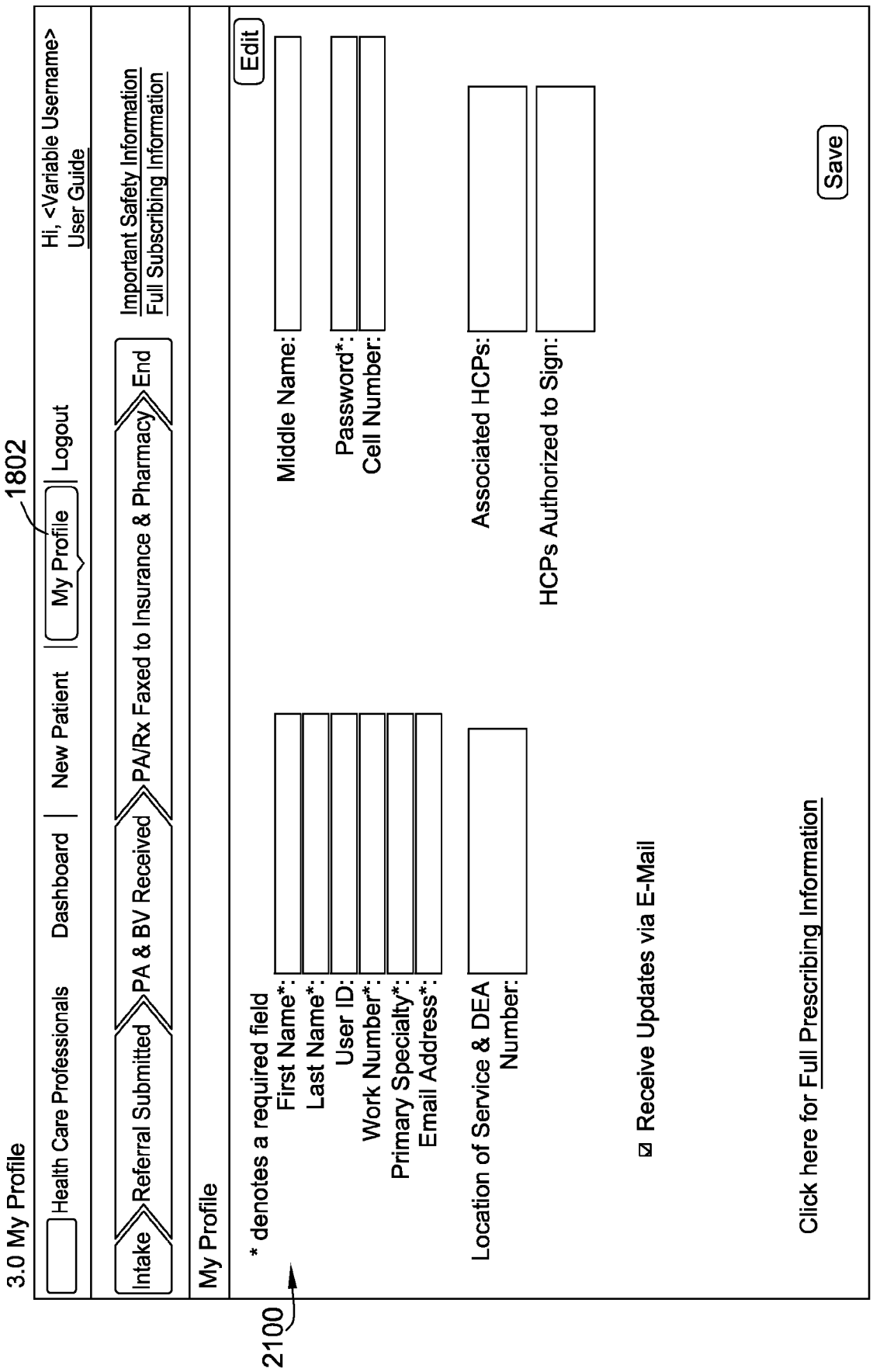

3.0 My Profile
1802
Health Care Professionals
Dashboard
New Patient
My Profile
Logout
Hi, <Variable Username>
User Guide
Intake
Referral Submitted
PA & BV Received
PA/Rx Faxed to Insurance & Pharmacy
End
Important Safety Information
Full Subscribing Information
My Profile
Edit
* denotes a required field
First Name*:
Last Name*:
User ID:
Work Number*:
Primary Specialty*:
Email Address*:
Location of Service & DEA Number:
Middle Name:
Password*:
Cell Number:
Associated HCPs:
HCPs Authorized to Sign:
☑ Receive Updates via E-Mail
Save
Click here for Full Prescribing Information
2100

FIG. 21

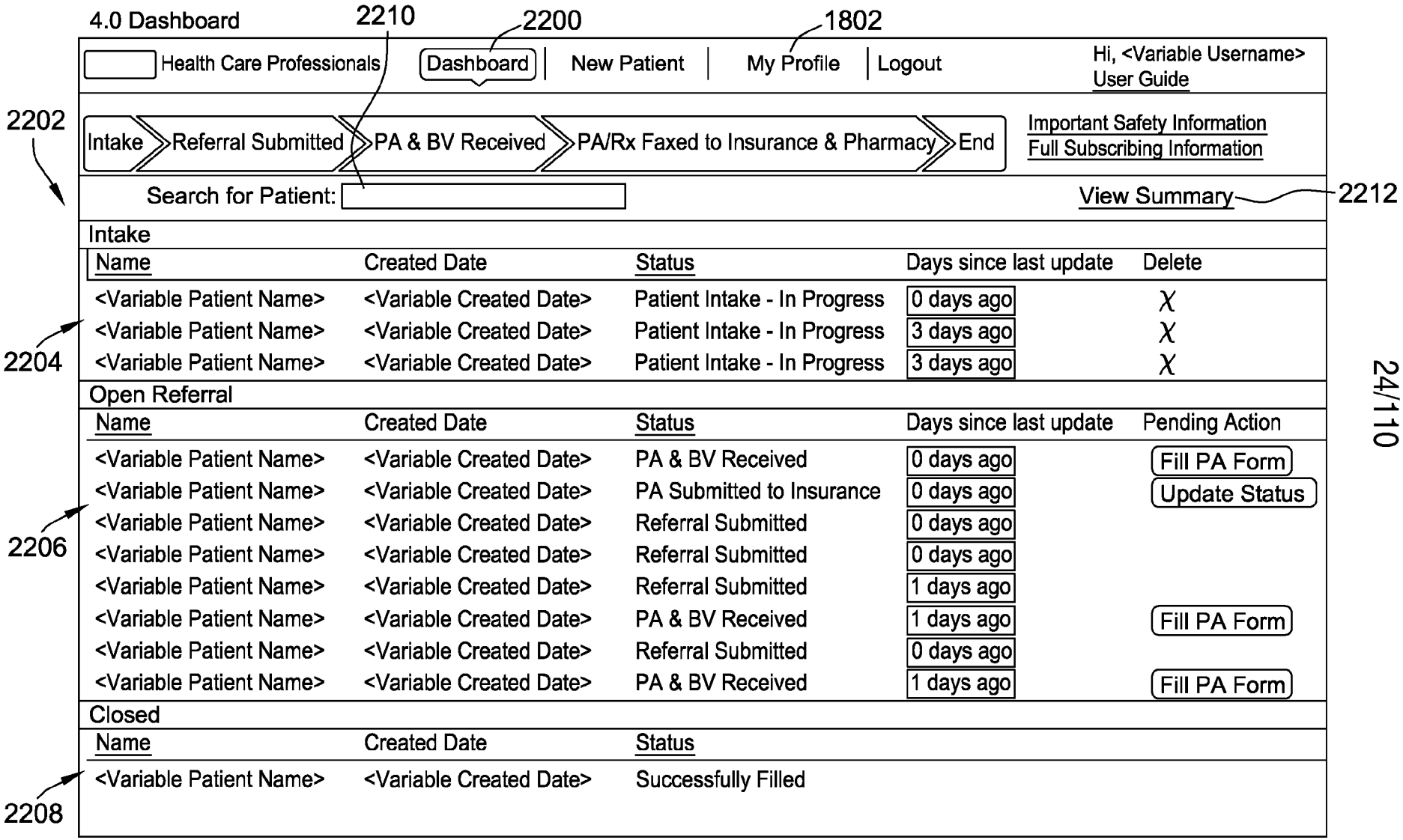

4.0 Dashboard
2210
2200
1802
Health Care Professionals
Dashboard
New Patient
My Profile
Logout
Hi, <Variable Username>
User Guide
2202
Intake
Referral Submitted
PA & BV Received
PA/Rx Faxed to Insurance & Pharmacy
End
Important Safety Information
Full Subscribing Information
Search for Patient:
View Summary
2212
Intake
Name
Created Date
Status
Days since last update
Delete
<Variable Patient Name>
<Variable Created Date>
Patient Intake - In Progress
0 days ago
3 days ago
2204
Open Referral
Name
Created Date
Status
Days since last update
Pending Action
PA & BV Received
PA Submitted to Insurance
Referral Submitted
1 days ago
Fill PA Form
Update Status
2206
Closed
Name
Created Date
Status
Successfully Filled
2208

FIG. 22

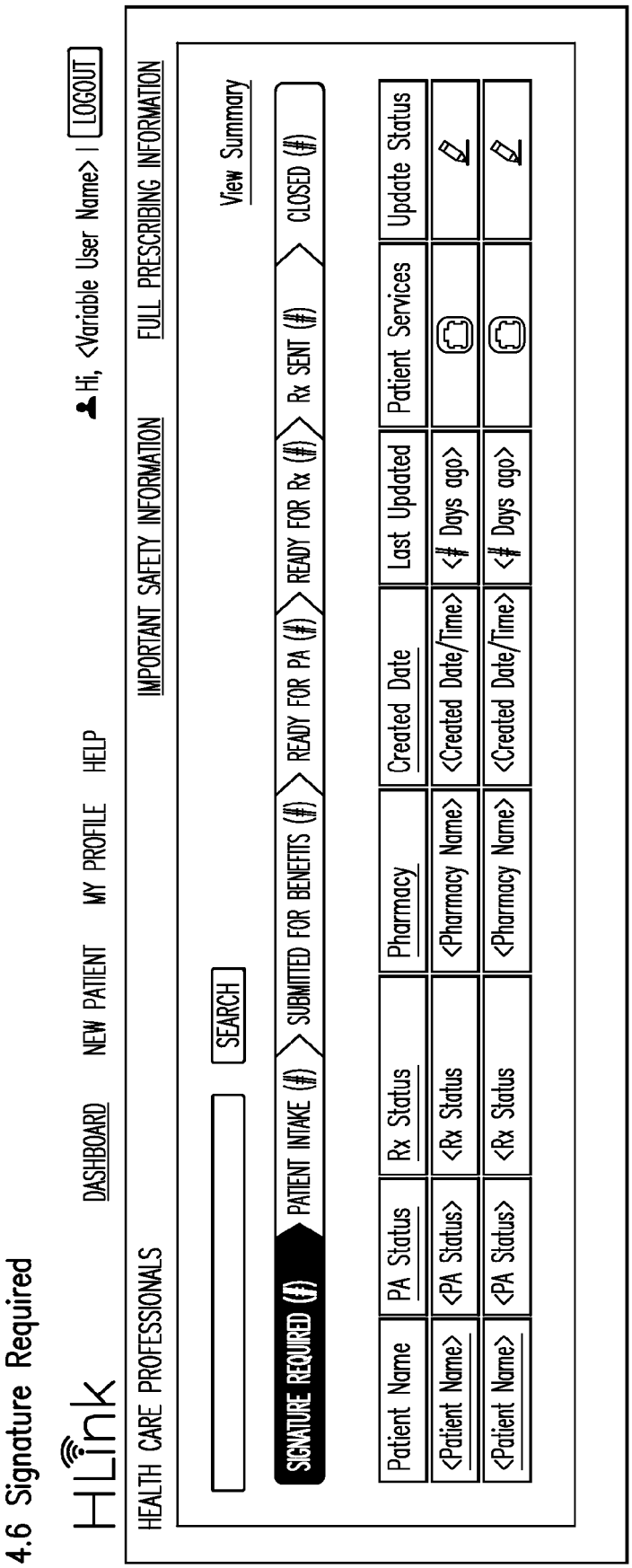
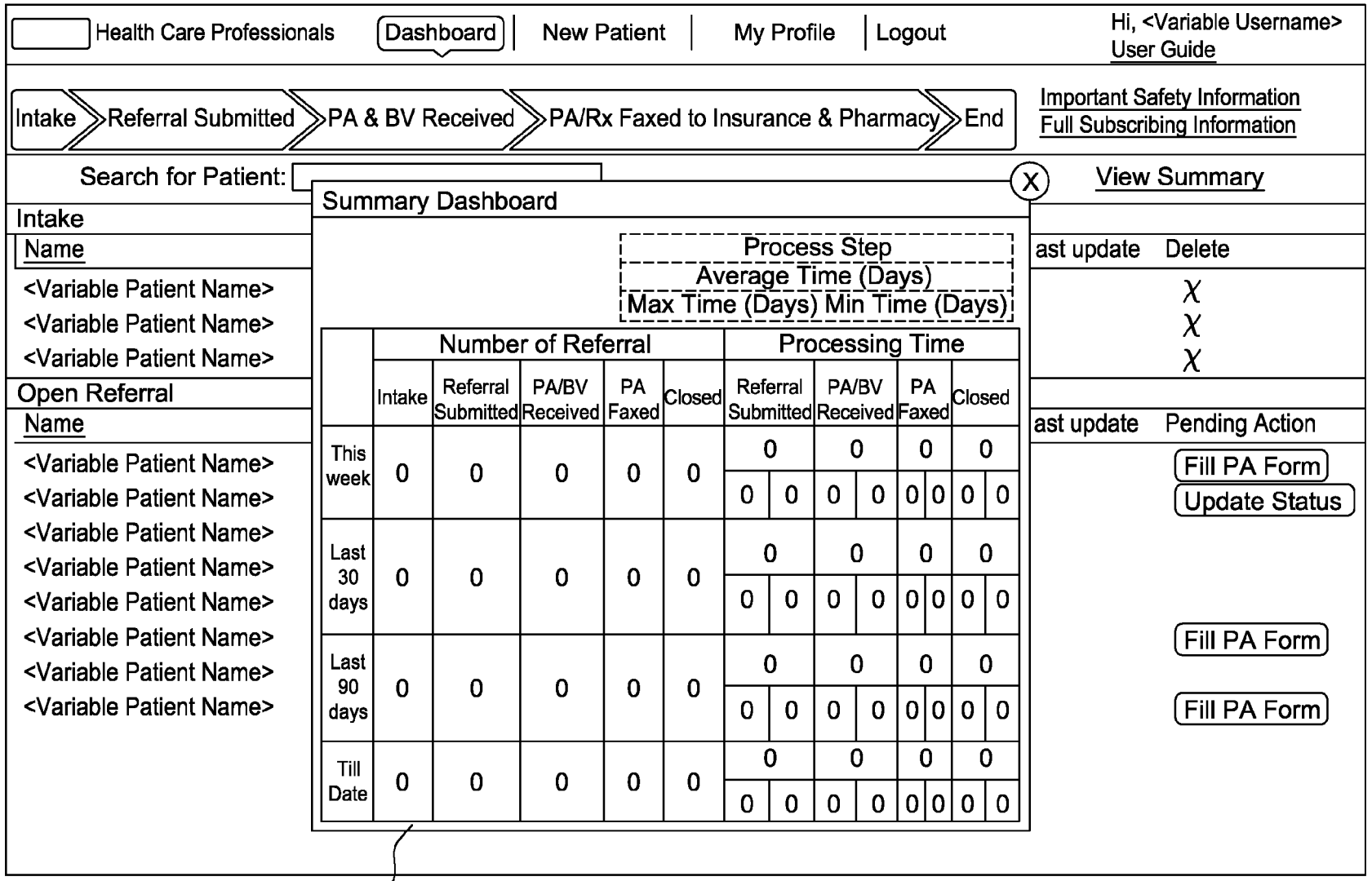

4.6 Signature Required
HLink
DASHBOARD
NEW PATIENT
MY PROFILE
HELP
Hi, <Variable User Name> | LOGOUT
HEALTH CARE PROFESSIONALS
IMPORTANT SAFETY INFORMATION
FULL PRESCRIBING INFORMATION
SEARCH
View Summary
SIGNATURE REQUIRED (#)
PATIENT INTAKE (#)
SUBMITTED FOR BENEFITS (#)
READY FOR PA (#)
READY FOR Rx (#)
Rx SENT (#)
CLOSED (#)
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

4.1 Summary Dashboard



2300

FIG. 23

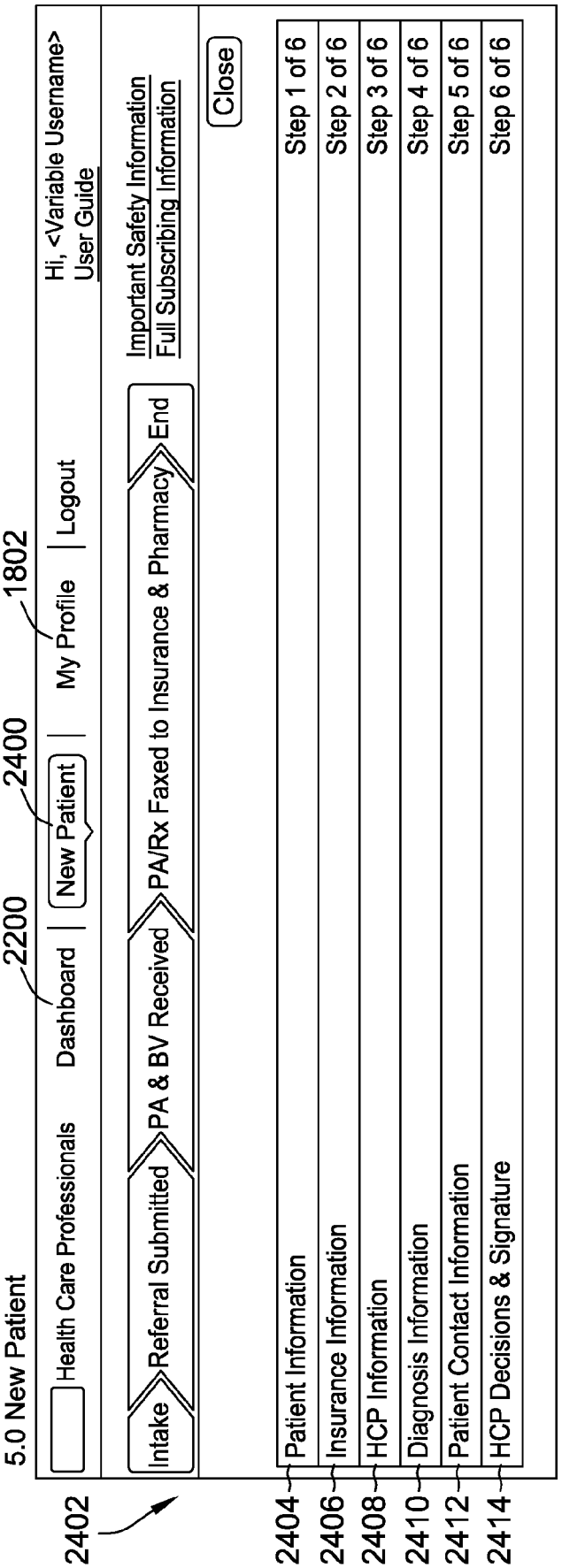

5.0 New Patient
Health Care Professionals
Dashboard
New Patient
My Profile
Logout
Hi, <Variable Username>
User Guide
Important Safety Information
Full Subscribing Information
Close
Intake
Referral Submitted
PA & BV Received
PA/Rx Faxed to Insurance & Pharmacy
End
Patient Information
Step 1 of 6
Insurance 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
2200
2400
1802
2402
2404
2406
2408
2410
2412
2414

FIG. 24

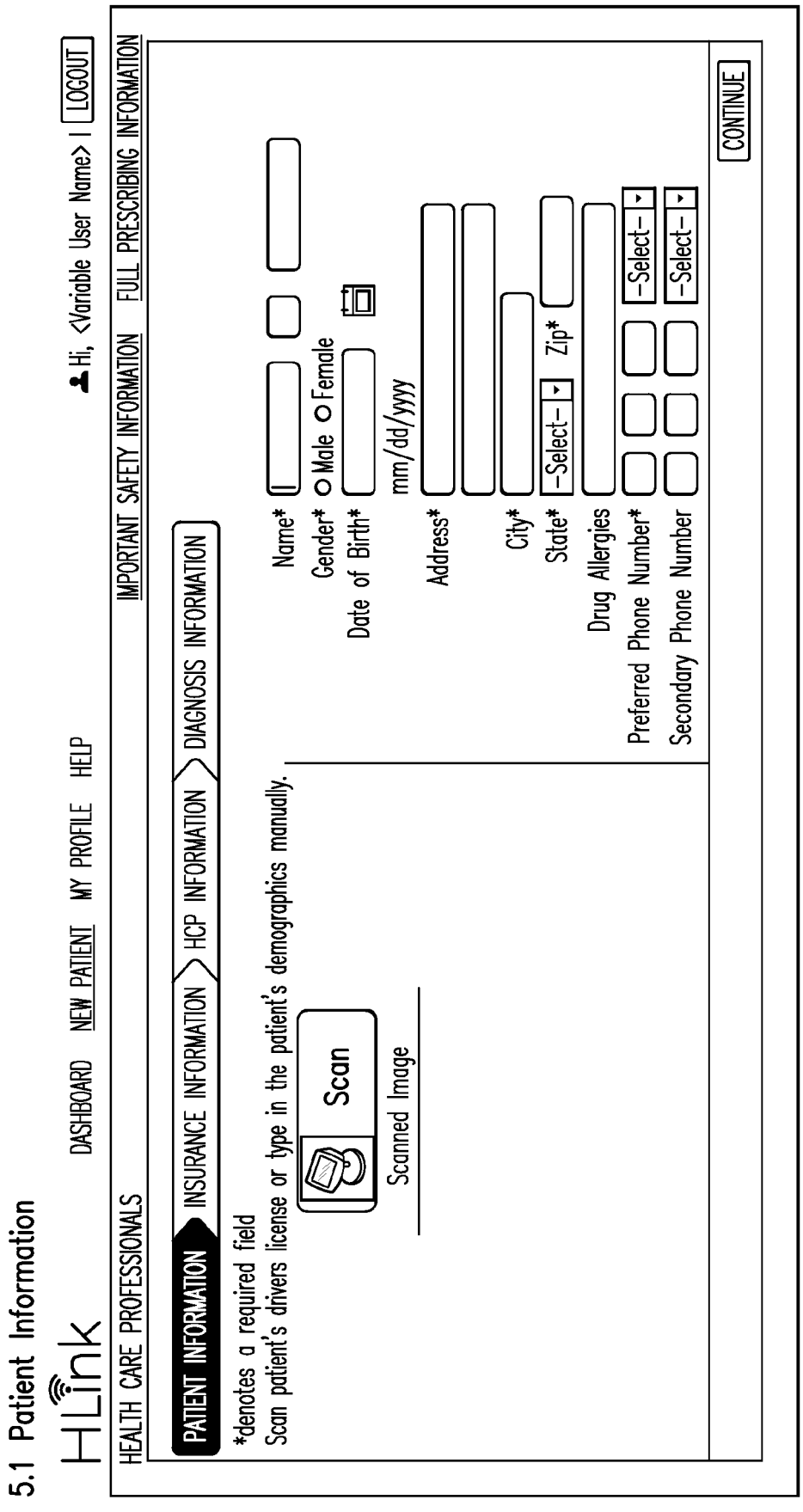

5.1 Patient Information
HLink
DASHBOARD
NEW PATIENT
MY PROFILE
HELP
Hi, <Variable User Name> | LOGOUT
HEALTH CARE PROFESSIONALS
IMPORTANT SAFETY INFORMATION
FULL PRESCRIBING INFORMATION
PATIENT INFORMATION
INSURANCE INFORMATION
HCP INFORMATION
DIAGNOSIS INFORMATION
*denotes a required field
Scan patient's drivers license or type in the patient's demographics manually.
Scan
Scanned Image
Name*
Gender* Male Female
Date of Birth*
mm/dd/yyyy
Address*
City*
State* -Select- Zip*
Drug Allergies
Preferred Phone Number* -Select-
Secondary Phone Number -Select-
CONTINUE
Phone Number Options:
-Select-
-Select-
Work
Home
Cell

FIG. 24B

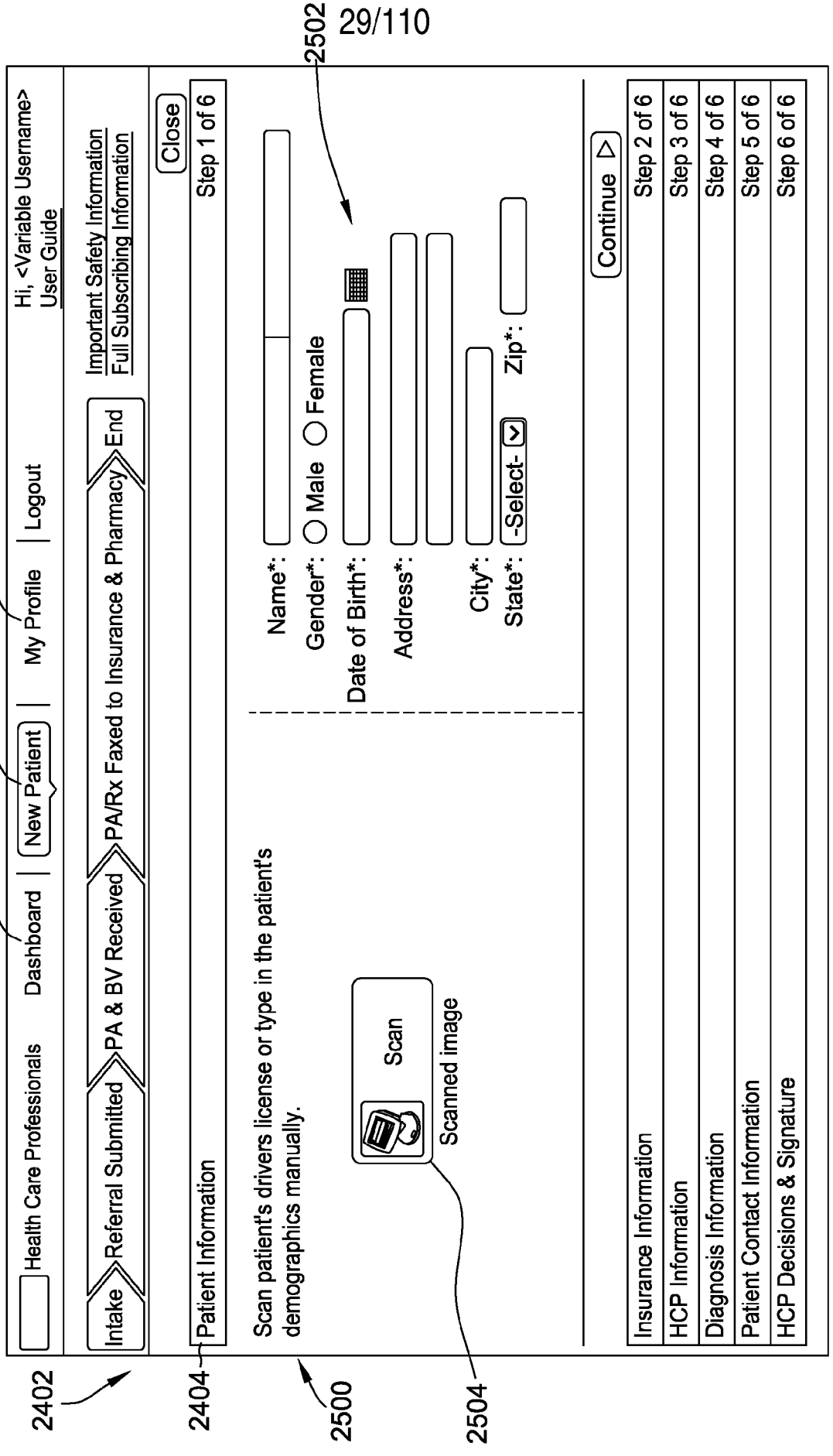

5.1 Patient Information
Health Care Professionals
Dashboard
New Patient
My Profile
Logout
Hi, <Variable Username>
User Guide
Important Safety Information
Full Subscribing Information
Intake
Referral Submitted
PA & BV Received
PA/Rx Faxed to Insurance & Pharmacy
End
Close
Patient Information
Step 1 of 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*: -Select-
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
2402
2404
2500
2504
2200
2400
1802
2502

FIG. 25

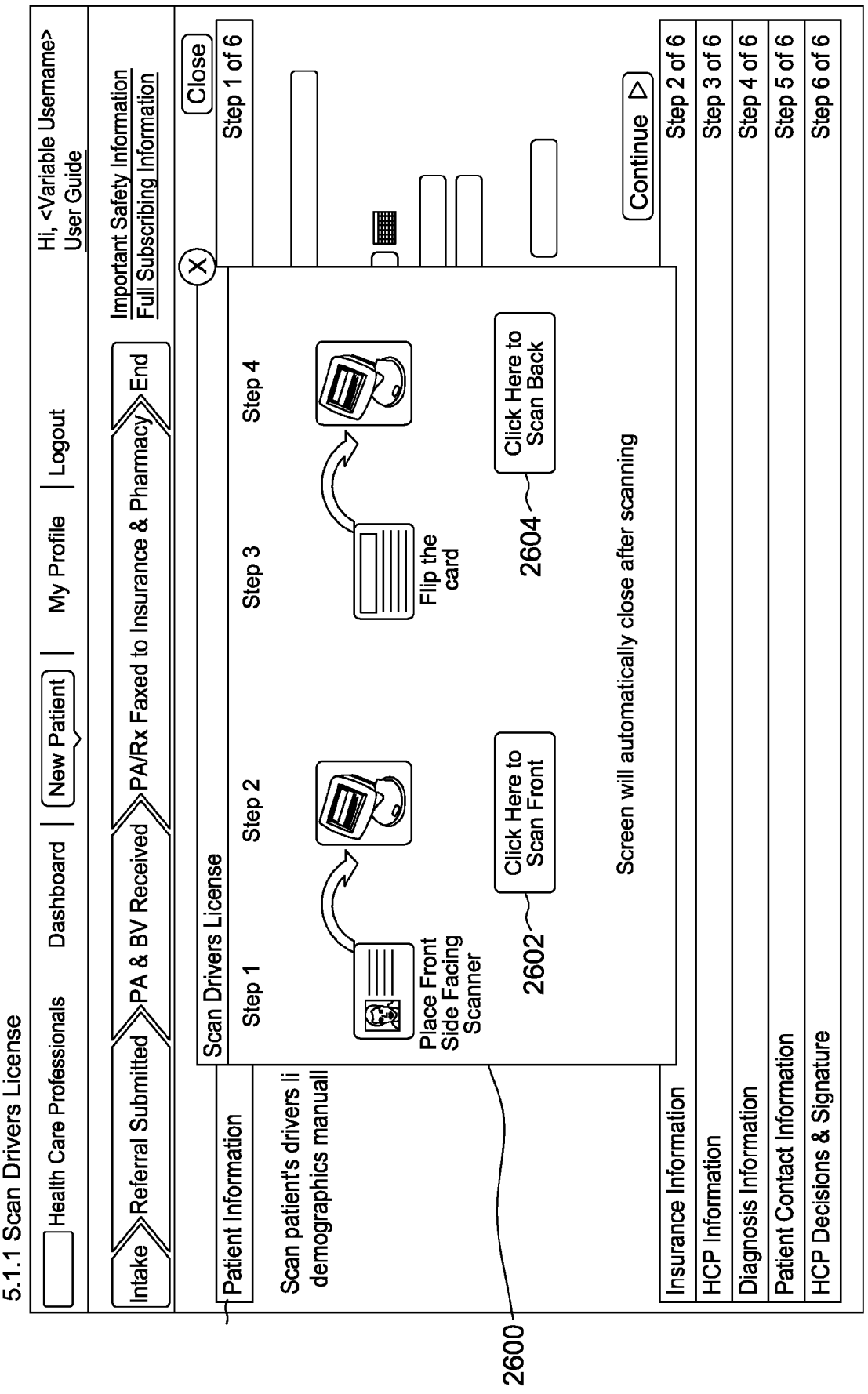

5.1.1 Scan Drivers License
Health Care Professionals
Dashboard
New Patient
My Profile
Logout
Hi, <Variable Username>
User Guide
Intake
Referral Submitted
PA & BV Received
PA/Rx Faxed to Insurance & Pharmacy
End
Important Safety Information
Full Subscribing Information
Close
Patient Information
Scan Drivers License
Step 1
Step 2
Step 3
Step 4
Step 1 of 6
Scan patient's drivers li
demographics manuall
Place Front
Side Facing
Scanner
Click Here to
Scan Front
Flip the
card
Click Here to
Scan Back
2602
2604
Screen will automatically close after scanning
Continue
Insurance Information
HCP Information
Diagnosis Information
Patient Contact Information
HCP Decisions & Signature
Step 2 of 6
Step 3 of 6
Step 4 of 6
Step 5 of 6
Step 6 of 6
2600

FIG. 26

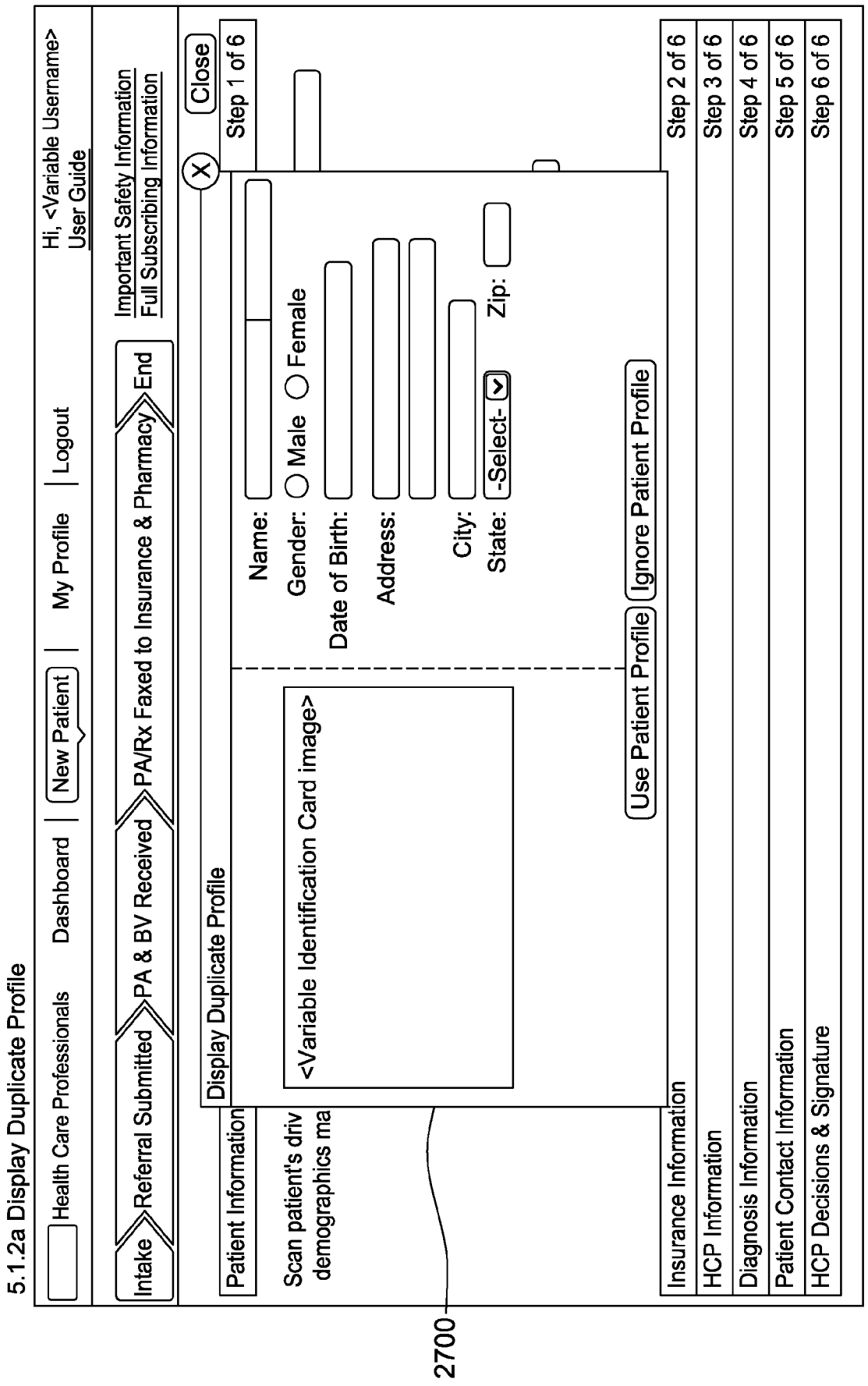

5.1.2a Display Duplicate Profile
Health Care Professionals
Dashboard
New Patient
My Profile
Logout
Hi, <Variable Username>
User Guide
Intake
Referral Submitted
PA & BV Received
PA/Rx Faxed to Insurance & Pharmacy
End
Important Safety Information
Full Subscribing Information
Close
Display Duplicate Profile
Step 1 of 6
Patient Information
Scan patient's driv
demographics ma
<Variable Identification Card image>
Name:
Gender: Male Female
Date of Birth:
Address:
City:
State: -Select-
Zip:
Use Patient Profile
Ignore Patient Profile
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
2700

FIG. 27

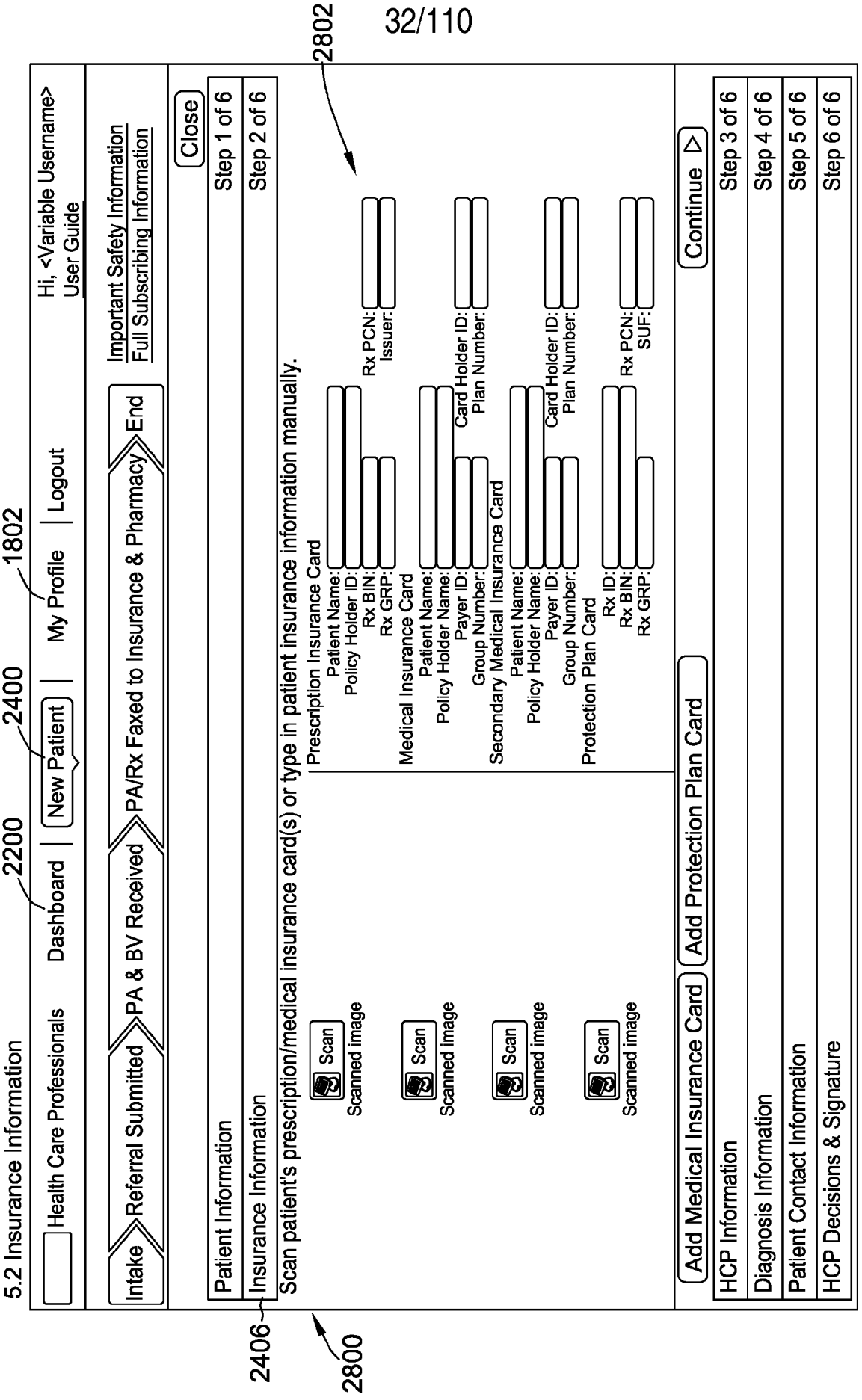

5.2 Insurance Information
2200
Health Care Professionals
Dashboard
2400
New Patient
1802
My Profile
Logout
Hi, <Variable Username>
User Guide
Intake
Referral Submitted
PA & BV Received
PA/Rx Faxed to Insurance & Pharmacy
End
Important Safety Information
Full Subscribing Information
Close
Patient Information
Step 1 of 6
Insurance Information
Step 2 of 6
2802
Scan patient's prescription/medical insurance card(s) or type in patient insurance information manually.
Prescription Insurance Card
Patient Name:
Policy Holder ID:
Rx BIN:
Rx GRP:
Rx PCN:
Issuer:
Scan
Scanned image
Medical Insurance Card
Patient Name:
Policy Holder Name:
Payer ID:
Group Number:
Card Holder ID:
Plan Number:
Scan
Scanned image
Secondary Medical Insurance Card
Patient Name:
Policy Holder Name:
Payer ID:
Group Number:
Card Holder ID:
Plan Number:
Scan
Scanned image
Protection Plan Card
Rx ID:
Rx BIN:
Rx GRP:
Rx PCN:
SUF:
Scan
Scanned image
2406
2800
Add Medical Insurance Card
Add Protection Plan Card
Continue
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

FIG. 28

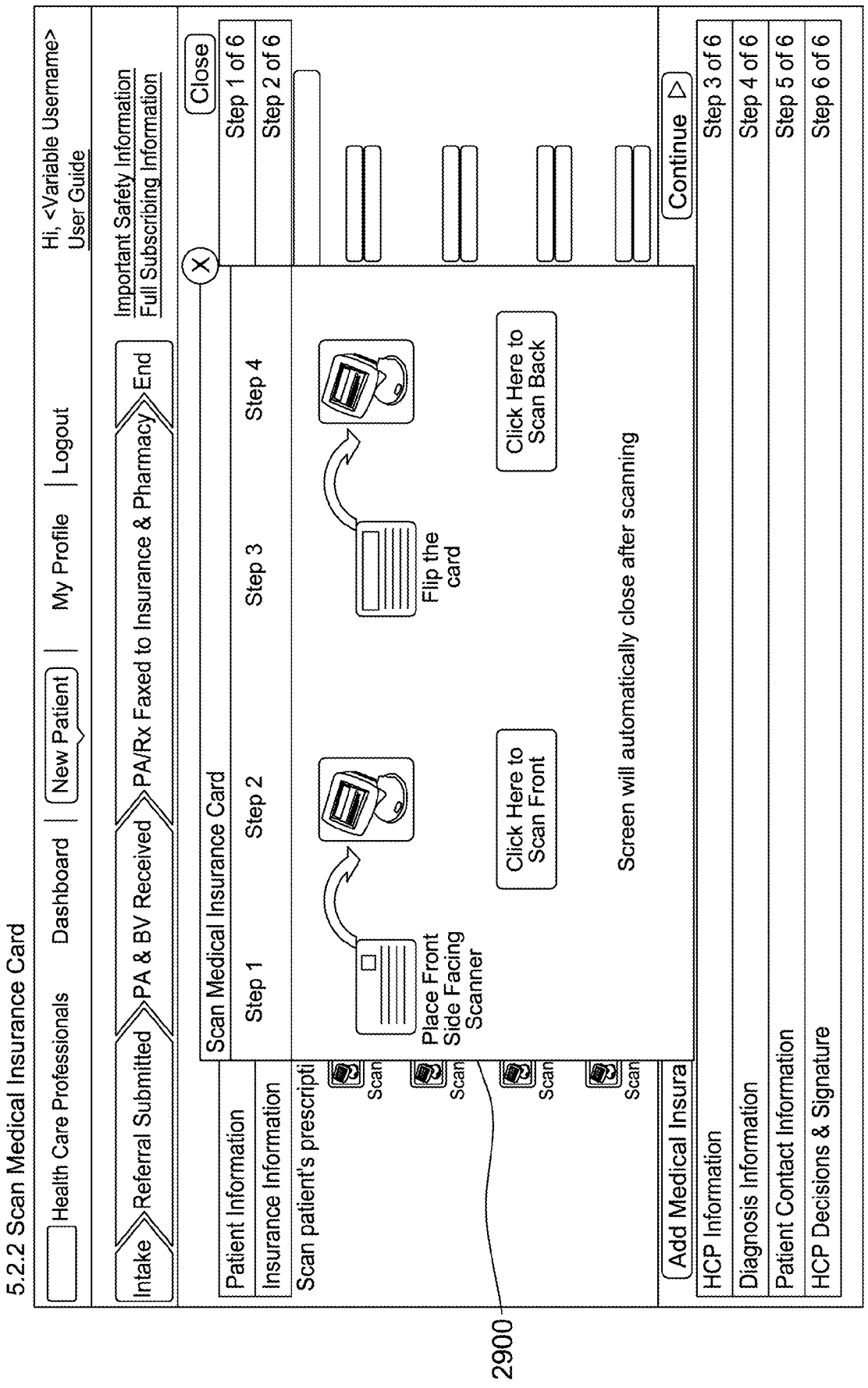

5.2.2 Scan Medical Insurance Card
Health Care Professionals
Dashboard
New Patient
My Profile
Logout
Hi, <Variable Username>
User Guide
Intake
Referral Submitted
PA & BV Received
PA/Rx Faxed to Insurance & Pharmacy
End
Important Safety Information
Full Subscribing Information
Close
Patient Information
Insurance Information
Scan patient's prescripti
Scan Medical Insurance Card
Step 1
Step 2
Step 3
Step 4
Step 1 of 6
Step 2 of 6
Place Front Side Facing Scanner
Flip the card
Click Here to Scan Front
Click Here to Scan Back
Screen will automatically close after scanning
Scan
Add Medical Insura
Continue
HCP Information
Diagnosis Information
Patient Contact Information
HCP Decisions & Signature
Step 3 of 6
Step 4 of 6
Step 5 of 6
Step 6 of 6
2900

FIG. 29

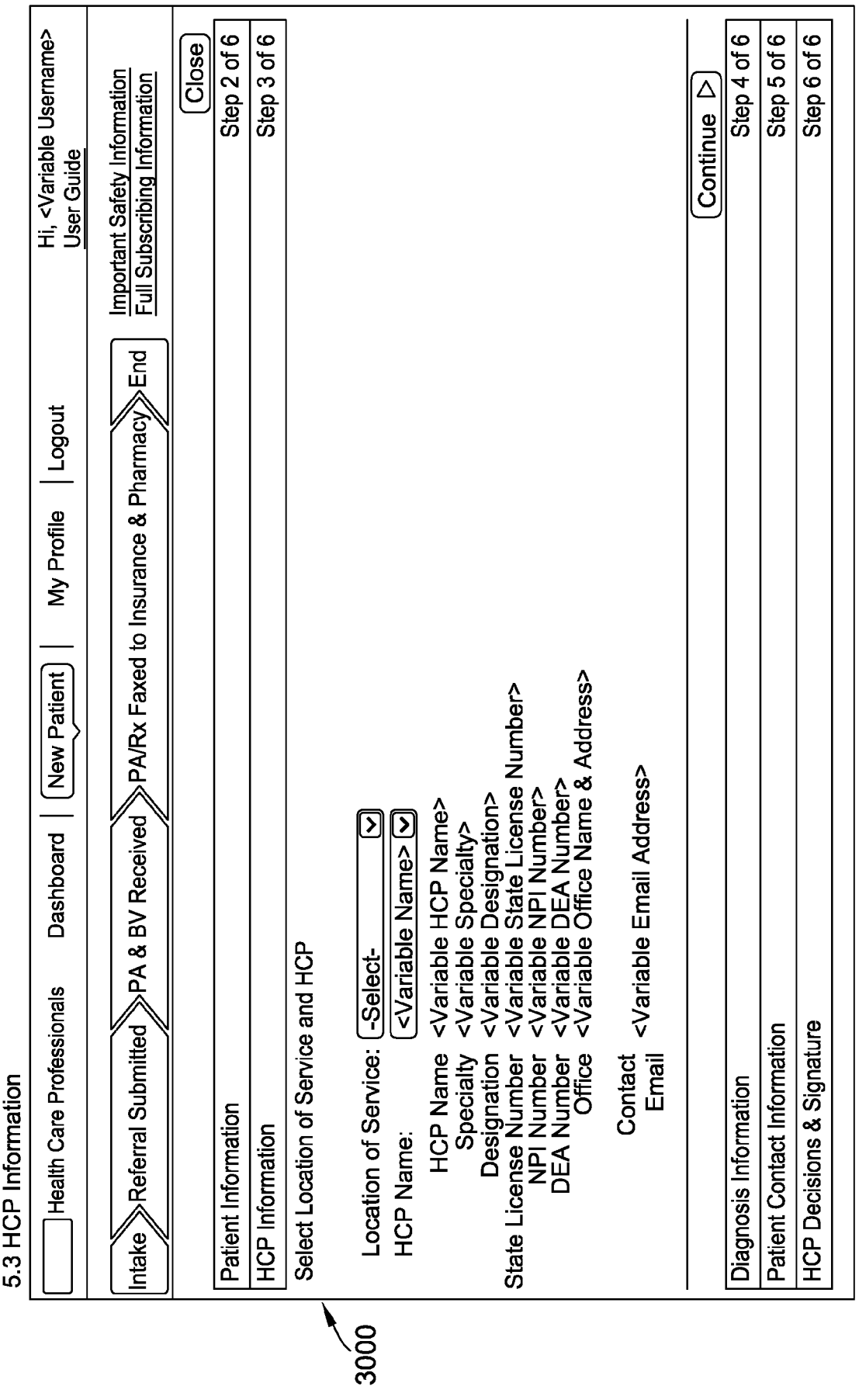

5.3 HCP Information
Health Care Professionals
Dashboard
New Patient
My Profile
Logout
Hi, <Variable Username>
User Guide
Intake
Referral Submitted
PA & BV Received
PA/Rx Faxed to Insurance & Pharmacy
End
Important Safety Information
Full Subscribing Information
Close
Patient Information
Step 2 of 6
HCP Information
Step 3 of 6
Select Location of Service and HCP
Location of Service:
-Select-
HCP Name:
<Variable Name>
HCP Name <Variable HCP Name>
Specialty <Variable Specialty>
Designation <Variable Designation>
State License Number <Variable State License Number>
NPI Number <Variable NPI Number>
DEA Number <Variable DEA Number>
Office <Variable Office Name & Address>
Contact
Email <Variable Email Address>
Continue
Diagnosis Information
Step 4 of 6
Patient Contact Information
Step 5 of 6
HCP Decisions & Signature
Step 6 of 6
3000

FIG. 30

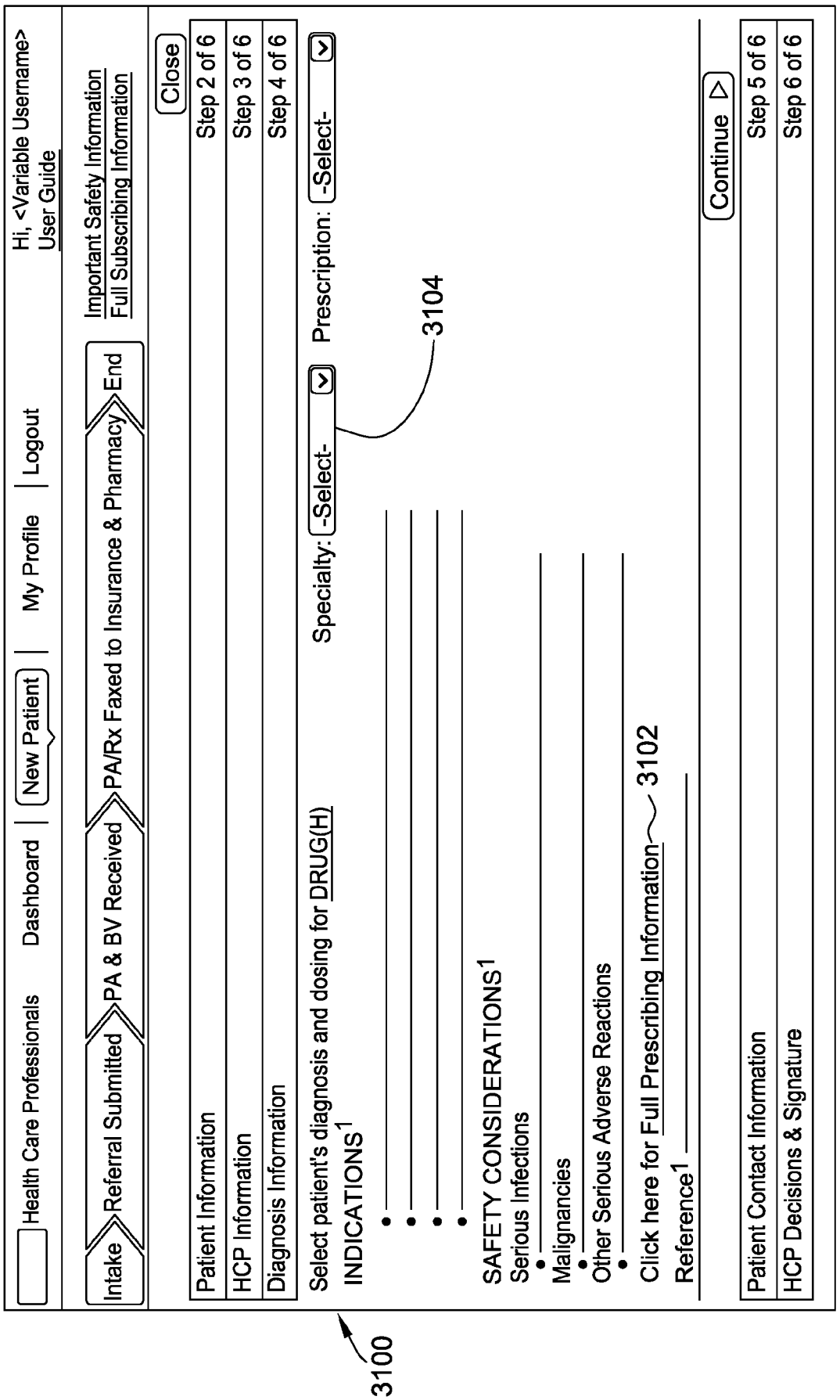

5.4 Diagnosis Information
Health Care Professionals
Dashboard
New Patient
My Profile
Logout
Hi, <Variable Username>
User Guide
Intake
Referral Submitted
PA & BV Received
PA/Rx Faxed to Insurance & Pharmacy
End
Important Safety Information
Full Subscribing Information
Close
Patient Information
Step 2 of 6
HCP Information
Step 3 of 6
Diagnosis Information
Step 4 of 6
Select patient's diagnosis and dosing for DRUG(H)
Specialty: -Select-
Prescription: -Select-
INDICATIONS[1]
SAFETY CONSIDERATIONS[1]
Serious Infections
Malignancies
Other Serious Adverse Reactions
Click here for Full Prescribing Information
Reference[1]
Continue
Patient Contact Information
Step 5 of 6
HCP Decisions & Signature
Step 6 of 6
3100
3102
3104

FIG. 31

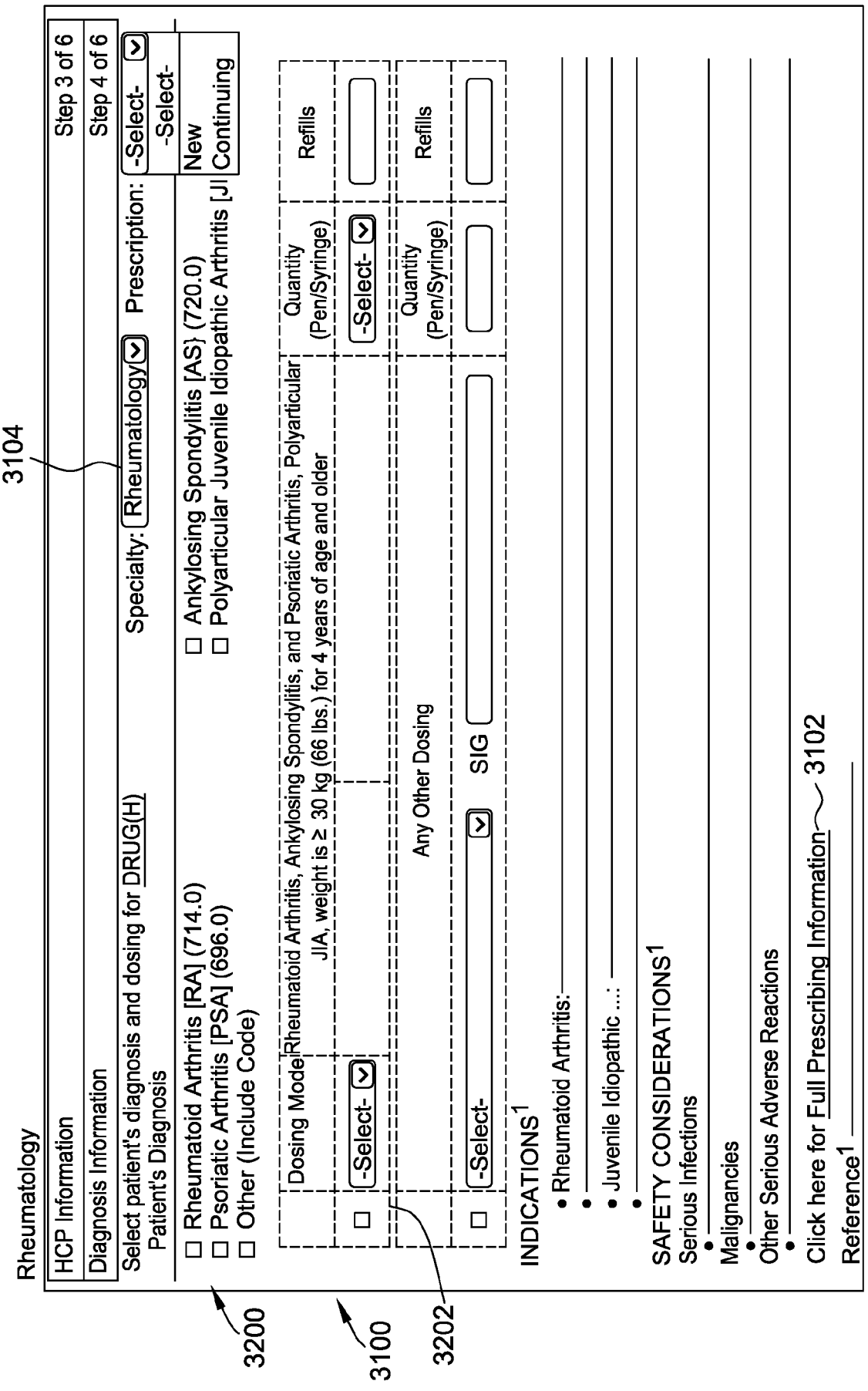

Rheumatology
HCP Information
Step 3 of 6
Diagnosis Information
Step 4 of 6
Select patient's diagnosis and dosing for DRUG(H)
Patient's Diagnosis
Specialty: Rheumatology
Prescription: -Select-
-Select-
New
Continuing
☐ Rheumatoid Arthritis [RA] (714.0)
☐ Psoriatic Arthritis [PSA] (696.0)
☐ Other (Include Code)
☐ Ankylosing Spondylitis [AS] (720.0)
☐ Polyarticular Juvenile Idiopathic Arthritis [JI
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-
Any Other Dosing
SIG
INDICATIONS[1]
• Rheumatoid Arthritis:
• Juvenile Idiopathic ...:
SAFETY CONSIDERATIONS[1]
Serious Infections
Malignancies
Other Serious Adverse Reactions
Click here for Full Prescribing Information
Reference[1]
3104
3200
3100
3202
3102

FIG. 32

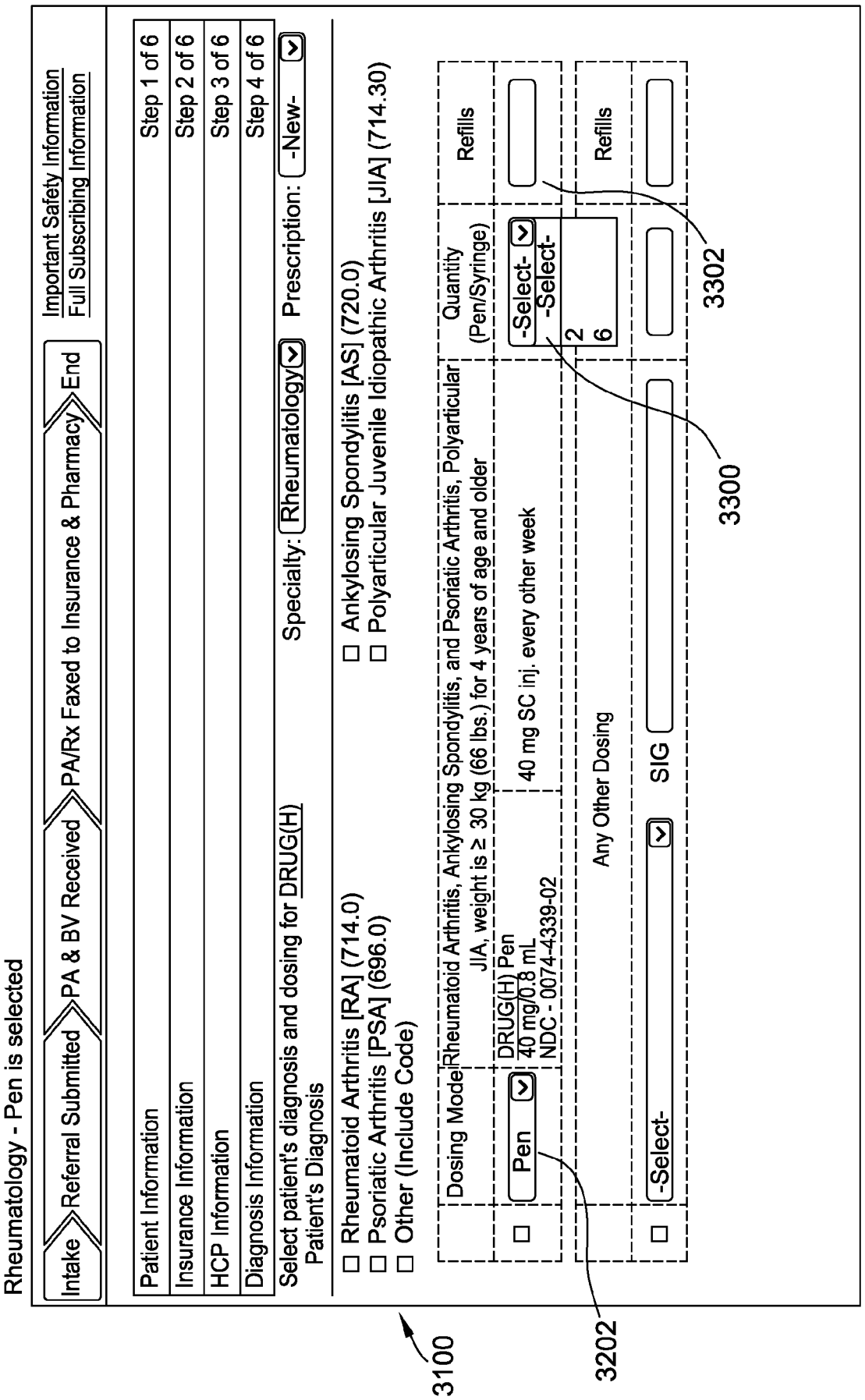

Rheumatology - Pen is selected
Intake
Referral Submitted
PA & BV Received
PA/Rx Faxed to Insurance & Pharmacy
End
Important Safety Information
Full Subscribing Information
Patient Information
Step 1 of 6
Insurance Information
Step 2 of 6
HCP Information
Step 3 of 6
Diagnosis Information
Step 4 of 6
Select patient's diagnosis and dosing for DRUG(H)
Specialty: Rheumatology
Prescription: -New-
Patient's Diagnosis
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 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
Pen
DRUG(H) Pen
40 mg/0.8 mL
NDC - 0074-4339-02
40 mg SC inj. every other week
-Select-
2
6
Refills
Any Other Dosing
-Select-
SIG
3100
3202
3300
3302

FIG. 33

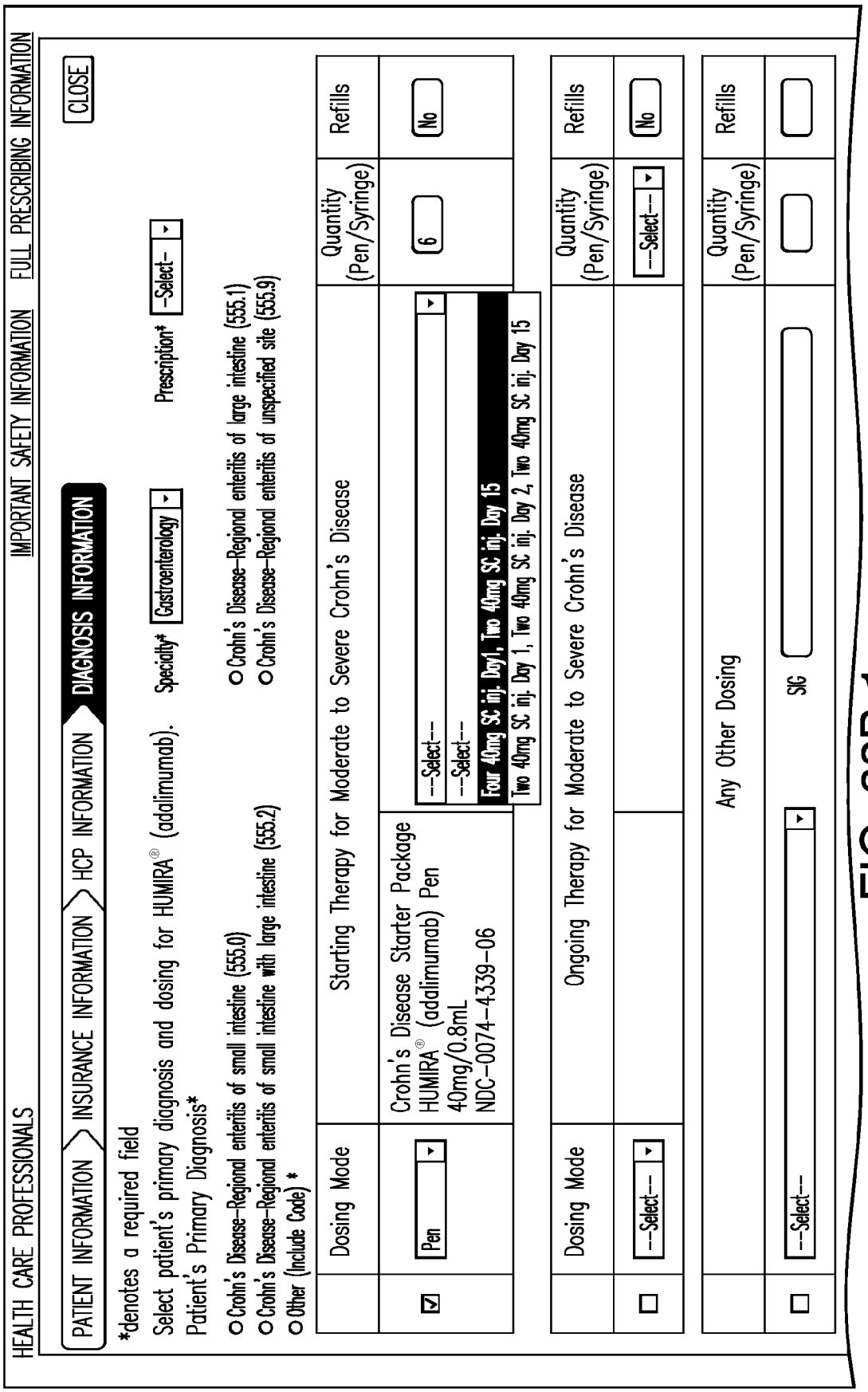

HLink
DASHBOARD NEW PATIENT MY PROFILE HELP
Hi, <Variable User Name> | LOGOUT
HEALTH CARE PROFESSIONALS
IMPORTANT SAFETY INFORMATION FULL PRESCRIBING INFORMATION
PATIENT INFORMATION
INSURANCE INFORMATION
HCP INFORMATION
DIAGNOSIS INFORMATION
CLOSE
*denotes a required field
Select patient's primary diagnosis and dosing for HUMIRA® (adalimumab).
Specialty* Gastroenterology
Prescription* -Select-
Patient's Primary Diagnosis*
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) *
Crohn's Disease–Regional enteritis of large intestine (555.1)
Crohn's Disease–Regional enteritis of unspecified site (555.9)
Dosing Mode
Starting Therapy for Moderate to Severe Crohn's Disease
Quantity (Pen/Syringe)
Refills
Pen
Crohn's Disease Starter Package HUMIRA® (adalimumab) Pen 40mg/0.8mL NDC–0074–4339–06
--Select--
--Select--
Four 40mg SC inj. Day1, Two 40mg SC inj. Day 15
Two 40mg SC inj. Day 1, Two 40mg SC inj. Day 2, Two 40mg SC inj. Day 15
6
No
Dosing Mode
Ongoing Therapy for Moderate to Severe Crohn's Disease
Quantity (Pen/Syringe)
Refills
--Select--
--Select--
No
Any Other Dosing
Quantity (Pen/Syringe)
Refills
--Select--
SIG

FIG. 33B-1

INDICATIONS[1]

- 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

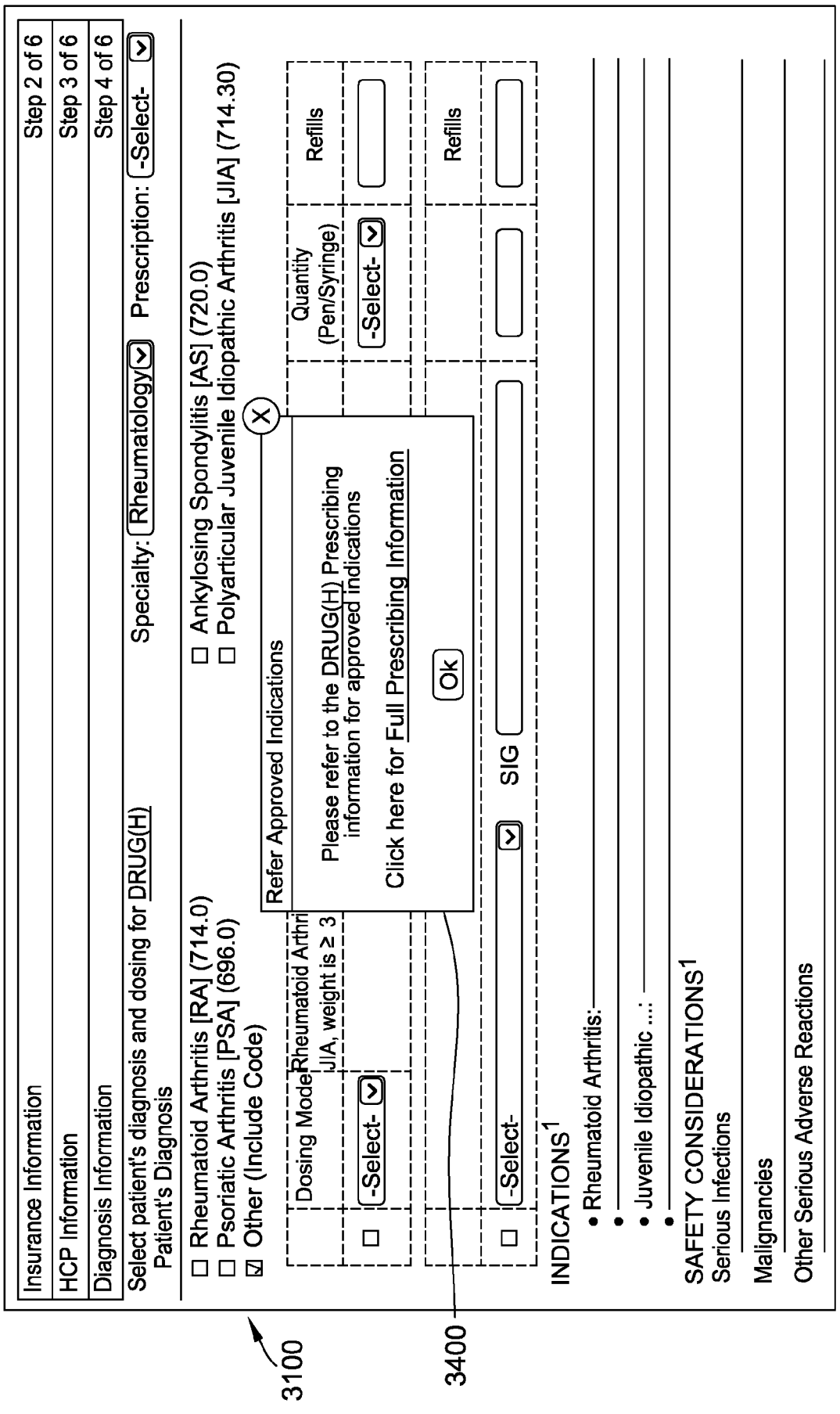

5.4.2 Refer to Approved Indications
Insurance Information
Step 2 of 6
HCP Information
Step 3 of 6
Diagnosis Information
Step 4 of 6
Select patient's diagnosis and dosing for DRUG(H)
Patient's Diagnosis
Specialty: Rheumatology
Prescription: -Select-
☐ Rheumatoid Arthritis [RA] (714.0)
☐ Psoriatic Arthritis [PSA] (696.0)
☑ Other (Include Code)
☐ Ankylosing Spondylitis [AS] (720.0)
☐ Polyarticular Juvenile Idiopathic Arthritis [JIA] (714.30)
Refer Approved Indications
Please refer to the DRUG(H) Prescribing information for approved indications
Click here for Full Prescribing Information
Ok
Dosing Mode
Rheumatoid Arthri
JIA, weight is ≥ 3
Quantity (Pen/Syringe)
Refills
-Select-
SIG
INDICATIONS[1]
• Rheumatoid Arthritis:
• Juvenile Idiopathic ...:
SAFETY CONSIDERATIONS[1]
Serious Infections
Malignancies
Other Serious Adverse Reactions
3100
3400

FIG. 34

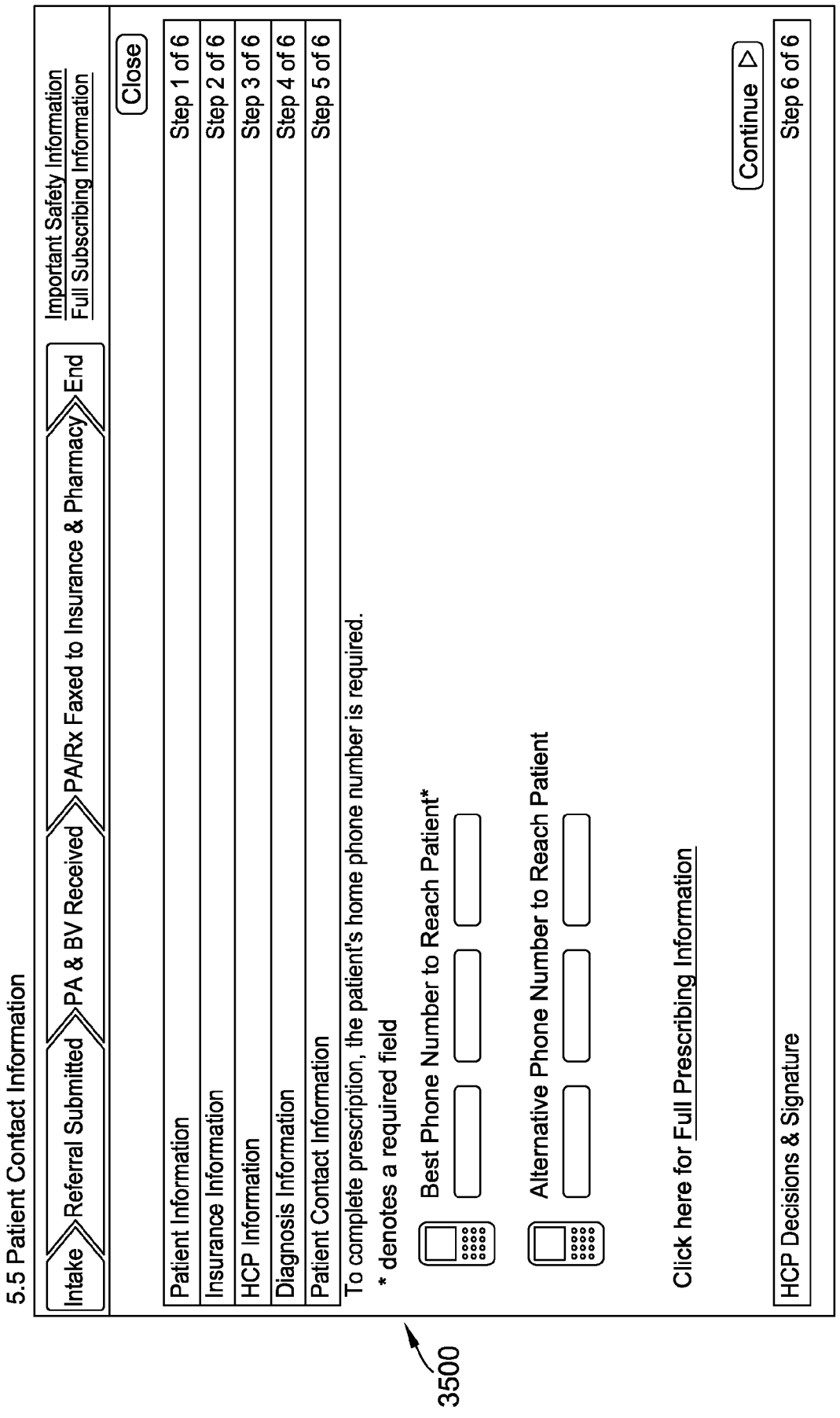

5.5 Patient Contact Information
Intake
Referral Submitted
PA & BV Received
PA/Rx Faxed to Insurance & Pharmacy
End
Important Safety Information
Full Subscribing Information
Close
Patient Information Step 1 of 6
Insurance Information Step 2 of 6
HCP Information Step 3 of 6
Diagnosis Information Step 4 of 6
Patient Contact Information Step 5 of 6
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
3500

FIG. 35

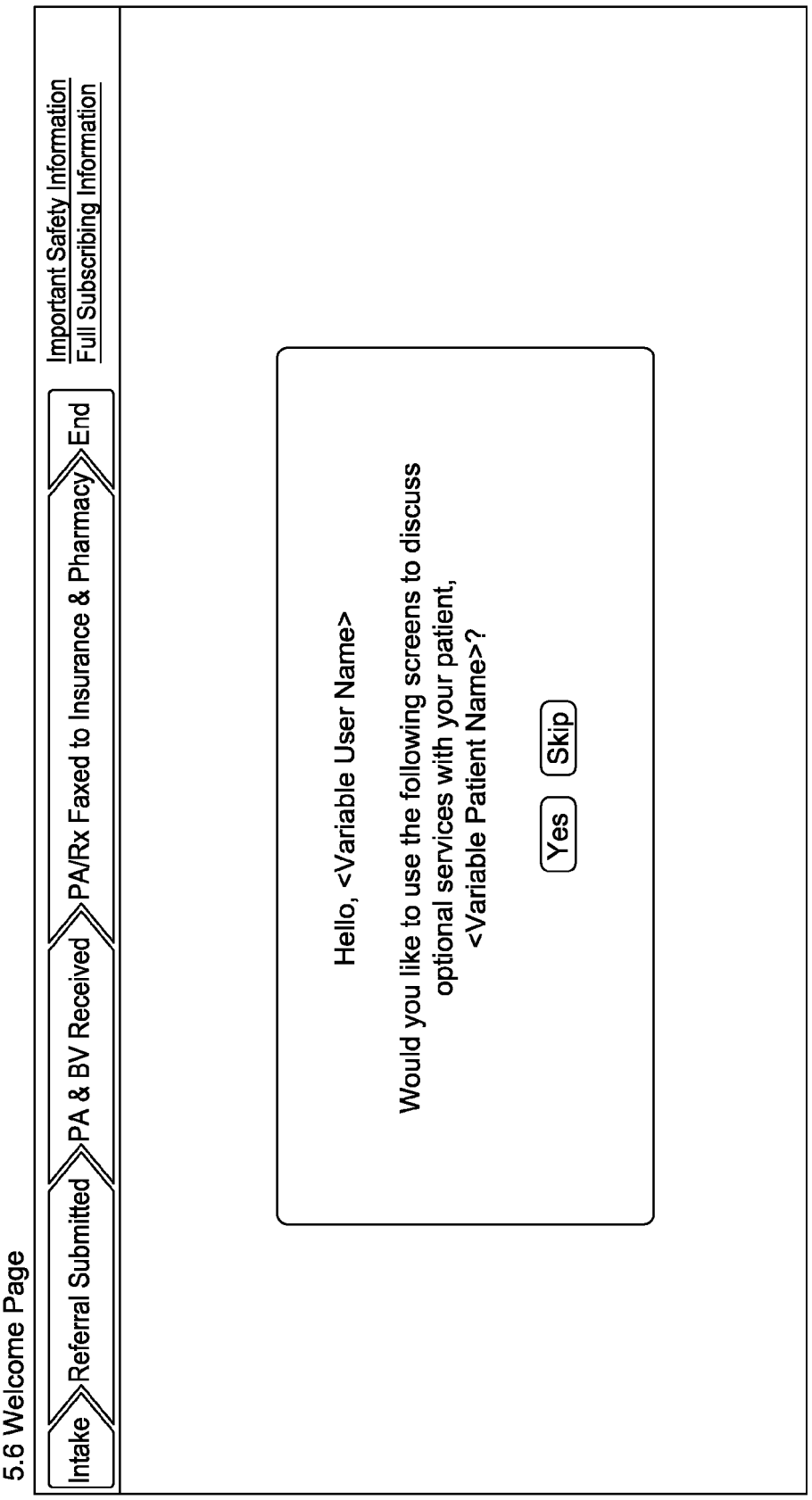

5.6 Welcome Page
Intake
Referral Submitted
PA & BV Received
PA/Rx Faxed to Insurance & Pharmacy
End
Important Safety Information
Full Subscribing Information
Hello, <Variable User Name>
Would you like to use the following screens to discuss optional services with your patient, <Variable Patient Name>?
Yes
Skip

FIG. 36

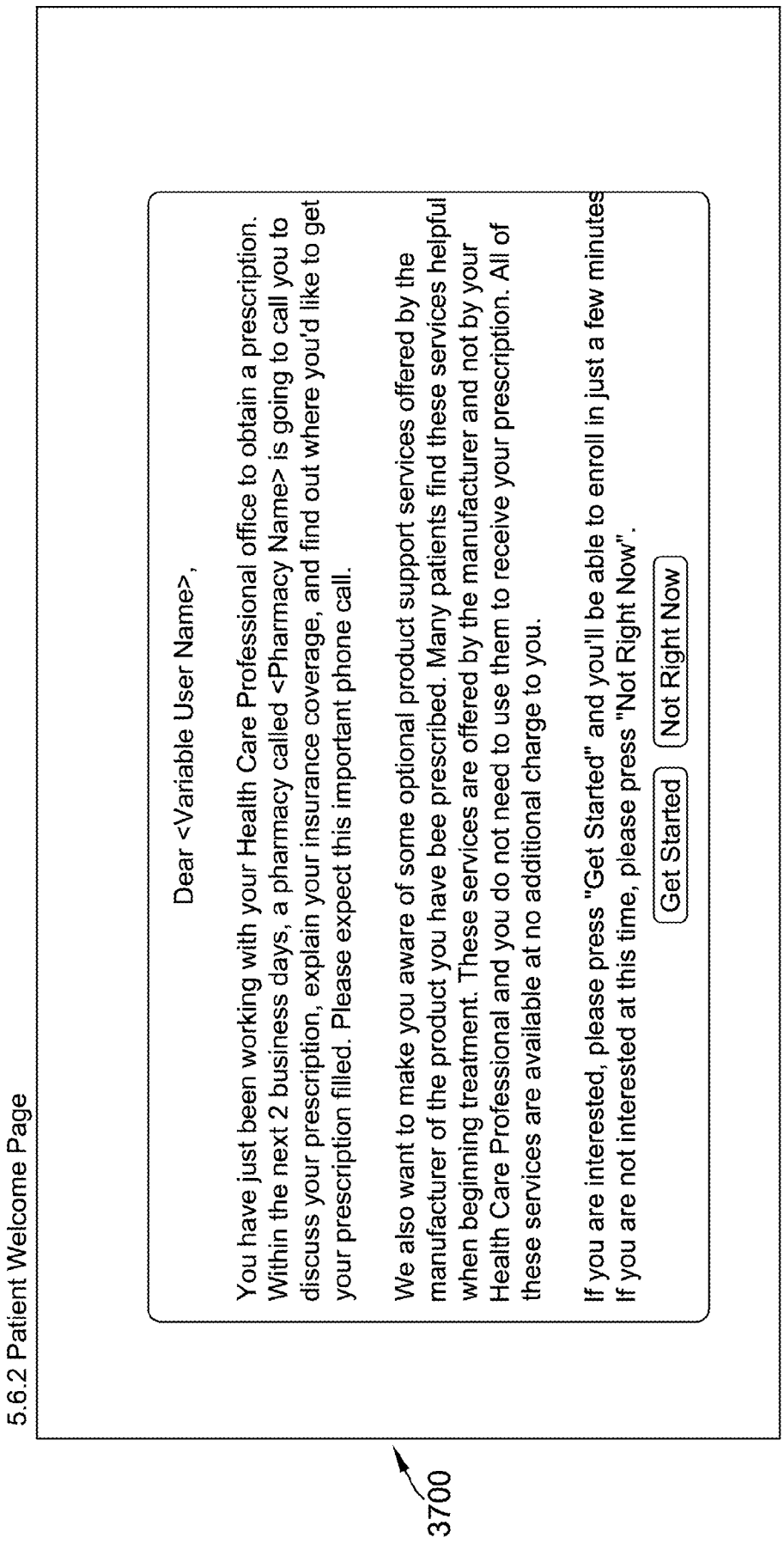

5.6.2 Patient Welcome Page
Dear <Variable User Name>,
You have just been working with your Health Care Professional office to obtain a prescription. Within the next 2 business days, a pharmacy called <Pharmacy Name> is going to call you to discuss your prescription, explain your insurance coverage, and 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 bee 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".
Get Started
Not Right Now
3700

FIG. 37

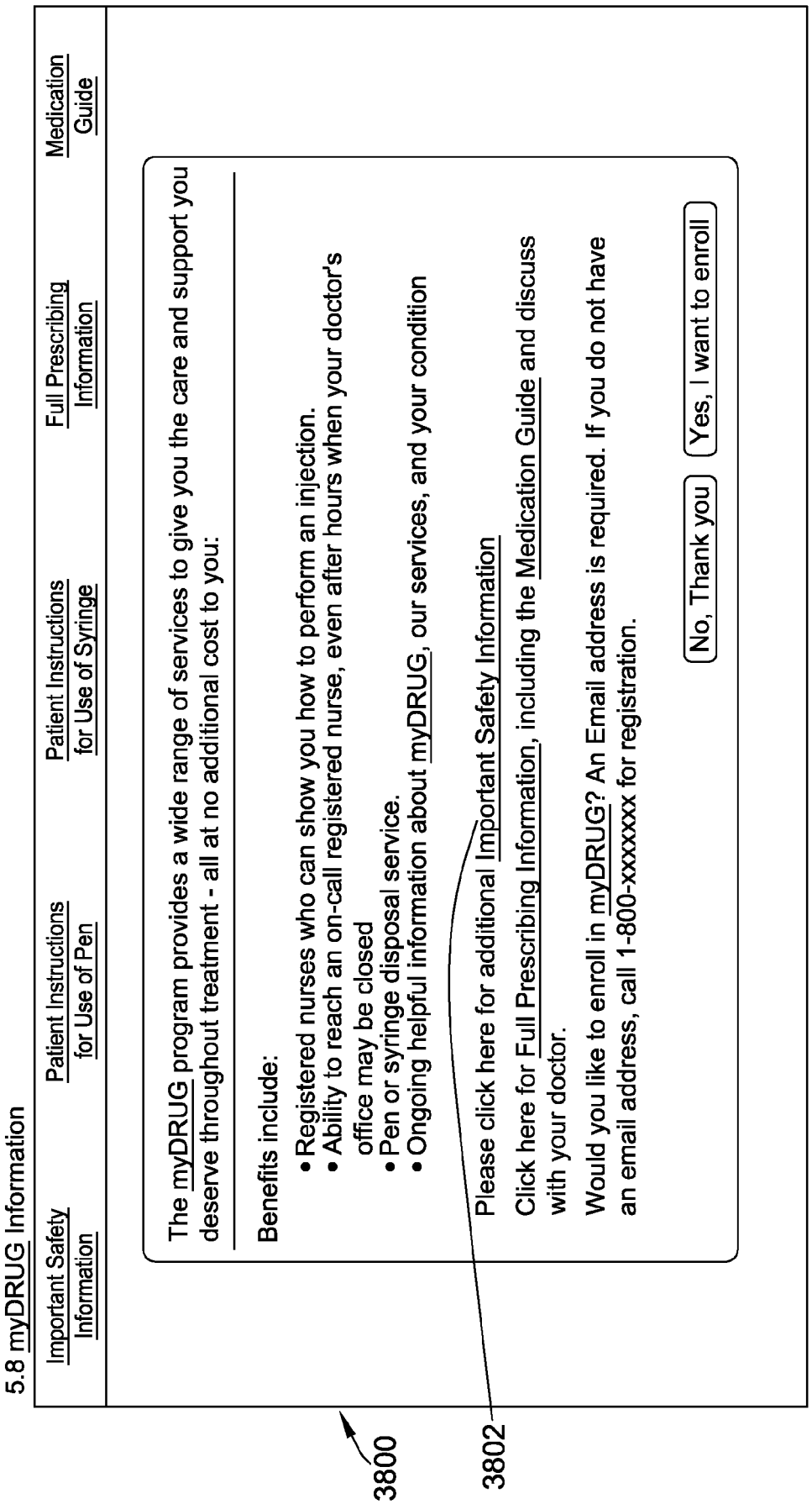

5.8 myDRUG Information
Important Safety Information
Patient Instructions for Use of Pen
Patient Instructions for Use of Syringe
Full Prescribing Information
Medication Guide
The myDRUG program provides a wide range of services to give you the care and support you deserve throughout treatment - all at no additional cost to you:
Benefits include:
• 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 myDRUG, our services, and your condition
Please click here for additional Important Safety Information
Click here for Full Prescribing Information, including the Medication Guide and discuss with your doctor.
Would you like to enroll in myDRUG? An Email address is required. If you do not have an email address, call 1-800-xxxxxxx for registration.
No, Thank you
Yes, I want to enroll
3800
3802

FIG. 38

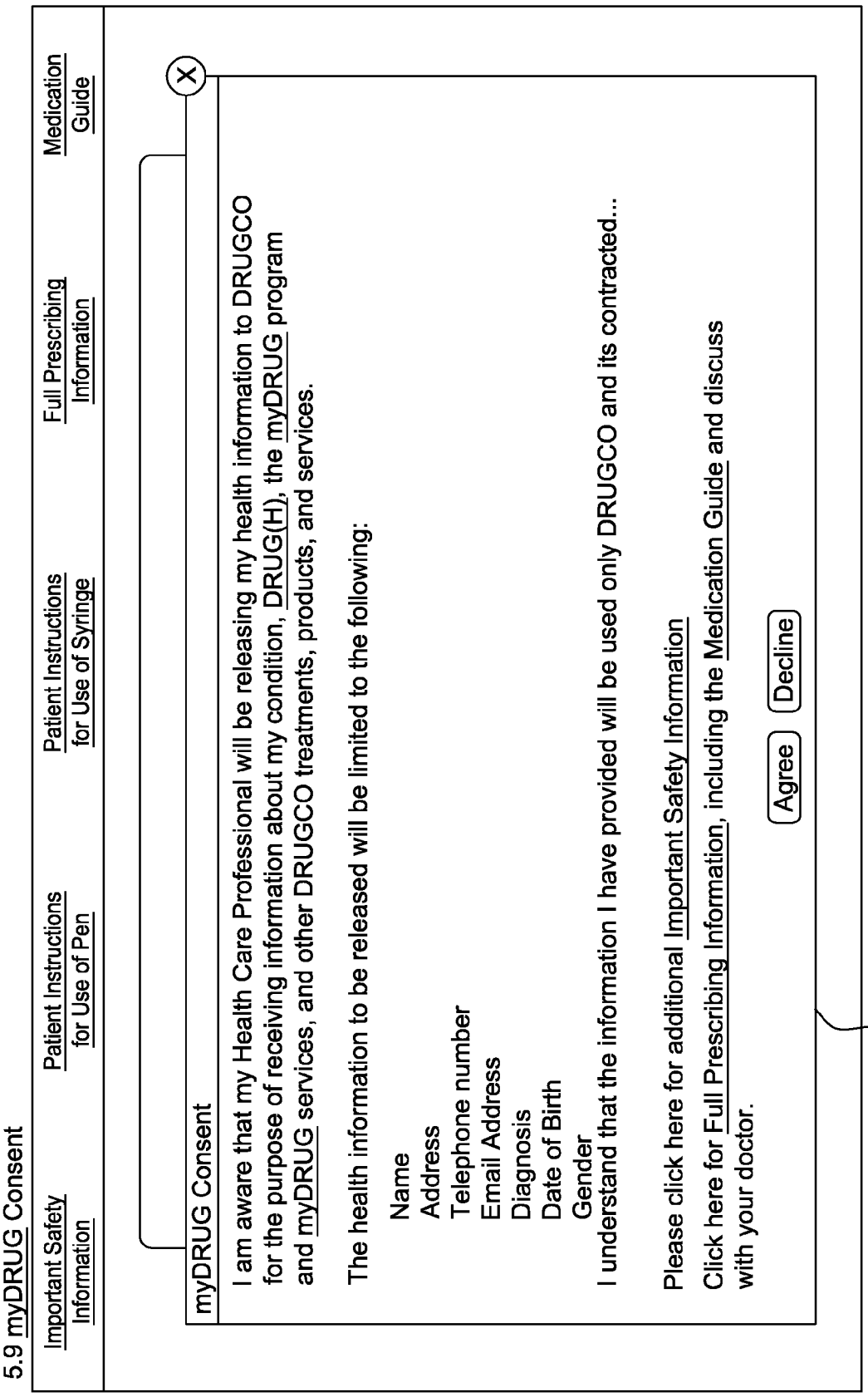

5.9 myDRUG Consent
Important Safety Information
Patient Instructions for Use of Pen
Patient Instructions for Use of Syringe
Full Prescribing Information
Medication Guide
myDRUG Consent
I am aware that my Health Care Professional will be releasing my health information to DRUGCO for the purpose of receiving 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

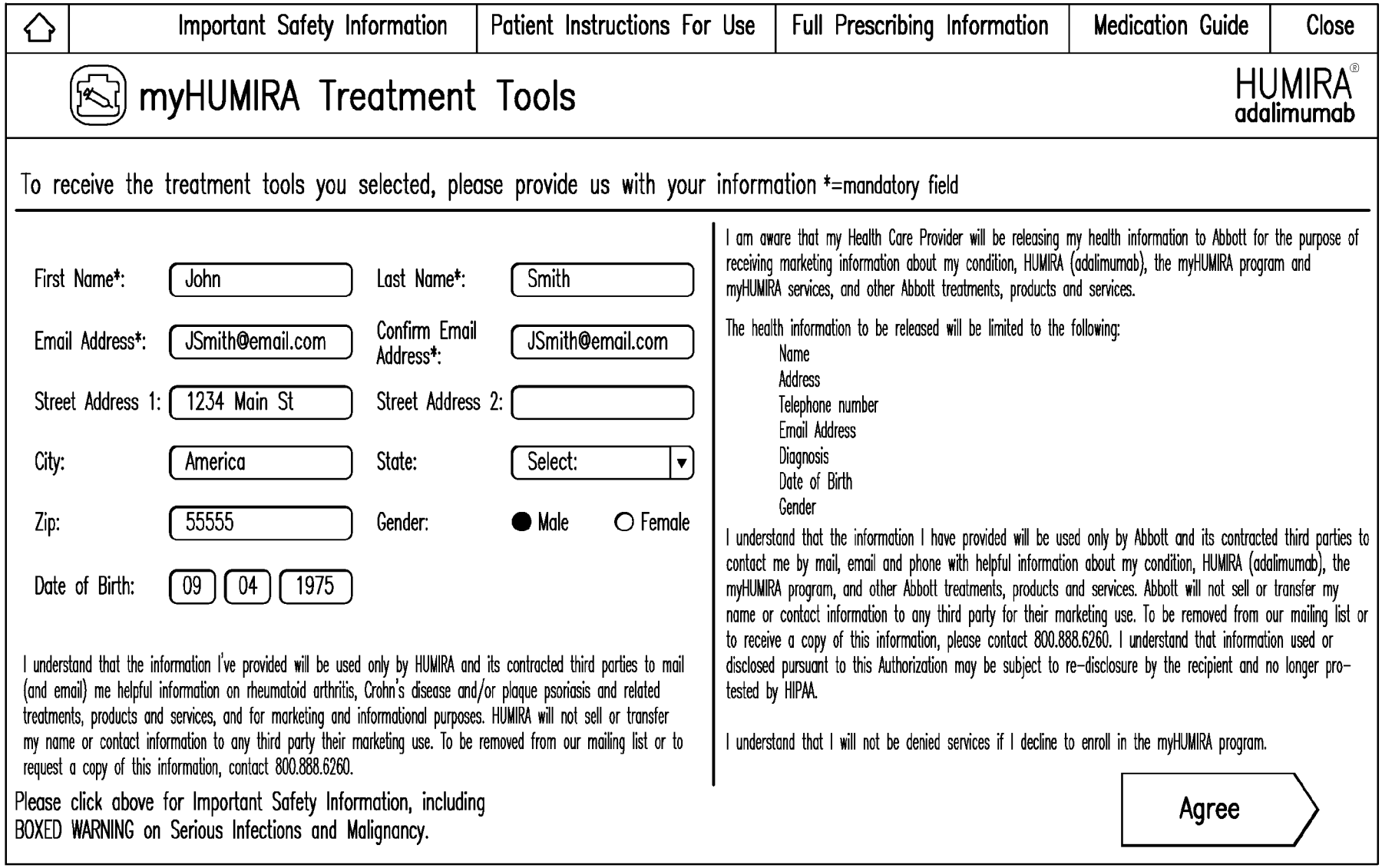

Important Safety Information
Patient Instructions For Use
Full Prescribing Information
Medication Guide
Close
myHUMIRA Treatment Tools
HUMIRA®
adalimumab
To receive the treatment tools you selected, please provide us with your information *=mandatory field
First Name*:
John
Last Name*:
Smith
Email Address*:
JSmith@email.com
Confirm Email Address*:
JSmith@email.com
Street Address 1:
1234 Main St
Street Address 2:
City:
America
State:
Select:
Zip:
55555
Gender:
Male
Female
Date of Birth:
09
04
1975
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.
Please click above for Important Safety Information, including BOXED WARNING on Serious Infections and Malignancy.
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.
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 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 protested by HIPAA.
I understand that I will not be denied services if I decline to enroll in the myHUMIRA program.
Agree

FIG. 39B

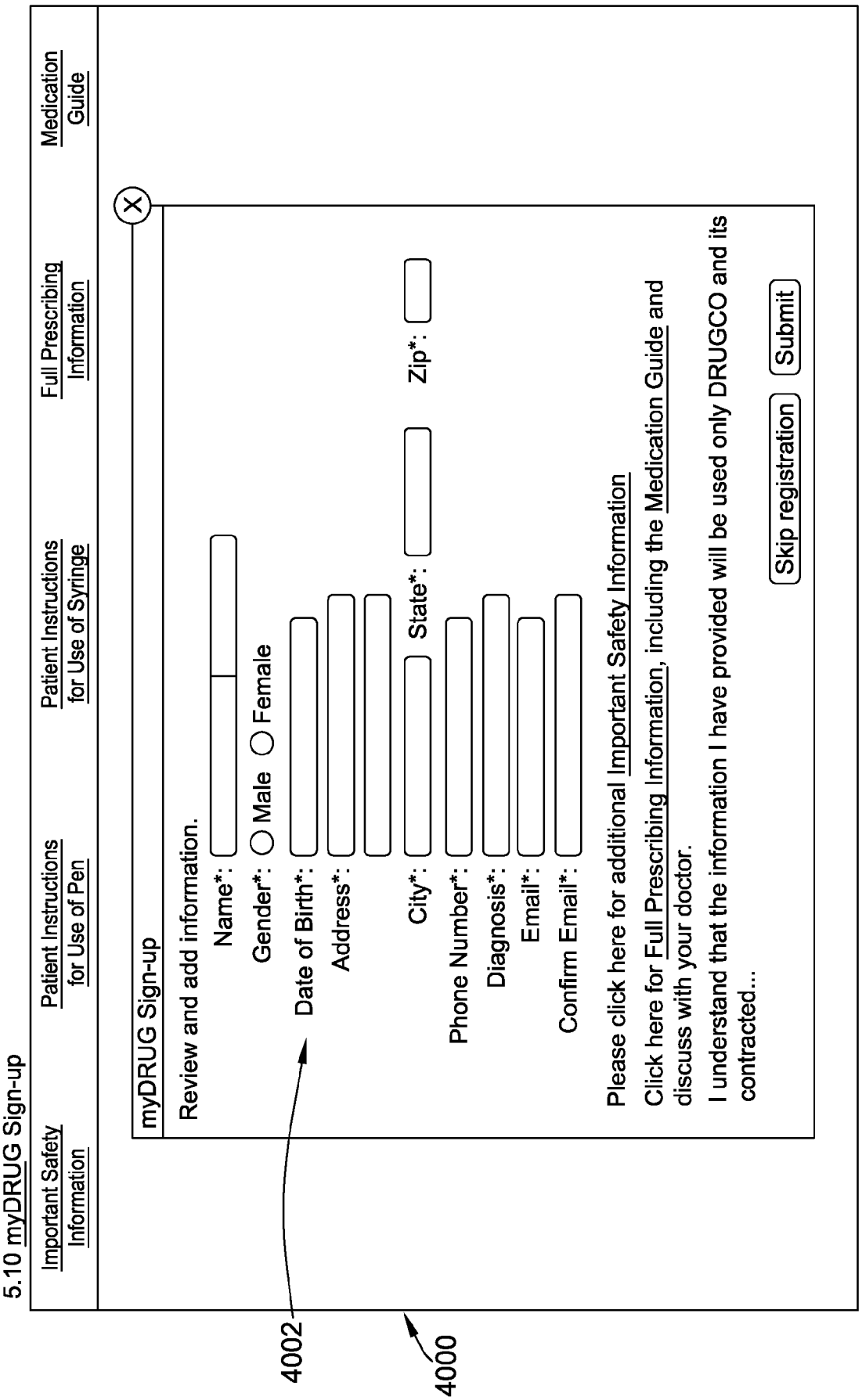

5.10 myDRUG Sign-up
Important Safety Information
Patient Instructions for Use of Pen
Patient Instructions for Use of Syringe
Full Prescribing Information
Medication Guide
myDRUG Sign-up
Review and add information.
Name*:
Gender*: Male Female
Date of Birth*:
Address*:
City*:
State*:
Zip*:
Phone Number*:
Diagnosis*:
Email*:
Confirm Email*:
Please click here for additional Important Safety Information
Click here for Full Prescribing Information, including the Medication Guide and discuss with your doctor.
I understand that the information I have provided will be used only DRUGCO and its contracted...
Skip registration
Submit
4002
4000

FIG. 40

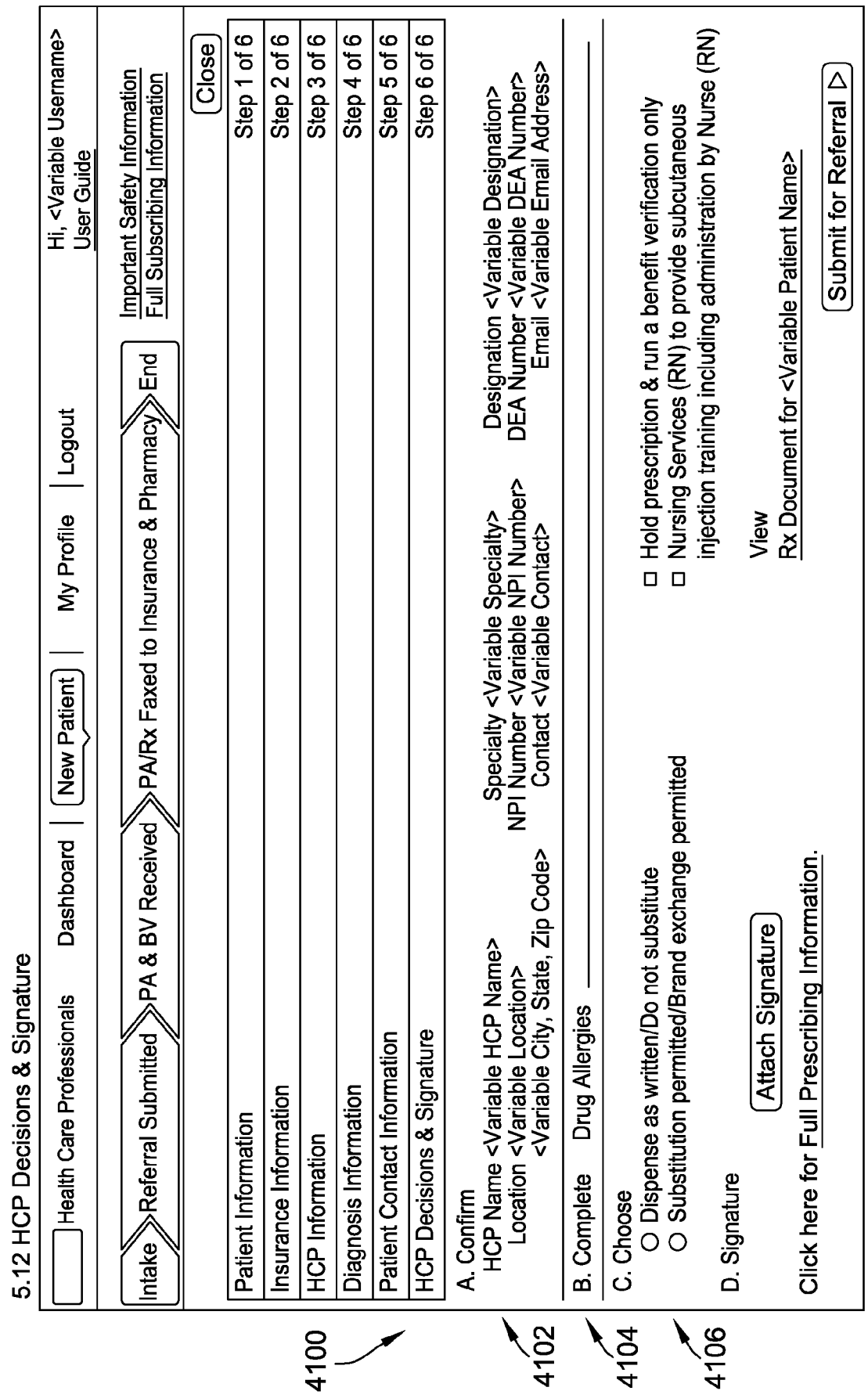
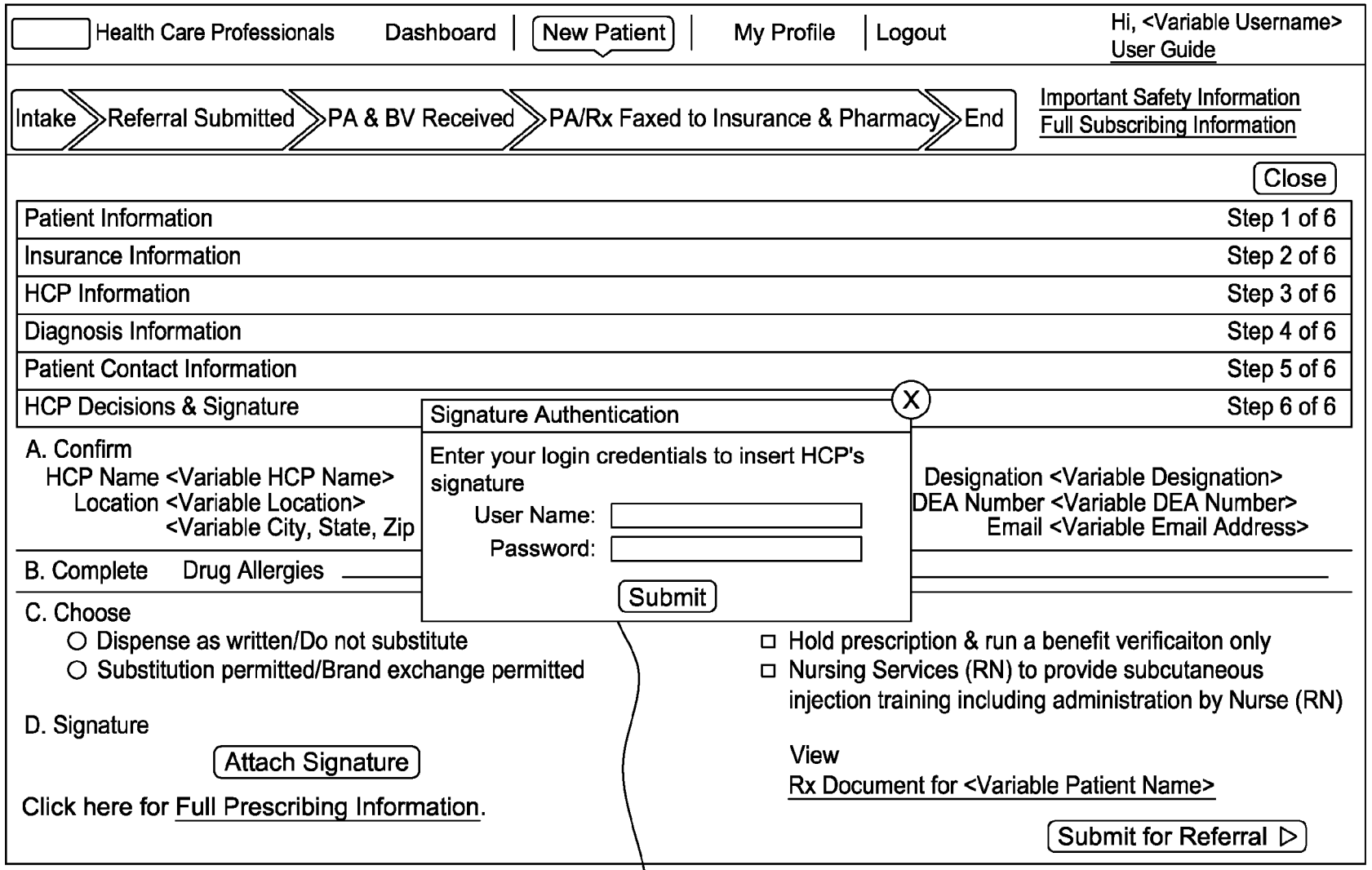

5.12 HCP Decisions & Signature
Health Care Professionals
Dashboard
New Patient
My Profile
Logout
Hi, <Variable Username>
User Guide
Intake
Referral Submitted
PA & BV Received
PA/Rx Faxed to Insurance & Pharmacy
End
Important Safety Information
Full Subscribing Information
Close
Patient Information
Step 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
Attach Signature
View
Rx Document for <Variable Patient Name>
Click here for Full Prescribing Information.
Submit for Referral
4100
4102
4104
4106

FIG. 41

5.12.1 Signature Authentication



4200

FIG. 42

5.12.2 PS Referral Form 4300

RHEUMATOLOGY

DRUG REFERRAL AND PRESCRIPTION FORM FOR QUESTIONS, PLEASE CALL (888) XXX-XXXX

PATIENT AND PRESCRIBER INFORMATION

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

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

Primary Insurance:		Secondary Insurance:	
Phone:		Phone:	
Cardholder ID #:	Group #:	Cardholder ID #:	Group #:
PCN:	BIN:	PCN:	BIN:
Policyholder Name:		Policyholder Name:	

INJECTION TRAINING

Complete ONLY if you desire to have DRUG(H) Nursing Services train patients

☐DRUG(H) Nursing Services (RN) to provide SC injection training for DRUG(H), including administration by Nurse (RN)

Order valid for 90 days

CLINICAL AND PRESCRIPTION INFORMATION

PATIENT'S DIAGNOSIS

☐ Rheumatoid Arthritis (714.0) ☐ Psoriatic Arthritis (696.0) ☐ Polyarticular Juvenile idiopathic Arthritis [JIA] (714.30)
☐ Ankylosing Spondylitis (720.0) ☐ Other (include code):

PRESCRIPTION ☐ New ☐ Continuing

Rheumatoid Arthritis, ...

☐ DRUG(H) Pen 40 mg/0.8 mL 40 mg SC inj. every other week ☐ #2 pens ☐ #6 pens Refills _____

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

☐ DRUG(H) Pre-filled Syringe... 20 mg SC inj. every other week ☐ #2 pens ☐ #6 pens Refills _____

Other

☐ DRUG(H) _____ SIG: _____ Qty: _____ Refills _____

If you wish to prescribe a non-biologic DRUG2 in combination with DRUG(H)...

PRESCRIBER SIGNATURE: PRESCRIBER SIGNATURE IS REQUIRED TO VALIDATE PRESCRIPTIONS

☐ I do not want to prescribe DRUG(H) at this time, but please verify drug coverage

☐ Dispense as written/Do not substitute
☐ Substitutions permitted/Brand exchange permitted

For states requiring...

This information...

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

FIG. 43

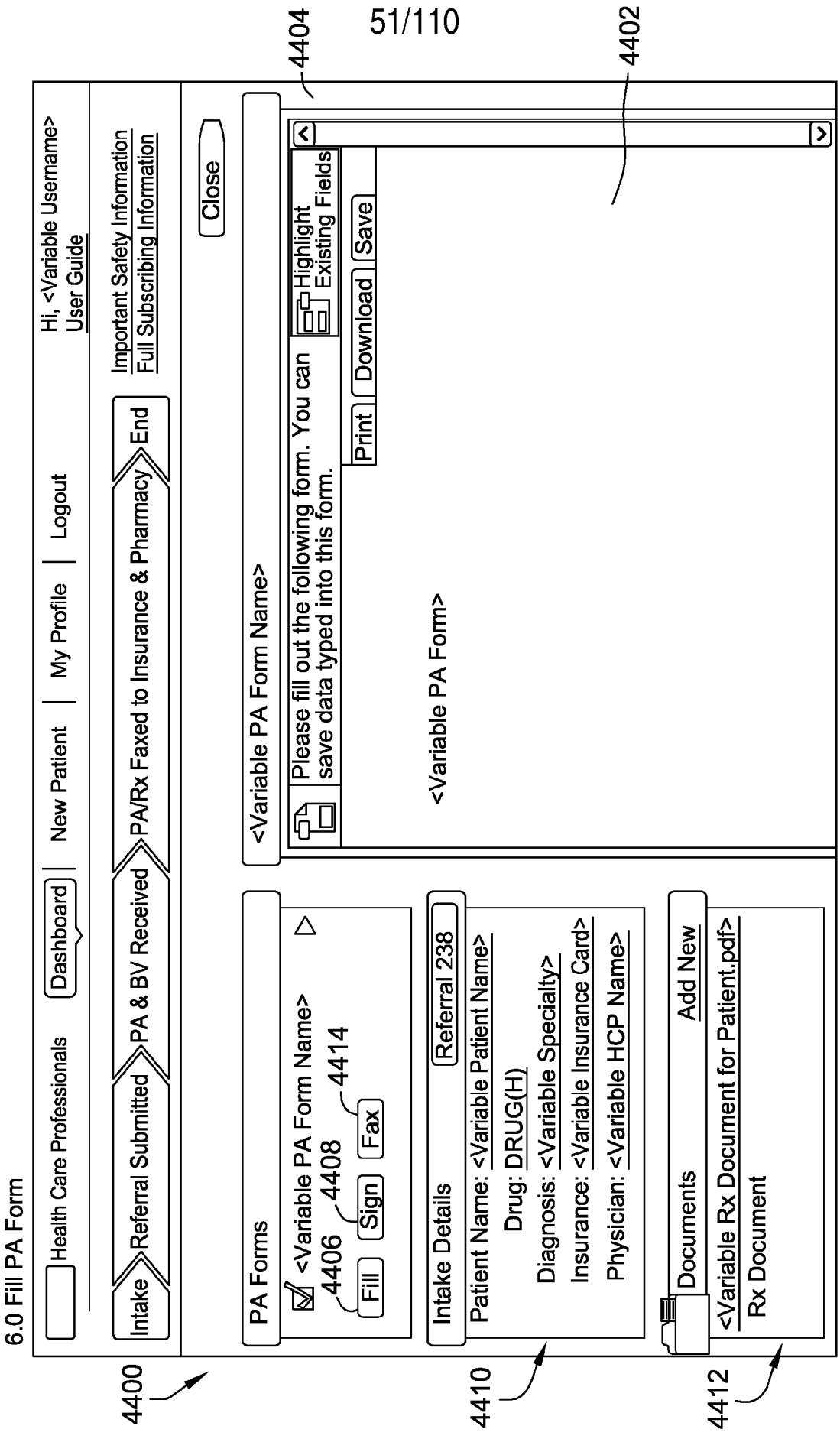

6.0 Fill PA Form
Health Care Professionals
Dashboard
New Patient
My Profile
Logout
Hi, <Variable Username>
User Guide
Intake
Referral Submitted
PA & BV Received
PA/Rx Faxed to Insurance & Pharmacy
End
Important Safety Information
Full Subscribing Information
Close
4400
4404
4402
<Variable PA Form Name>
Please fill out the following form. You can save data typed into this form.
Highlight Existing Fields
Print
Download
Save
<Variable PA Form>
PA Forms
<Variable PA Form Name>
4406
4408
4414
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>
4410
Documents
Add New
<Variable Rx Document for Patient.pdf>
Rx Document
4412

FIG. 44

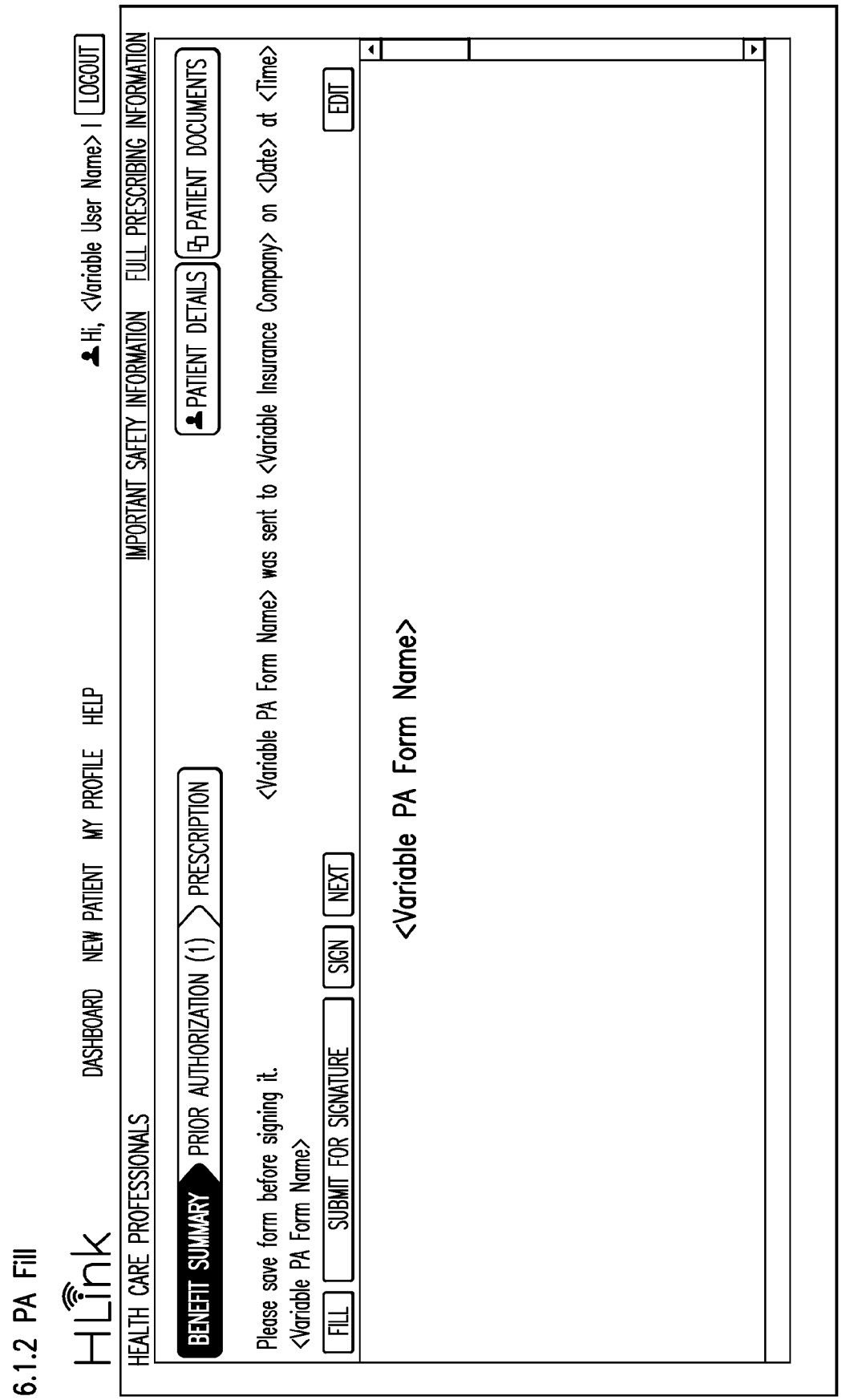

6.1.2 PA Fill
HLink
DASHBOARD NEW PATIENT MY PROFILE HELP
Hi, <Variable User Name> | LOGOUT
HEALTH CARE PROFESSIONALS
IMPORTANT SAFETY INFORMATION FULL PRESCRIBING INFORMATION
BENEFIT SUMMARY PRIOR AUTHORIZATION (1) PRESCRIPTION
PATIENT DETAILS
PATIENT DOCUMENTS
Please save form before signing it.
<Variable PA Form Name>
<Variable PA Form Name> was sent to <Variable Insurance Company> on <Date> at <Time>
FILL
SUBMIT FOR SIGNATURE
SIGN
NEXT
EDIT
<Variable PA Form Name>

FIG. 44B

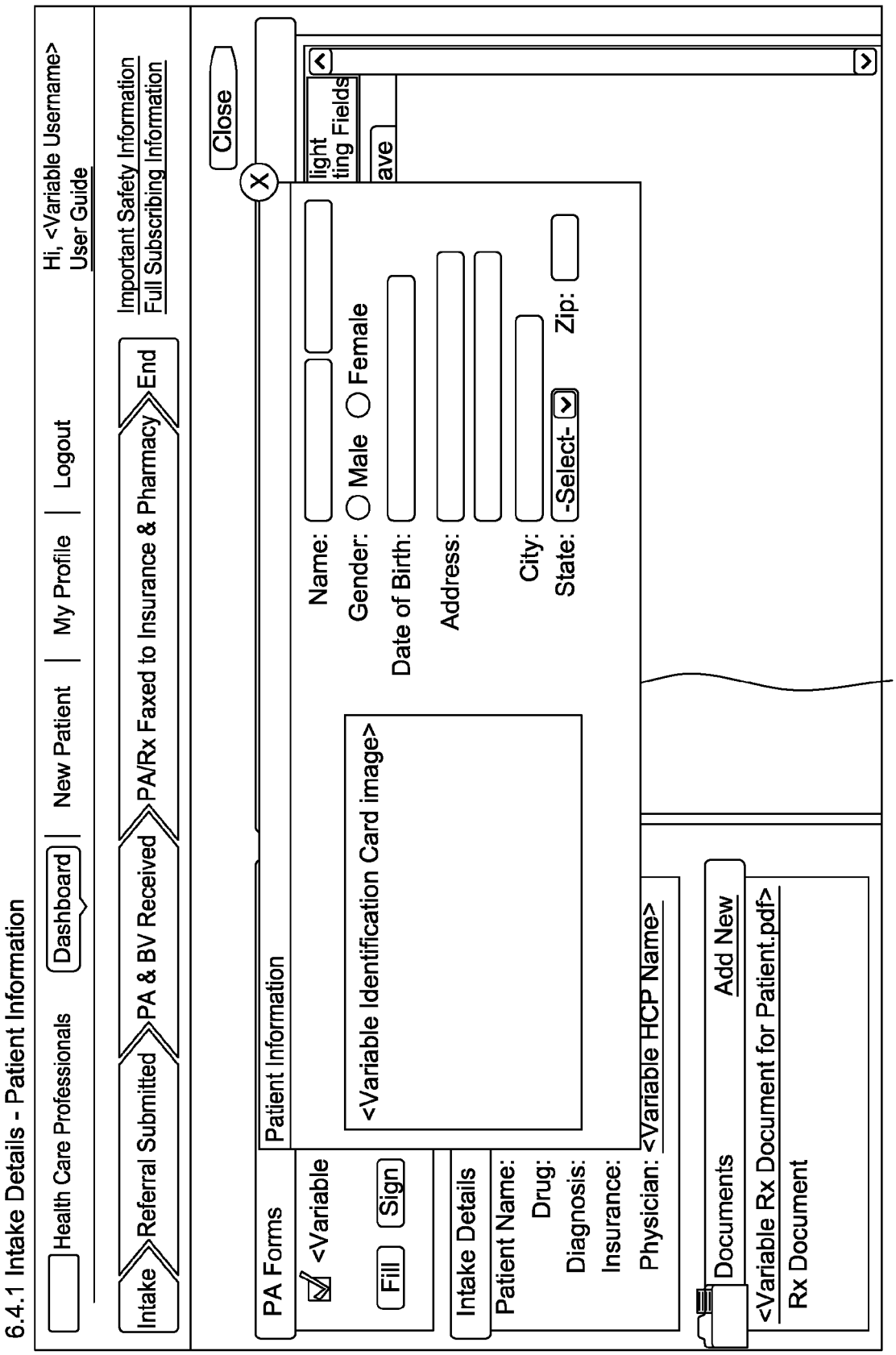

6.4.1 Intake Details - Patient Information
Health Care Professionals
Dashboard
New Patient
My Profile
Logout
Hi, <Variable Username>
User Guide
Intake
Referral Submitted
PA & BV Received
PA/Rx Faxed to Insurance & Pharmacy
End
Important Safety Information
Full Subscribing Information
Close
PA Forms
<Variable
Fill
Sign
Patient Information
<Variable Identification Card image>
Name:
Gender: Male Female
Date of Birth:
Address:
City:
State: -Select-
Zip:
light
ting Fields
ave
Intake Details
Patient Name:
Drug:
Diagnosis:
Insurance:
Physician: <Variable HCP Name>
Documents
Add New
<Variable Rx Document for Patient.pdf>
Rx Document
4500

FIG. 45

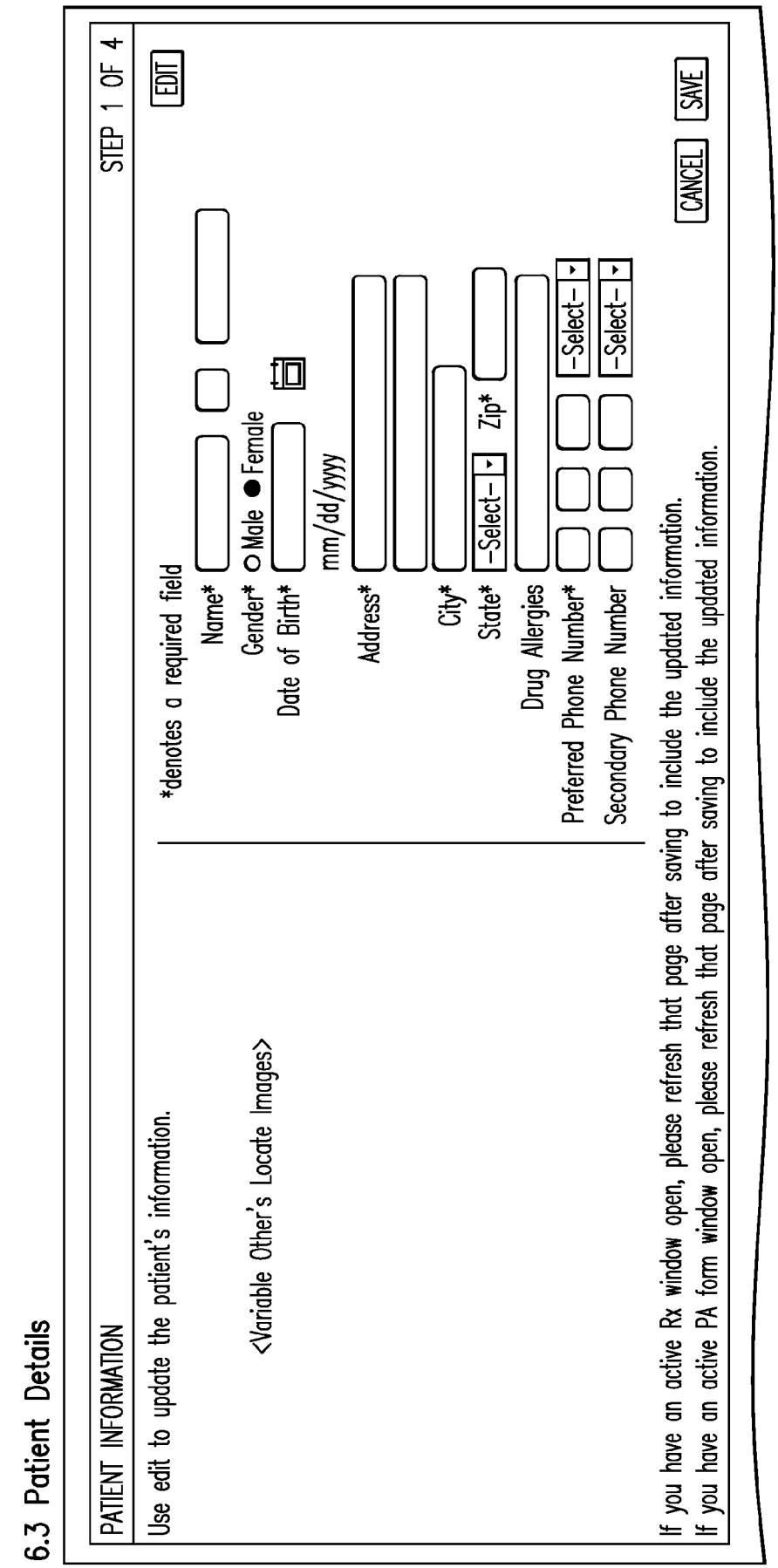

6.3 Patient Details
PATIENT INFORMATION
STEP 1 OF 4
Use edit to update the patient's information.
EDIT
<Variable Other's Locate Images>
*denotes a required field
Name*
Gender* Male Female
Date of Birth*
mm/dd/yyyy
Address*
City*
State* -Select- Zip*
Drug Allergies
Preferred Phone Number* -Select-
Secondary Phone Number -Select-
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

FIG. 45B-1

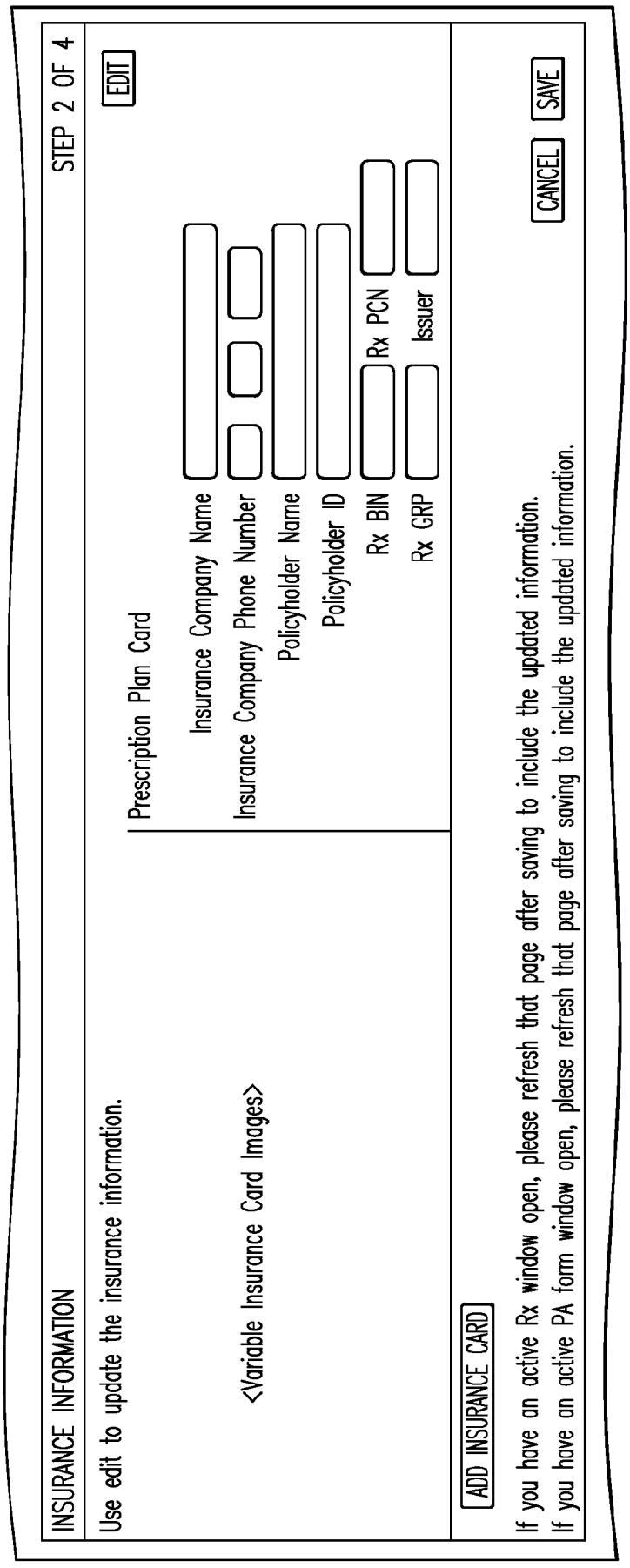

INSURANCE INFORMATION
STEP 2 OF 4
Use edit to update the insurance information.
EDIT
Prescription Plan Card
<Variable Insurance Card Images>
Insurance Company Name
Insurance Company Phone Number
Policyholder Name
Policyholder ID
Rx BIN
Rx PCN
Rx GRP
Issuer
ADD INSURANCE CARD
CANCEL
SAVE
If you have an 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-2

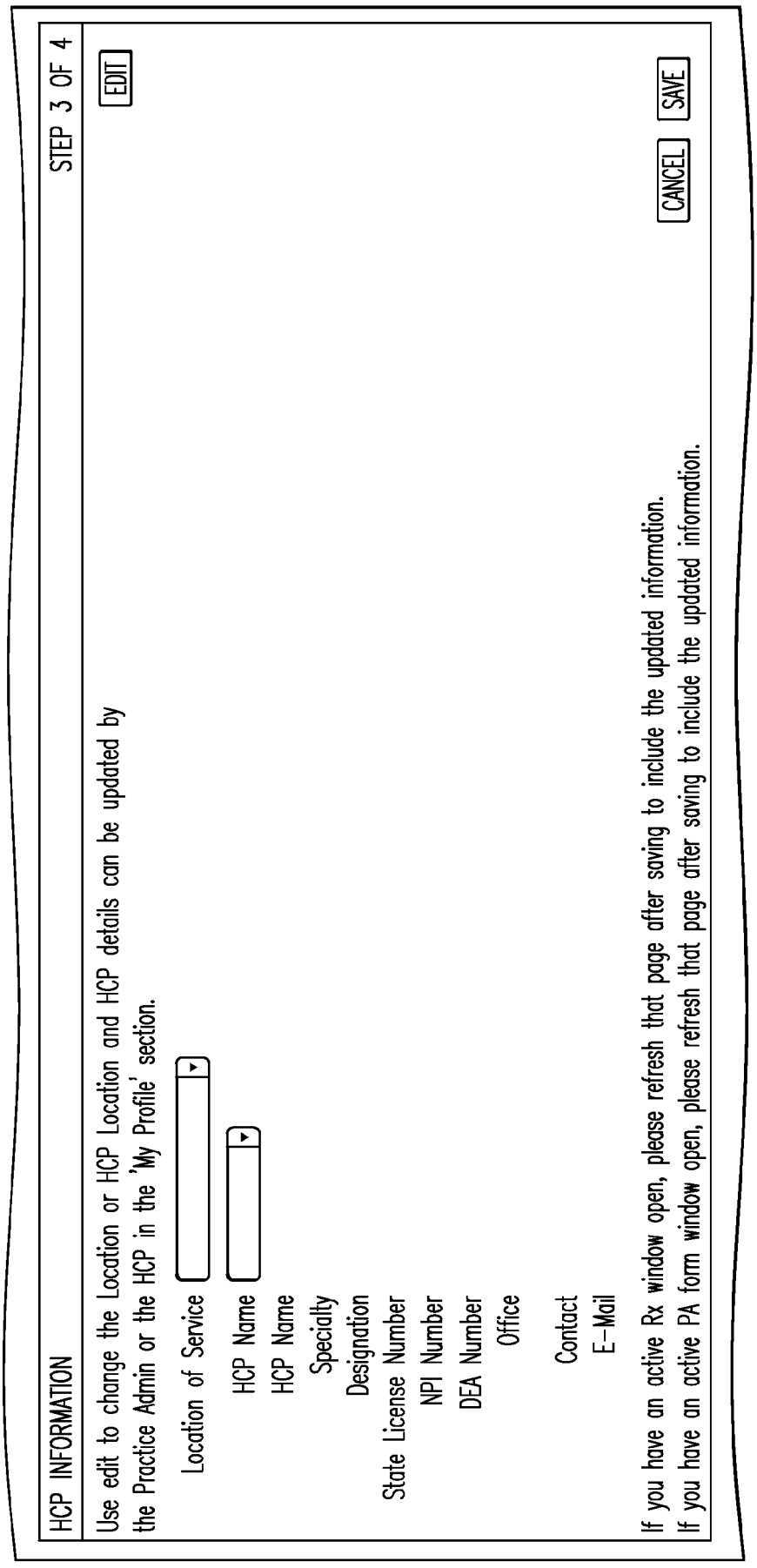

HCP INFORMATION
STEP 3 OF 4
EDIT
Use edit to change the Location or HCP Location and HCP details can be updated by the Practice Admin or the HCP in the 'My Profile' section.
Location of Service
HCP Name
HCP Name
Specialty
Designation
State License Number
NPI Number
DEA Number
Office
Contact
E-Mail
If 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.
CANCEL
SAVE

FIG. 45B-3

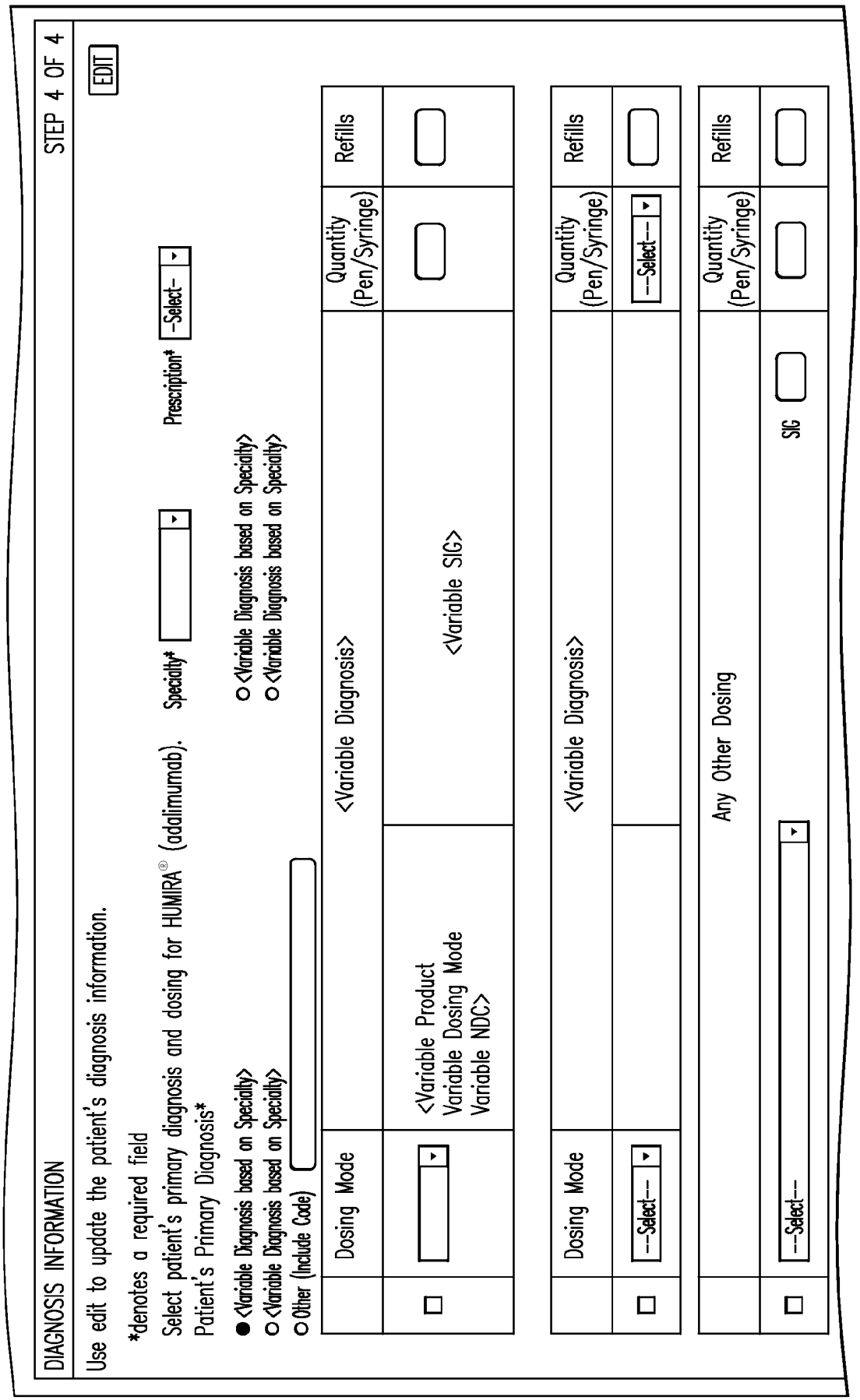

DIAGNOSIS INFORMATION
STEP 4 OF 4
Use edit to update the patient's diagnosis information.
EDIT
*denotes a required field
Select patient's primary diagnosis and dosing for HUMIRA® (adalimumab).
Specialty*
Prescription*
-Select-
Patient's Primary Diagnosis*
<Variable Diagnosis based on Specialty>
<Variable Diagnosis based on Specialty>
<Variable Diagnosis based on Specialty>
Other (Include Code)
Dosing Mode
<Variable Diagnosis>
Quantity (Pen/Syringe)
Refills
<Variable Product
Variable Dosing Mode
Variable NDC>
<Variable SIG>
--Select--
Any Other Dosing
SIG

FIG. 45C-1

INDICATIONS[1]

- 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

SAFETY CONSIDERATIONS[1]

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

SAVE

CANCEL

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.

CLOSE

FIG. 45C-3

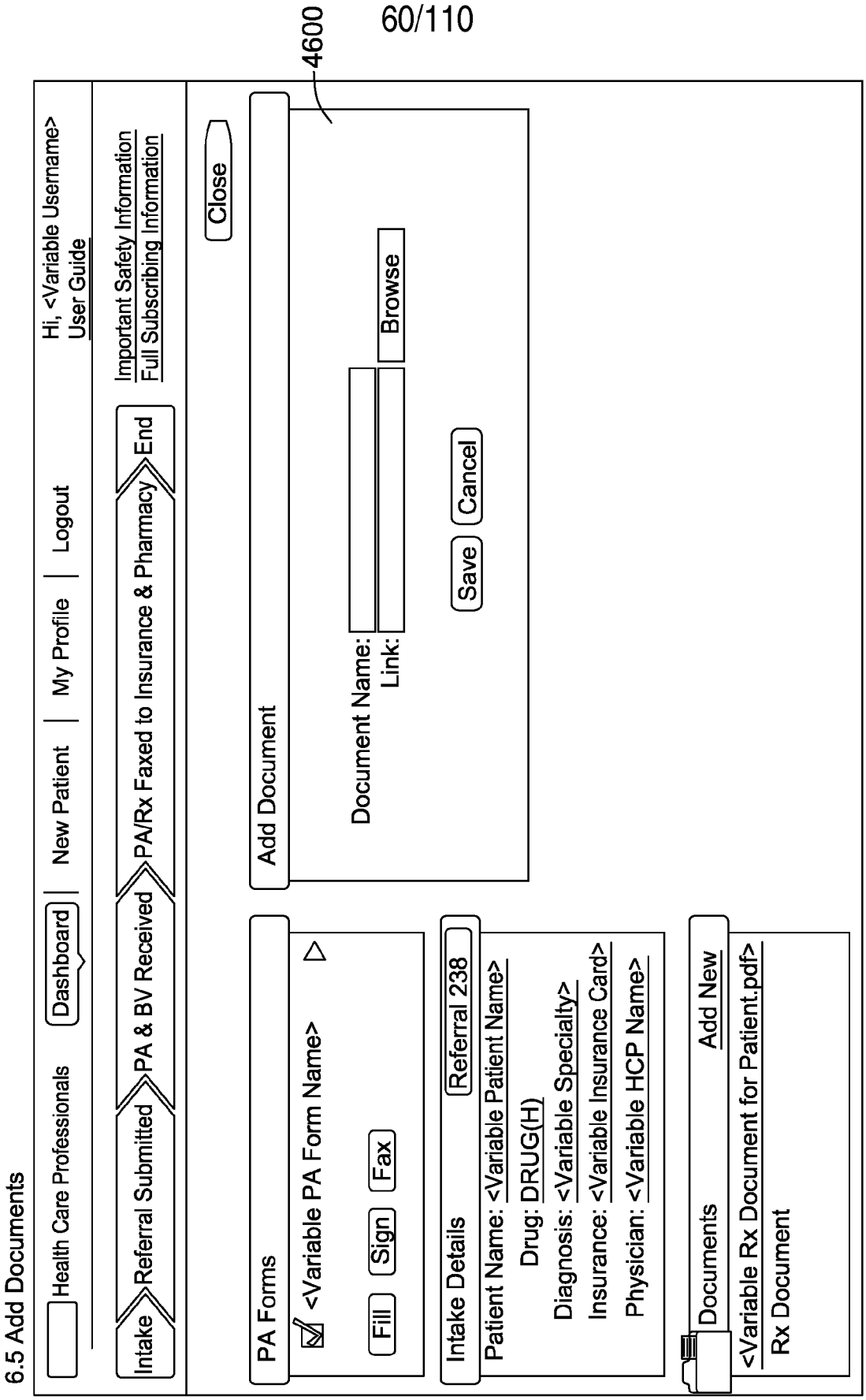

6.5 Add Documents
Health Care Professionals
Dashboard
New Patient
My Profile
Logout
Hi, <Variable Username>
User Guide
Intake
Referral Submitted
PA & BV Received
PA/Rx Faxed to Insurance & Pharmacy
End
Important Safety Information
Full Subscribing Information
Close
4600
Add Document
Document Name:
Link:
Browse
Save
Cancel
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

FIG. 46

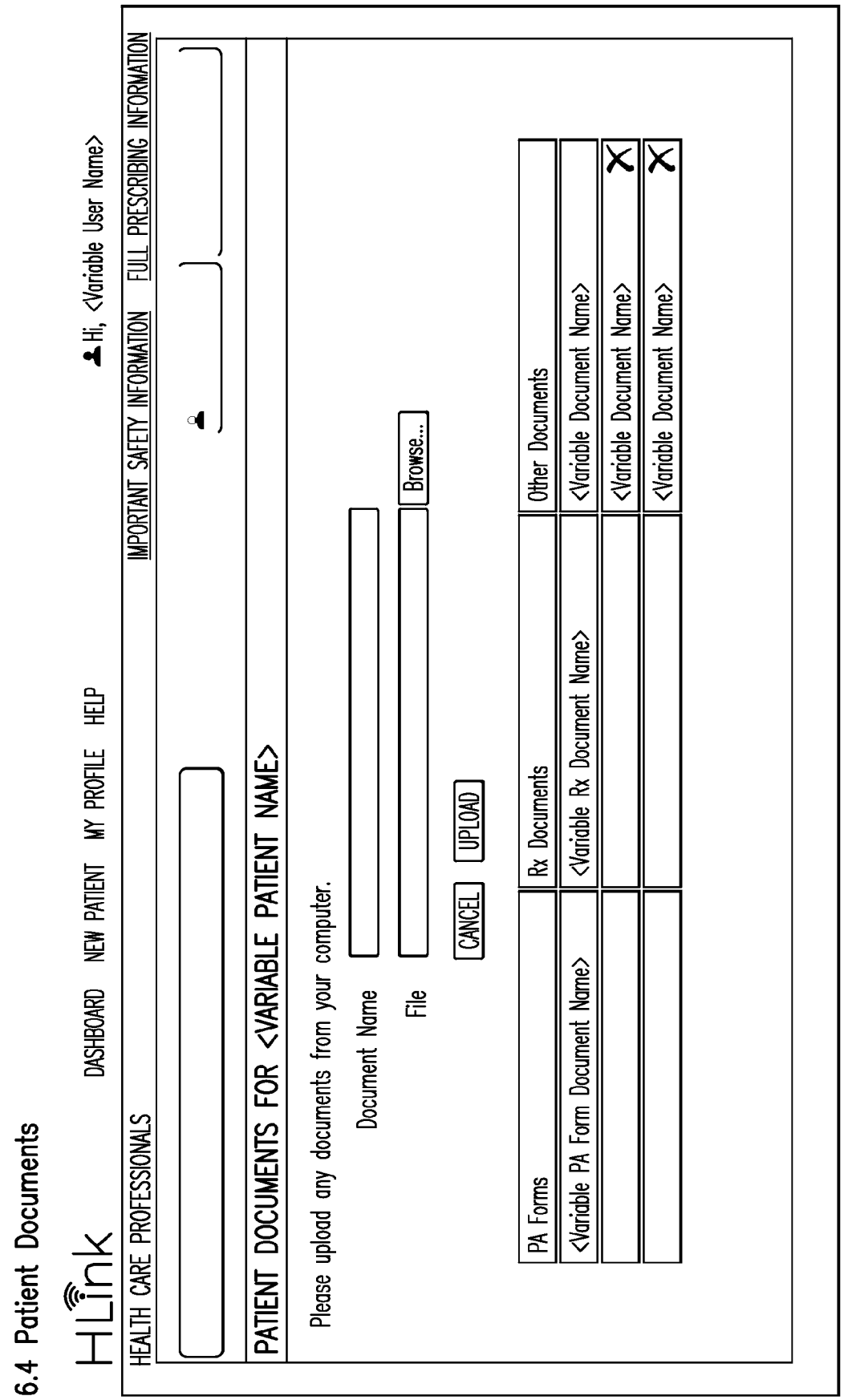

6.4 Patient Documents
HLink
DASHBOARD NEW PATIENT MY PROFILE HELP
Hi, <Variable User Name>
HEALTH CARE PROFESSIONALS
IMPORTANT SAFETY INFORMATION FULL PRESCRIBING INFORMATION
PATIENT DOCUMENTS FOR <VARIABLE PATIENT NAME>
Please upload any documents from your computer.
Document Name
File
Browse...
CANCEL
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>
<Variable Document Name>

FIG. 46B

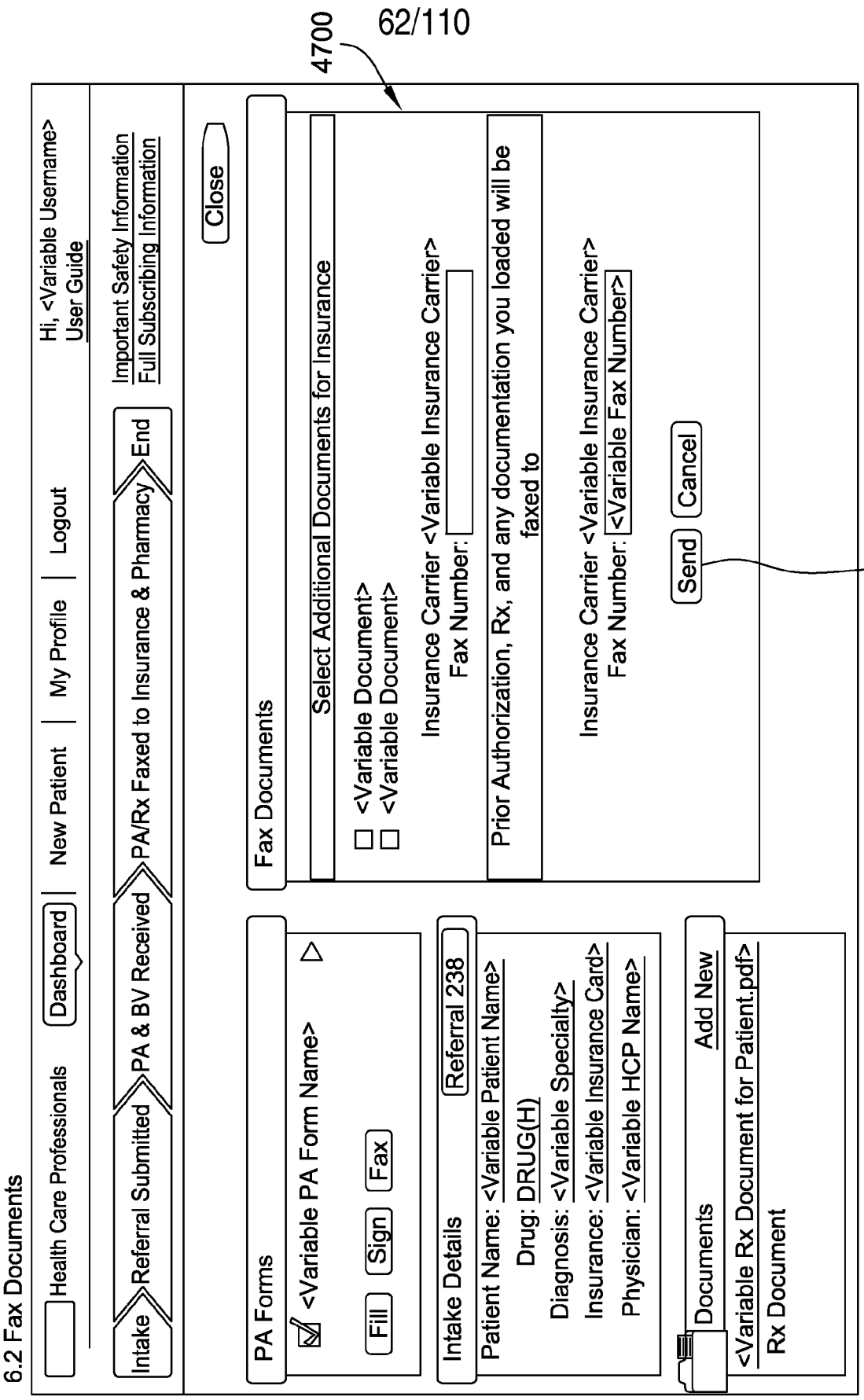

6.2 Fax Documents
Health Care Professionals
Dashboard
New Patient
My Profile
Logout
Hi, <Variable Username>
User Guide
Intake
Referral Submitted
PA & BV Received
PA/Rx Faxed to Insurance & Pharmacy
End
Important Safety Information
Full Subscribing Information
Close
4700
62/110
Fax Documents
Select Additional 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>
Send
Cancel
4702
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

FIG. 47

6.4 Patient Documents

HLink 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

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

FIG. 48

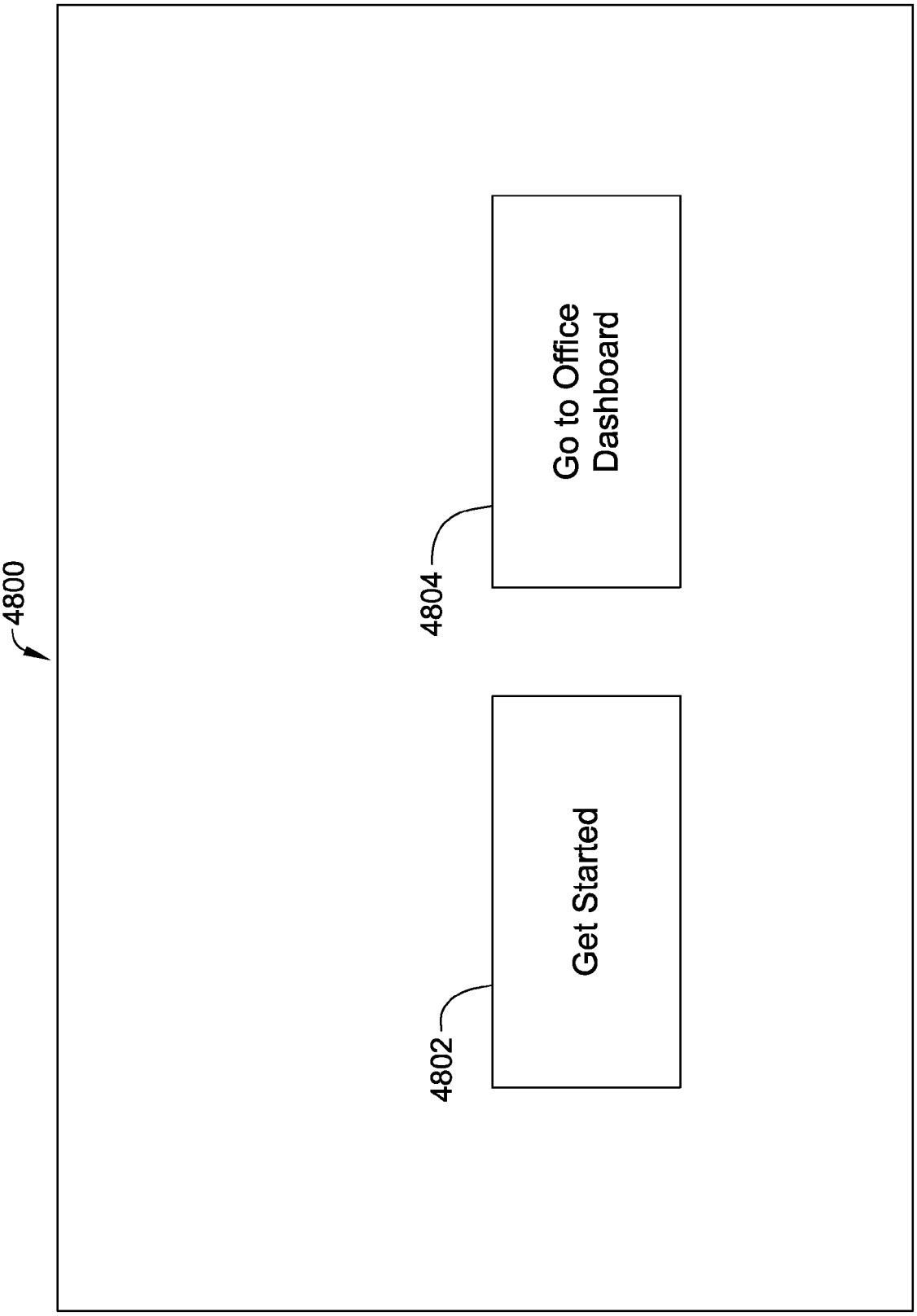
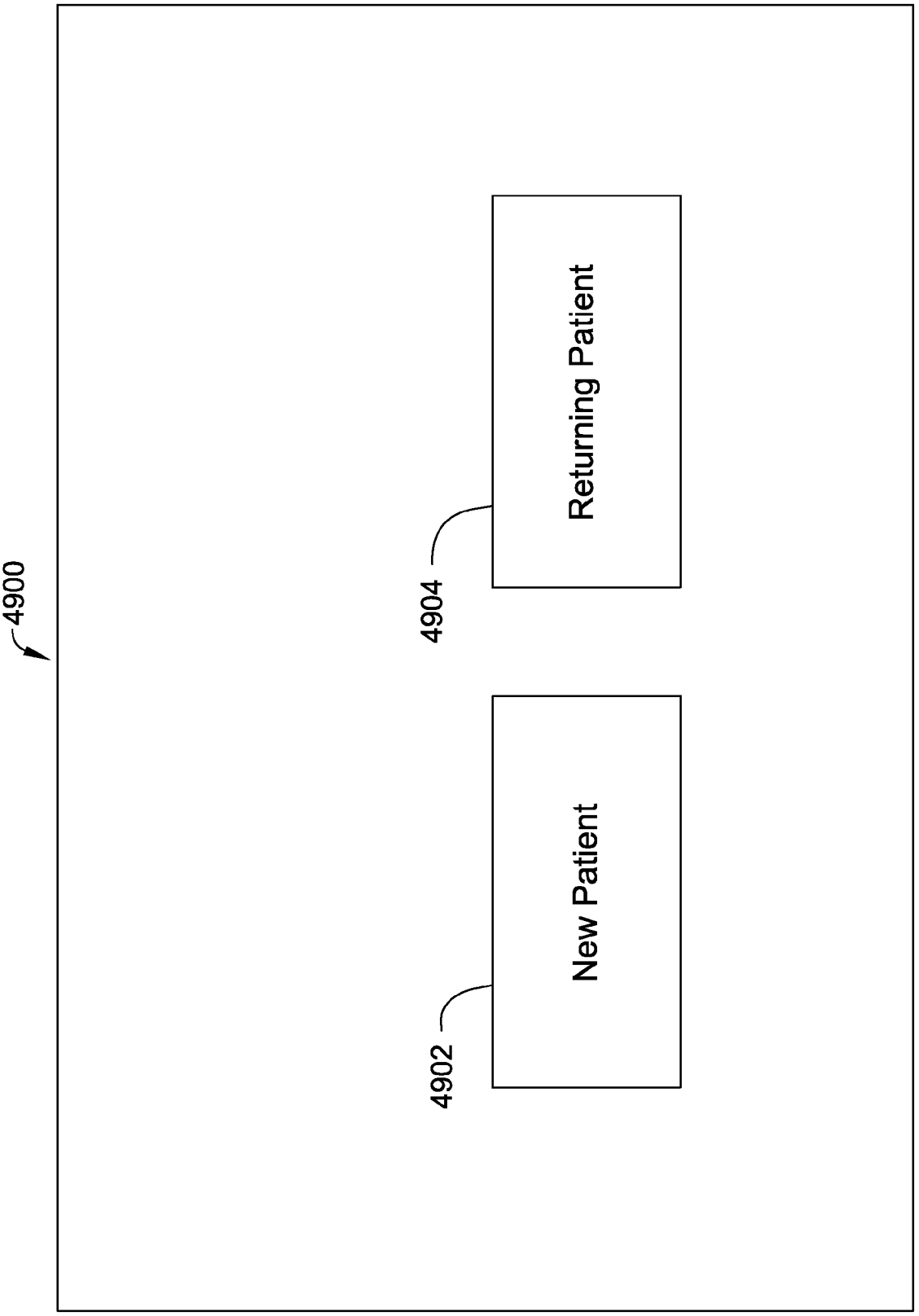


FIG. 49



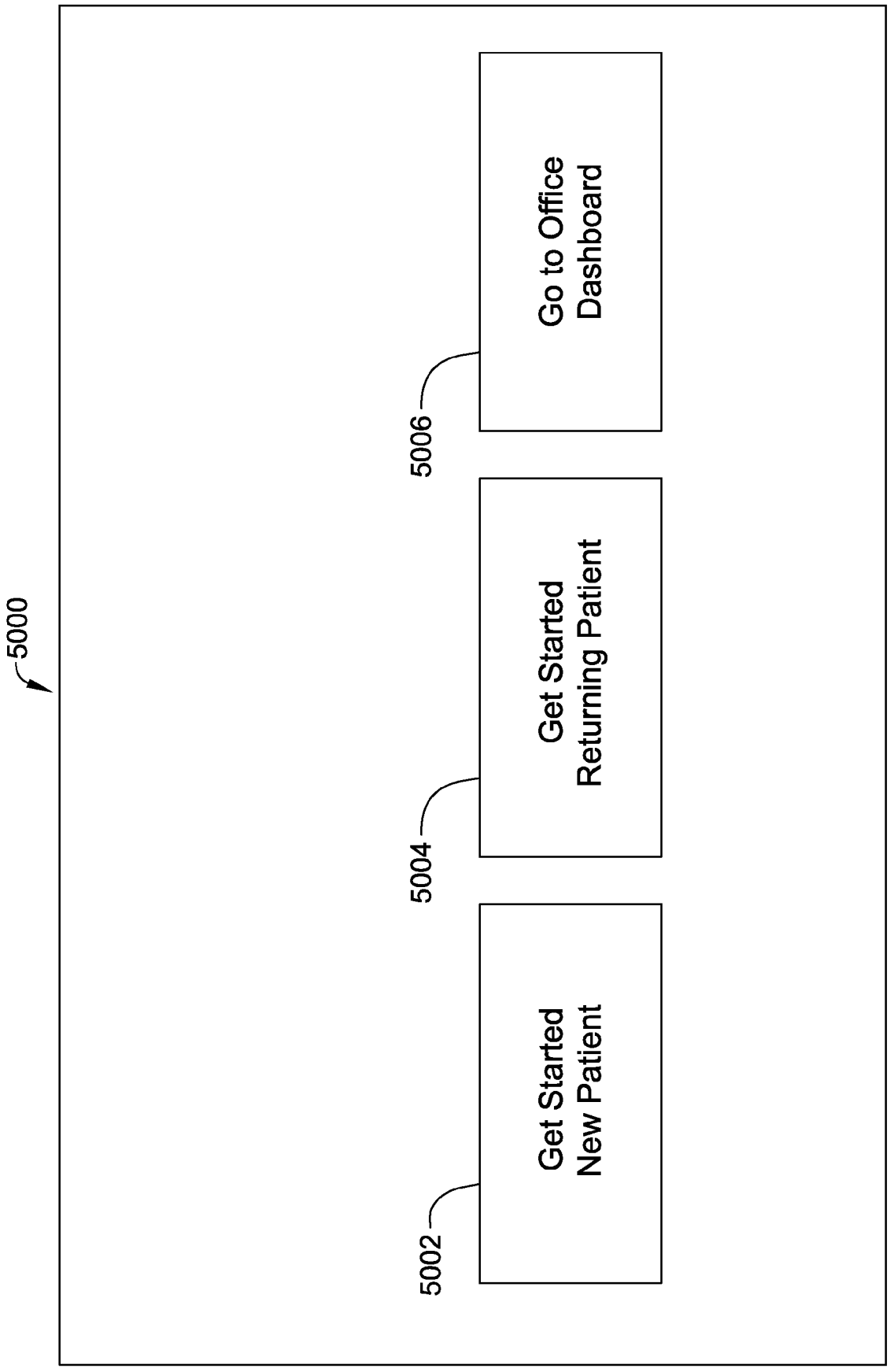

5000
5002
Get Started New Patient
5004
Get Started Returning Patient
5006
Go to Office Dashboard

FIG. 50

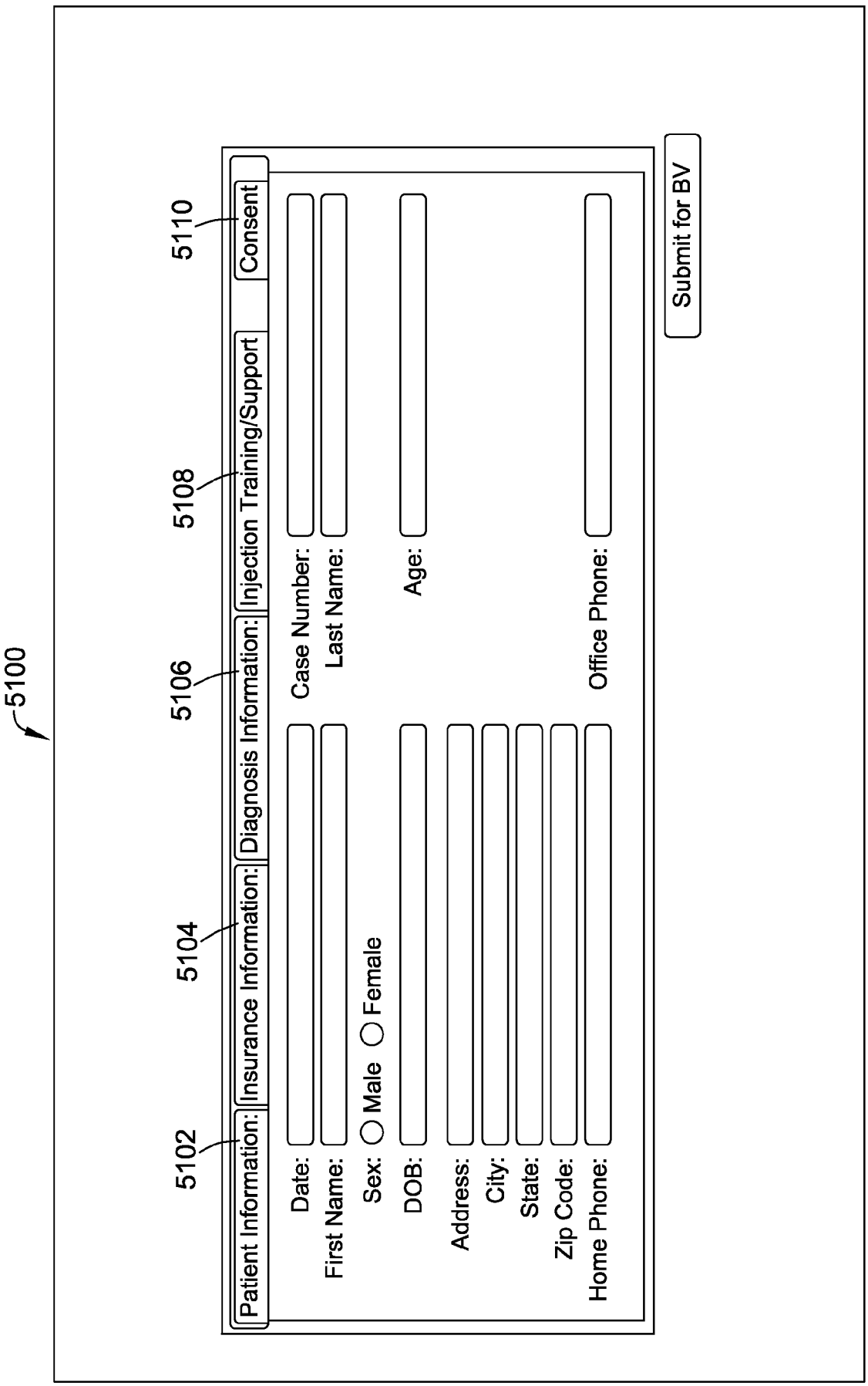

5100
5102
5104
5106
5108
5110
Patient Information:
Insurance Information:
Diagnosis Information:
Injection Training/Support
Consent
Date:
First Name:
Sex: Male Female
DOB:
Address:
City:
State:
Zip Code:
Home Phone:
Case Number:
Last Name:
Age:
Office Phone:
Submit for BV

FIG. 51

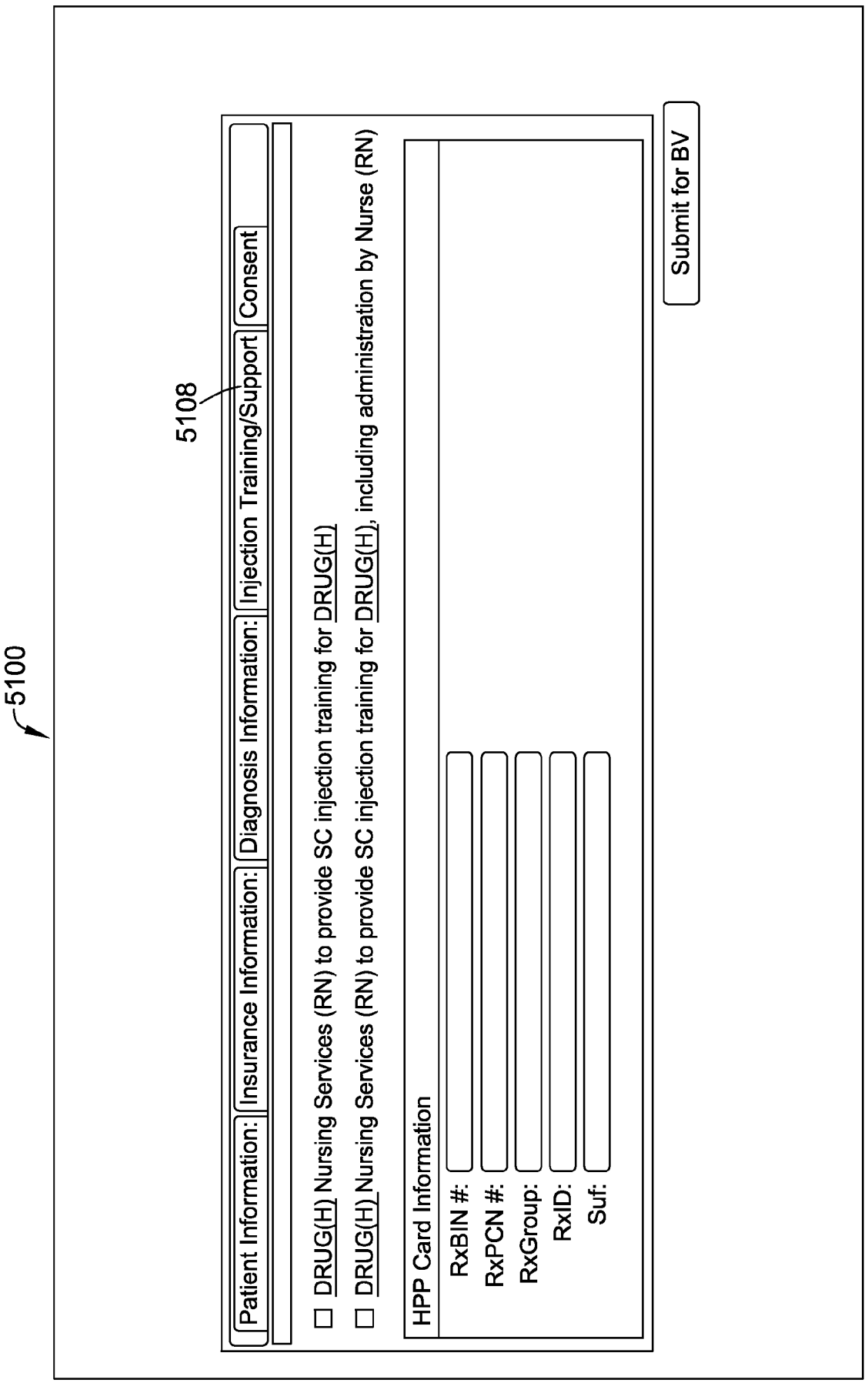
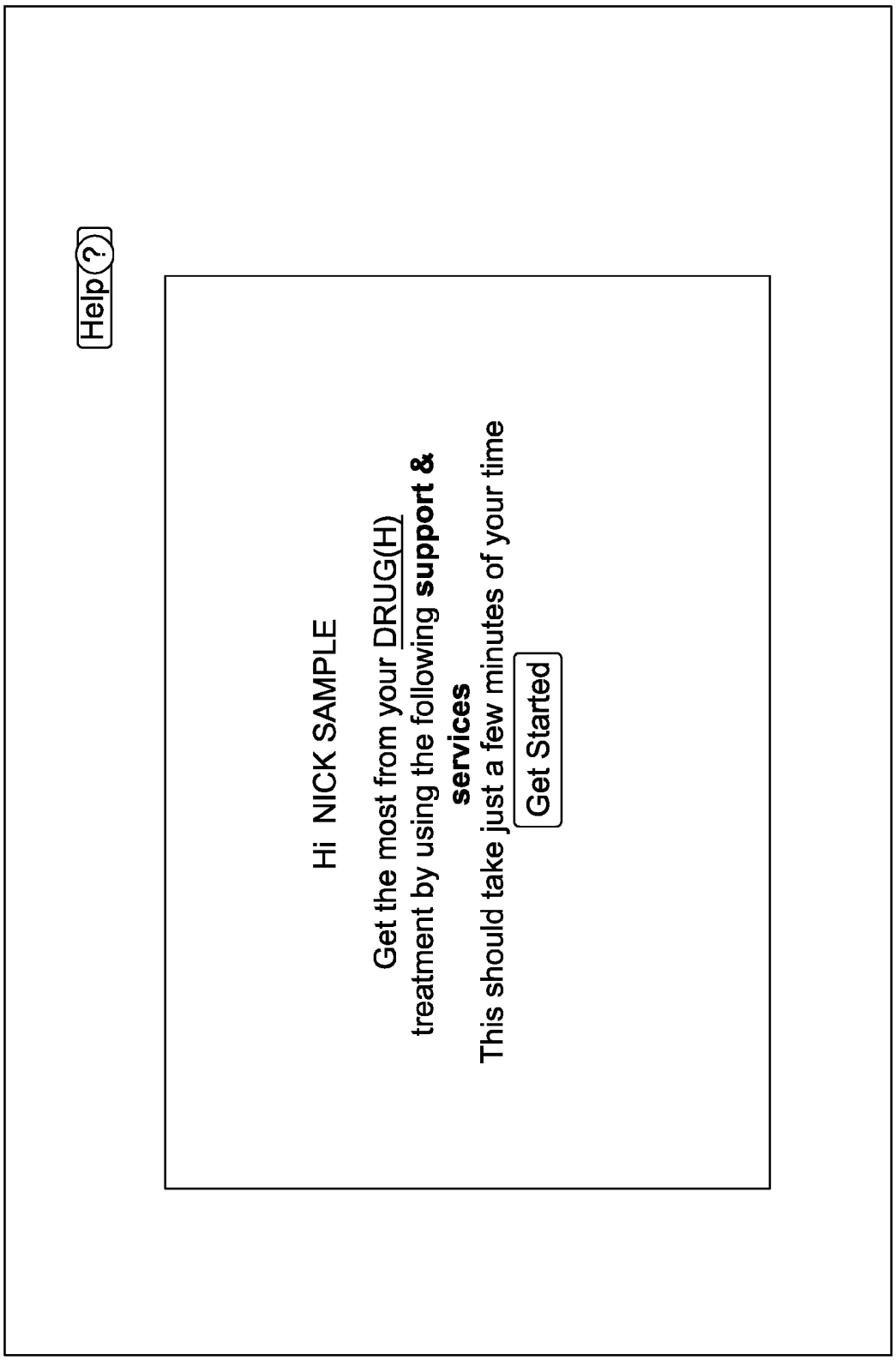

5100
5108
Patient Information:
Insurance Information:
Diagnosis Information:
Injection Training/Support
Consent
☐ DRUG(H) Nursing Services (RN) to provide SC injection training for DRUG(H)
☐ DRUG(H) Nursing Services (RN) to provide SC injection training for DRUG(H), including administration by Nurse (RN)
HPP Card Information
RxBIN #:
RxPCN #:
RxGroup:
RxID:
Suf:
Submit for BV

FIG. 51A

FIG. 52


Help (?)
Hi NICK SAMPLE
Get the most from your DRUG(H) treatment by using the following **support & services**
This should take just a few minutes of your time
Get Started

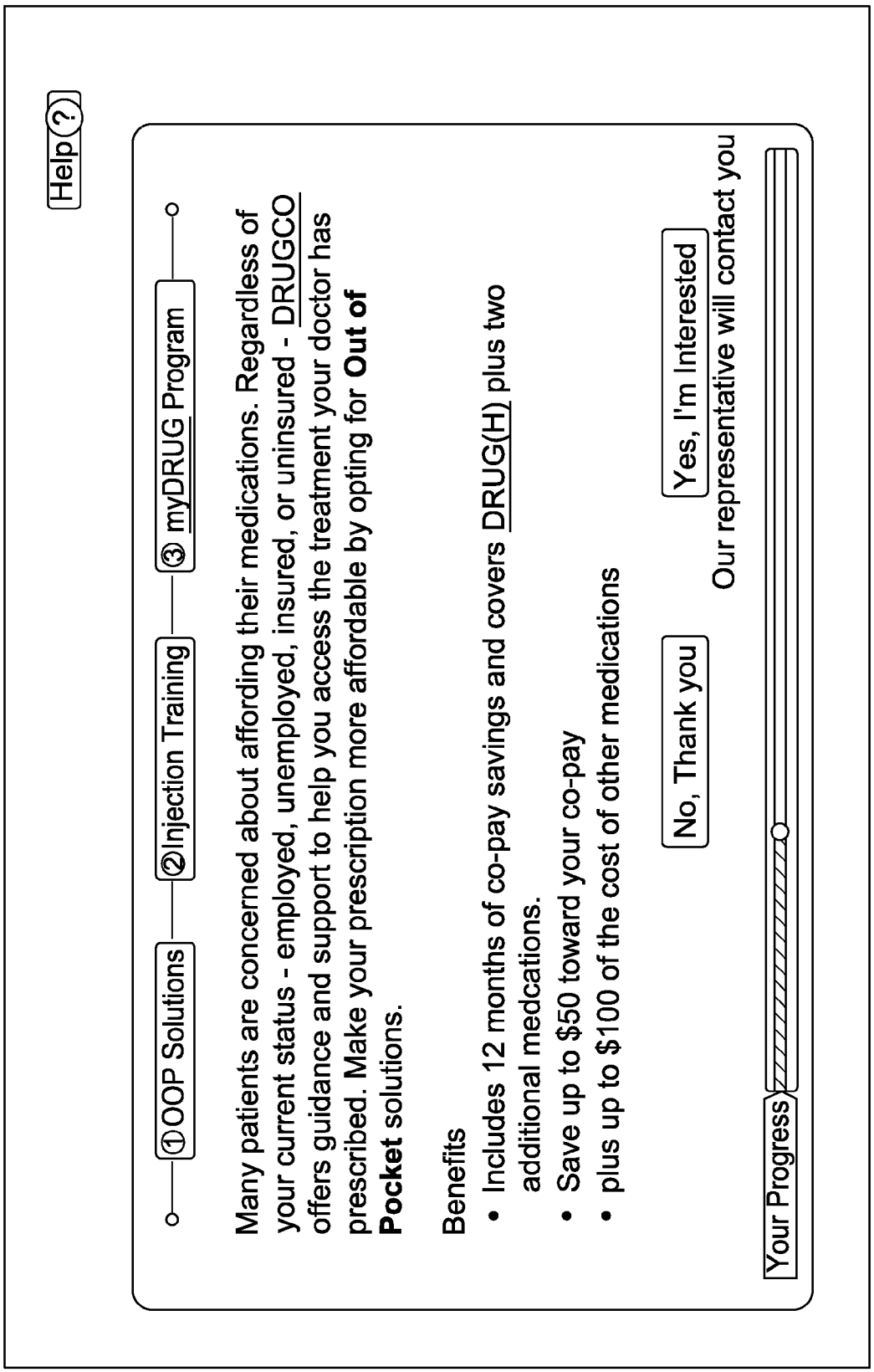

Help (?)
①OOP Solutions
②Injection Training
③ myDRUG Program
Many patients are concerned about affording their medications. Regardless of your current status - employed, unemployed, insured, or uninsured - DRUGCO offers guidance and support to help you access the treatment your doctor has prescribed. 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 medcations.
• 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

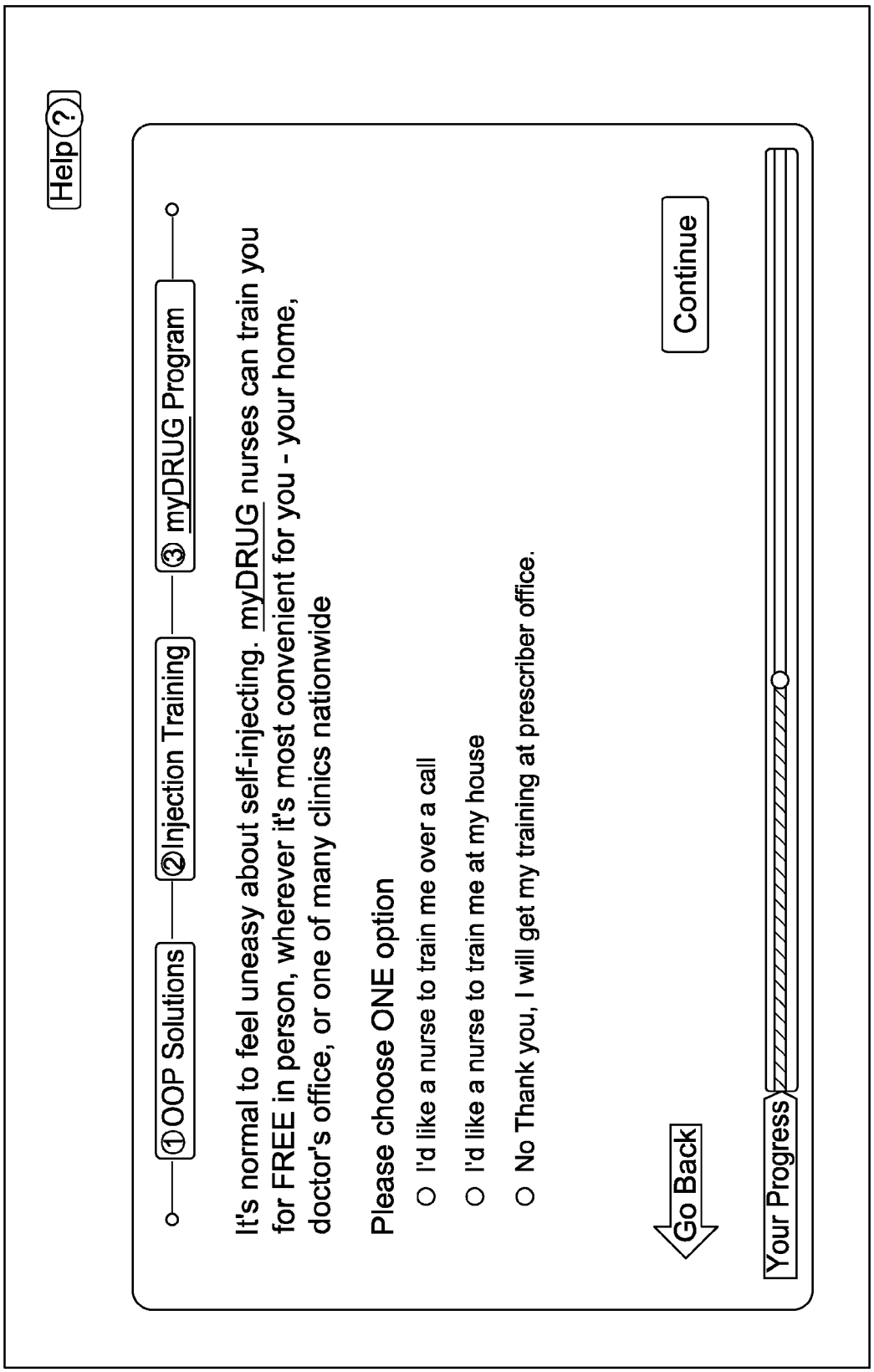

Help (?)
①OOP Solutions
②Injection Training
③ myDRUG Program
It's normal to feel uneasy about self-injecting. myDRUG nurses can train you for FREE in person, wherever it's most convenient for you - your home, doctor's office, or one of many clinics nationwide
Please choose ONE option
I'd like a nurse 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.
Continue
Go Back
Your Progress

FIG. 54

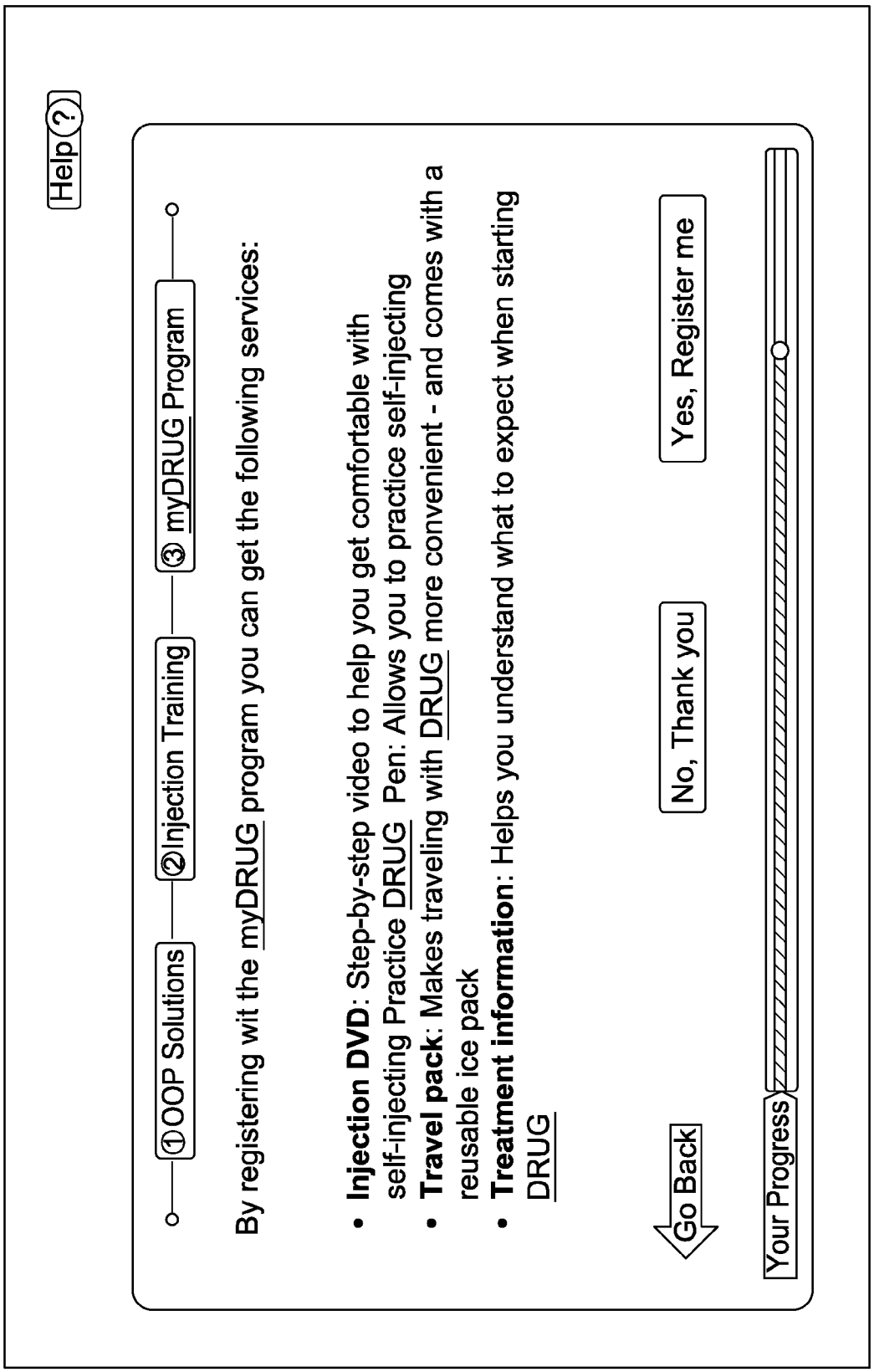
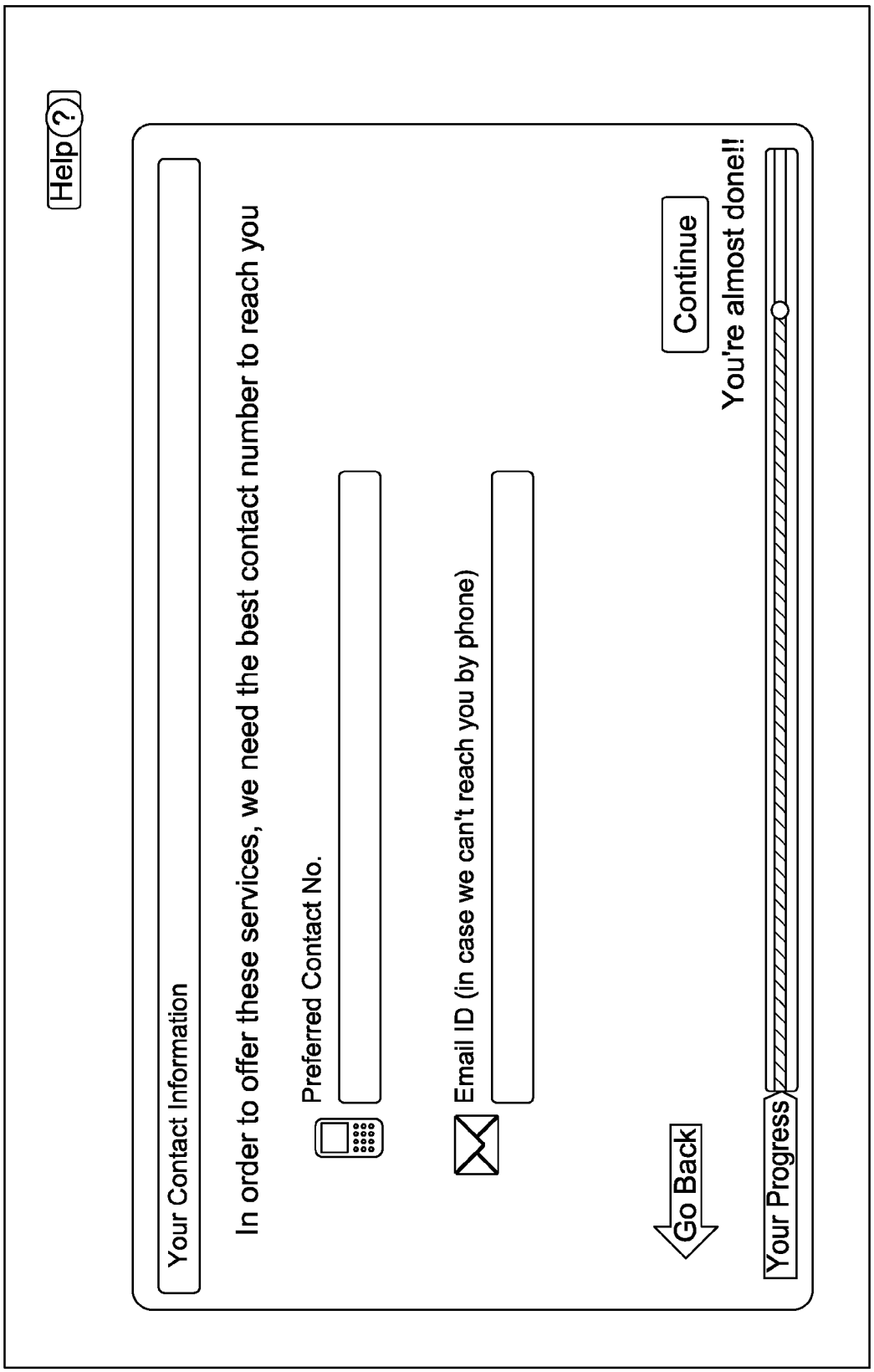

Help (?)
①OOP Solutions
②Injection Training
③ myDRUG Program
By registering wit the myDRUG program you can get the following services:
• Injection DVD: Step-by-step video to help you get comfortable with self-injecting Practice DRUG Pen: Allows you to practice self-injecting
• Travel pack: Makes traveling 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

FIG. 56


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)
Continue
You're almost done!!
Go Back
Your Progress

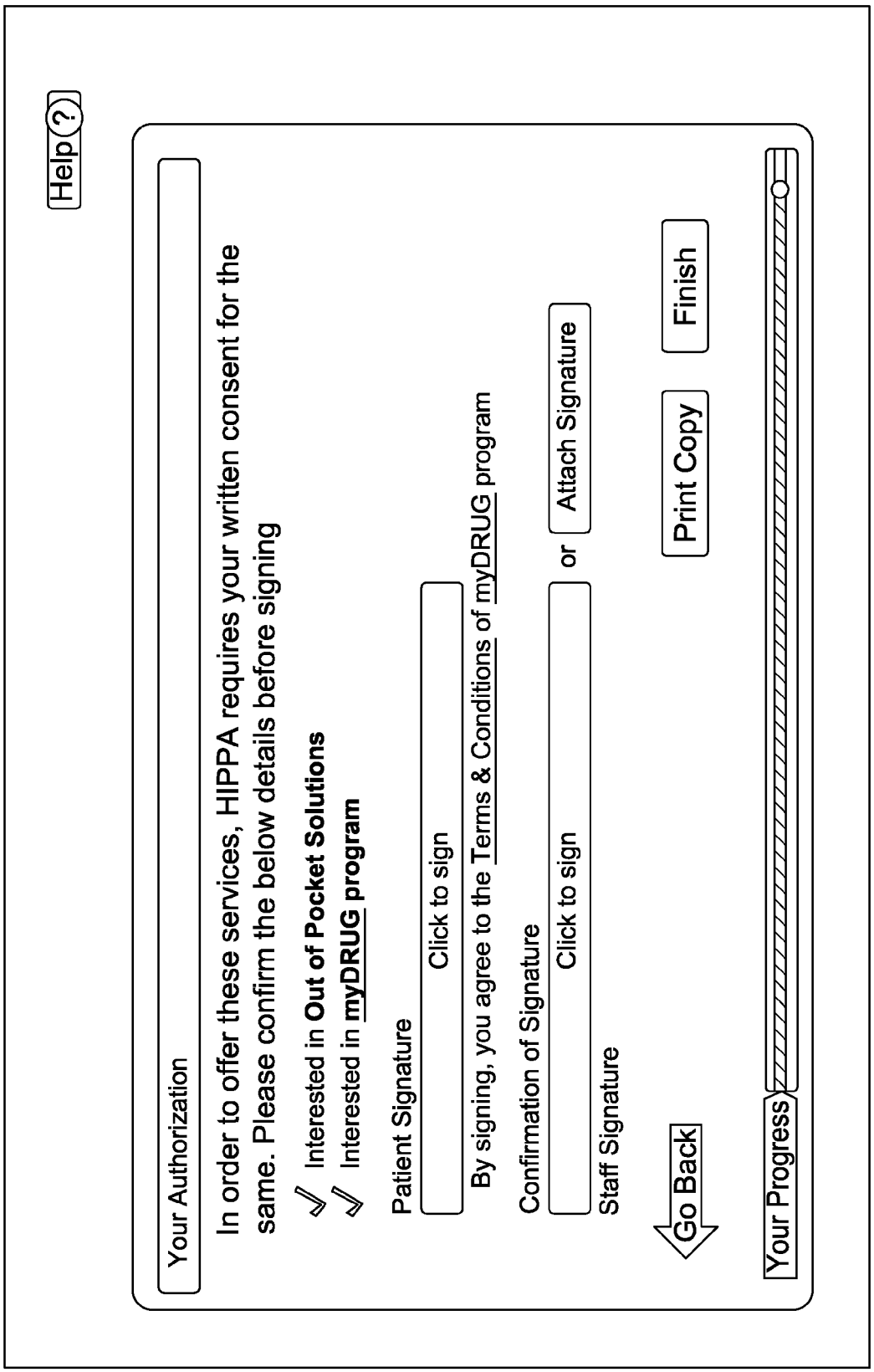

Help (?)
Your Authorization
In order to offer these services, HIPPA requires your written consent for the same. Please confirm the below details before signing
Interested in Out of Pocket Solutions
Interested in myDRUG program
Patient Signature
Click to sign
By signing, you agree to the Terms & Conditions of myDRUG program
Confirmation of Signature
Click to sign
or
Attach Signature
Staff Signature
Go Back
Print Copy
Finish
Your Progress

FIG. 57

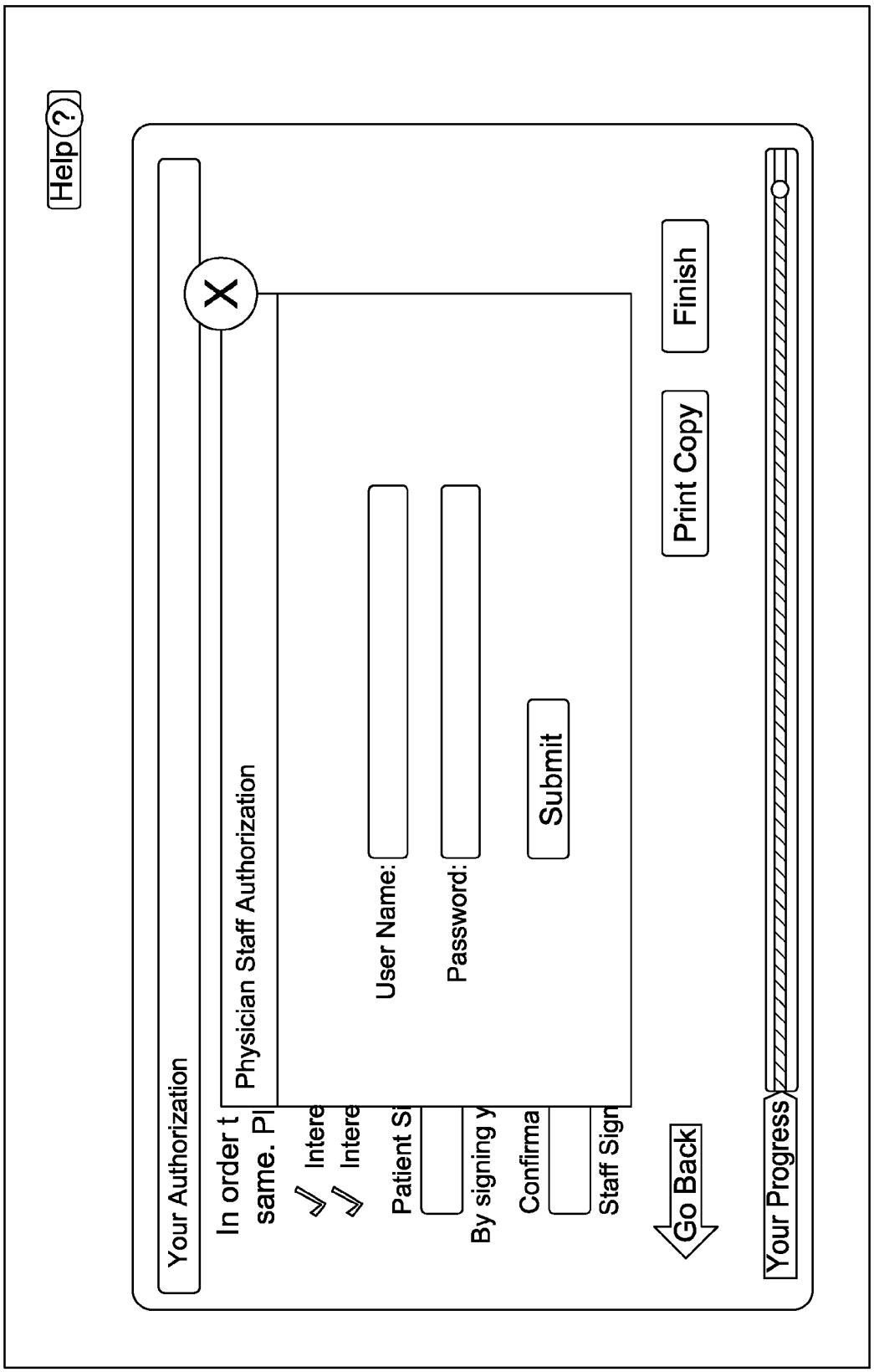

Help (?)
Your Authorization
In order t
same. Pl
Physician Staff Authorization
Intere
Intere
Patient Si
By signing y
Confirma
Staff Sign
User Name:
Password:
Submit
Print Copy
Finish
Go Back
Your Progress

FIG. 58

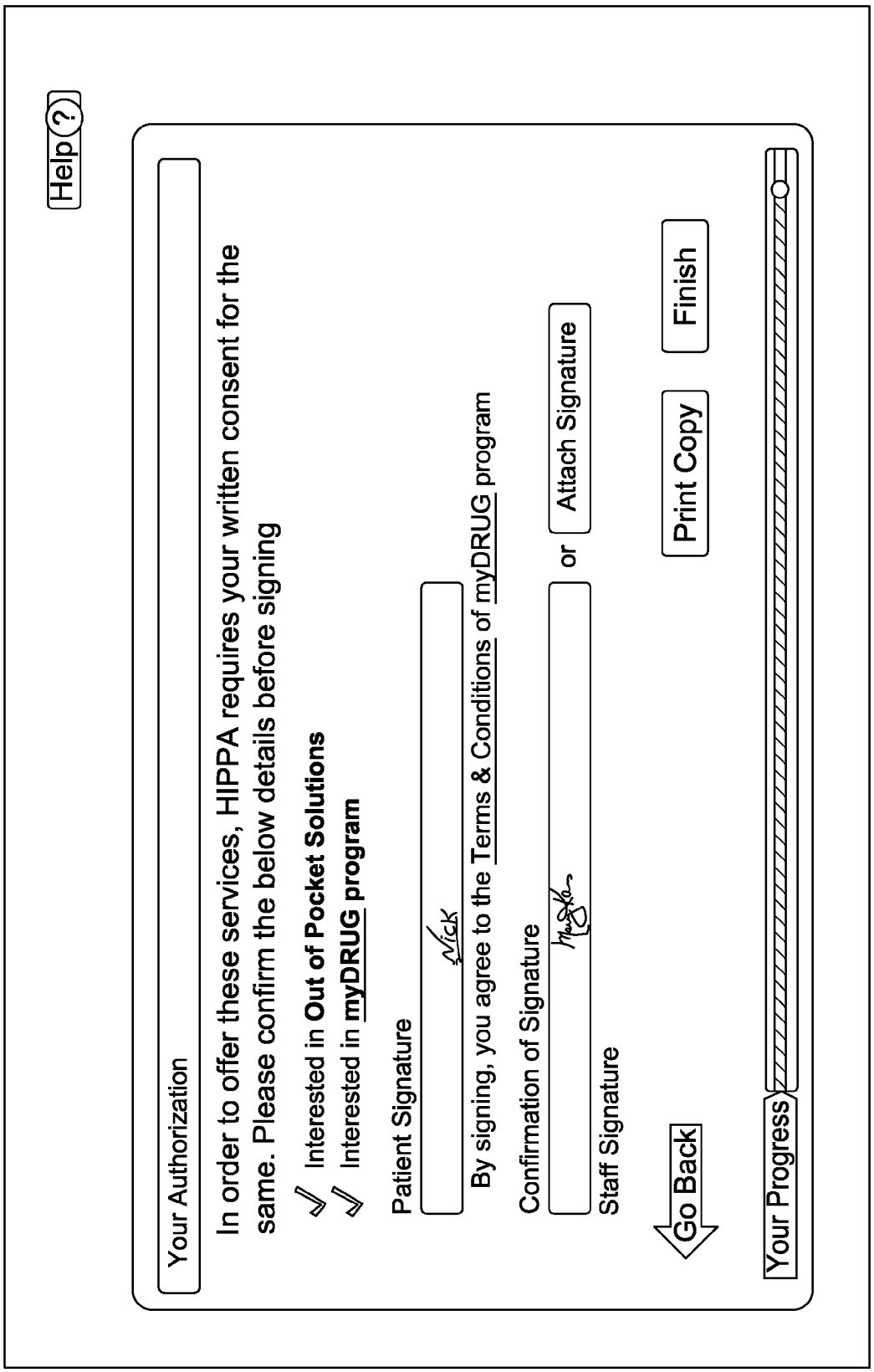
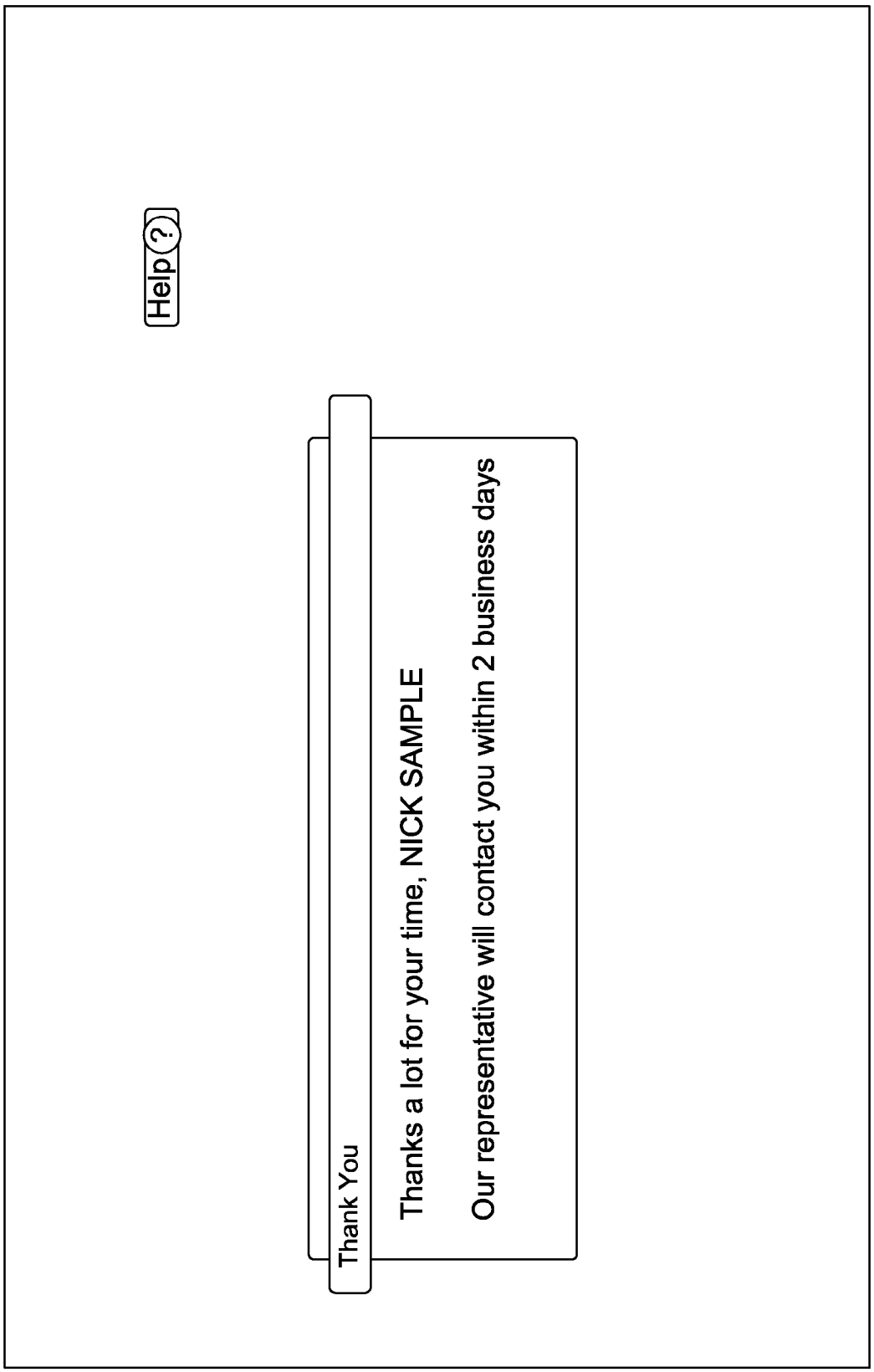

Help (?)
Your Authorization
In order to offer these services, HIPPA requires your written consent for the same. Please confirm the below details before signing
Interested in Out of Pocket Solutions
Interested in myDRUG program
Patient Signature
Nick
By signing, you agree to the Terms & Conditions of myDRUG program
Confirmation of Signature
or
Attach Signature
Staff Signature
Go Back
Print Copy
Finish
Your Progress

FIG. 59

FIG. 60


Help (?)
Thank You
Thanks a lot for your time, NICK SAMPLE
Our representative will contact you within 2 business days

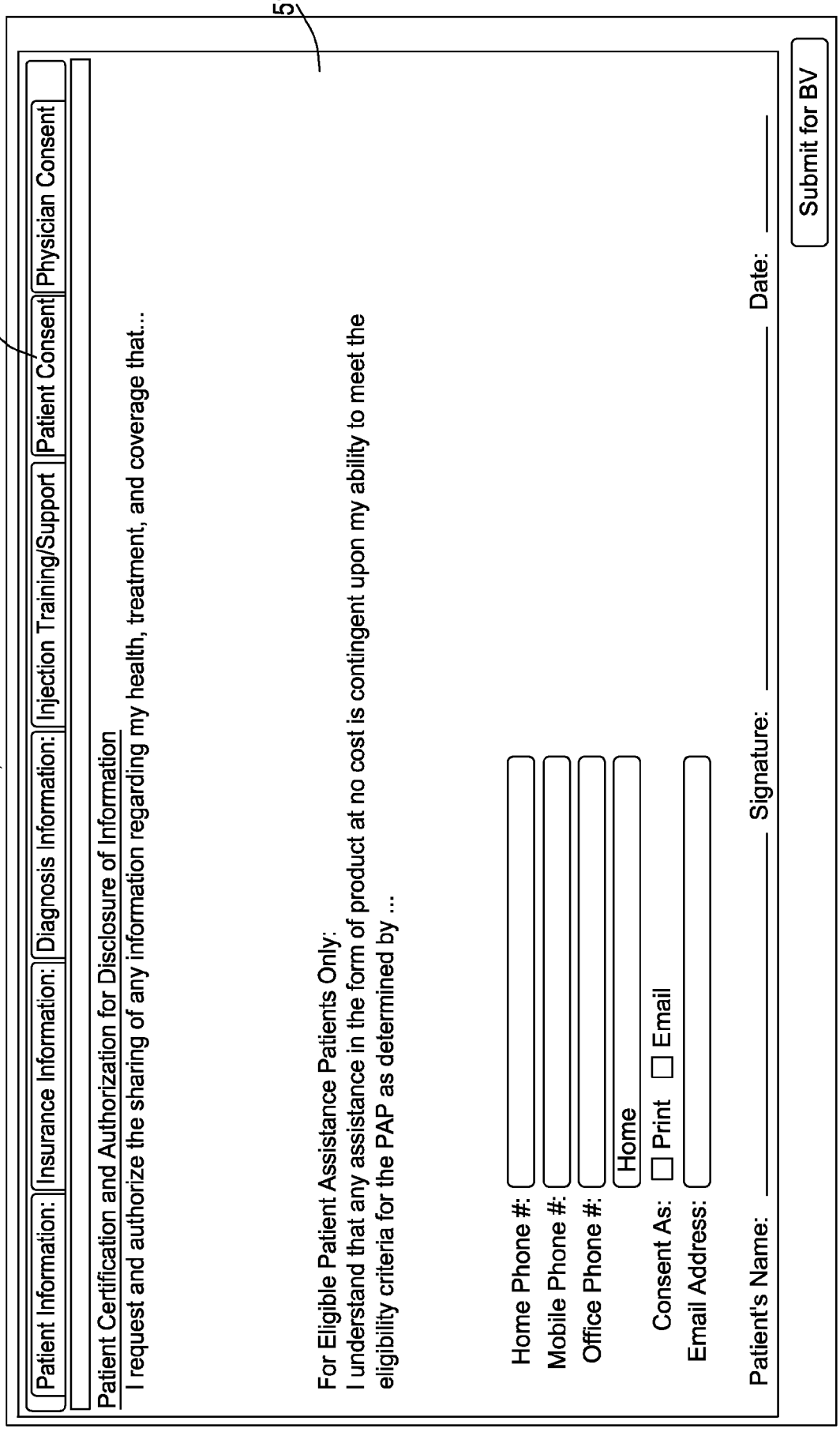

5100
5112
5120
78/110
Patient Information:
Insurance Information:
Diagnosis Information:
Injection Training/Support
Patient Consent
Physician Consent
Patient Certification and Authorization for Disclosure of Information
I request and authorize the sharing of any information regarding my health, treatment, 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

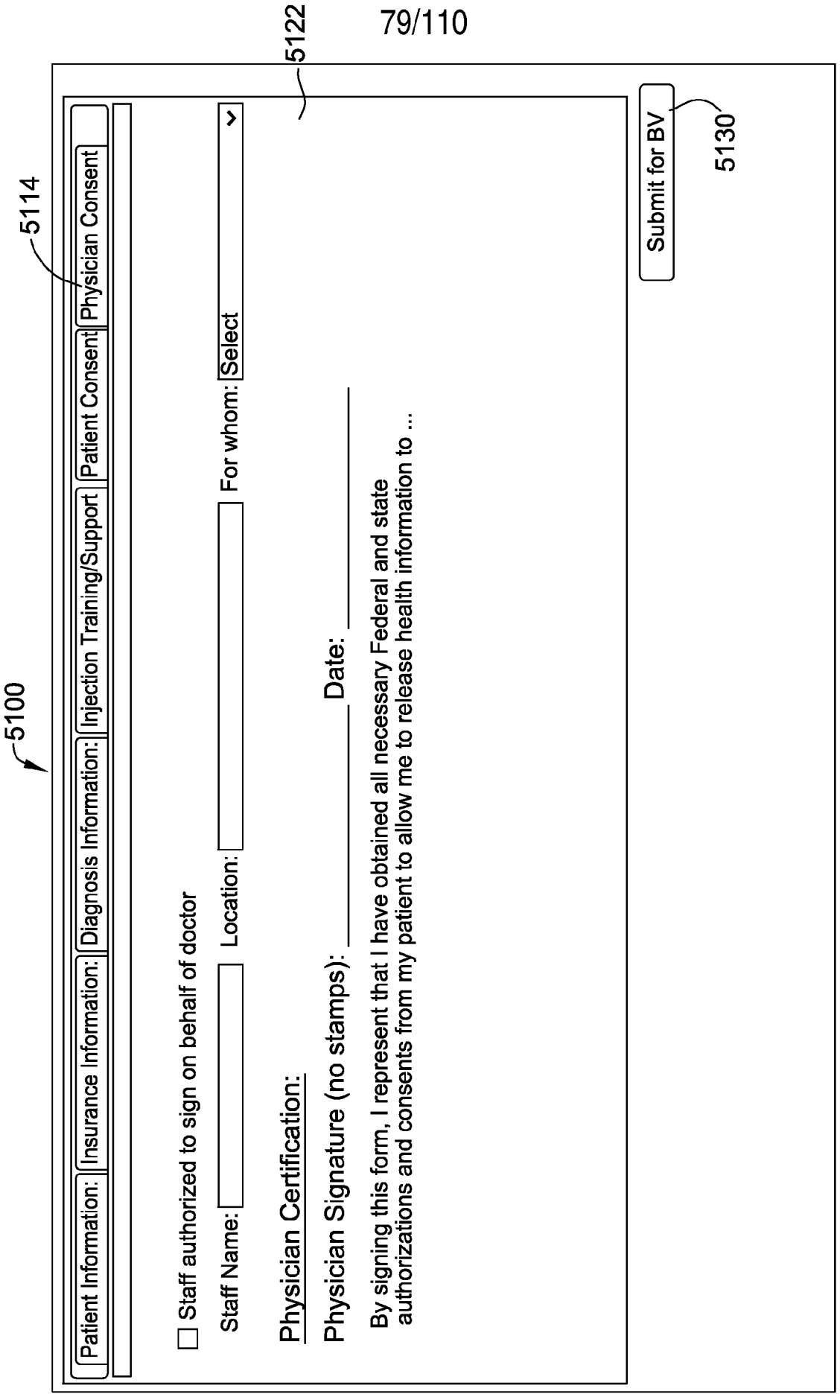

5100
5114
Patient Information:
Insurance Information:
Diagnosis Information:
Injection Training/Support
Patient Consent
Physician Consent
5122
Staff authorized to sign on behalf of doctor
Staff Name:
Location:
For whom:
Select
Physician Certification:
Physician Signature (no stamps):
Date:
By signing 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

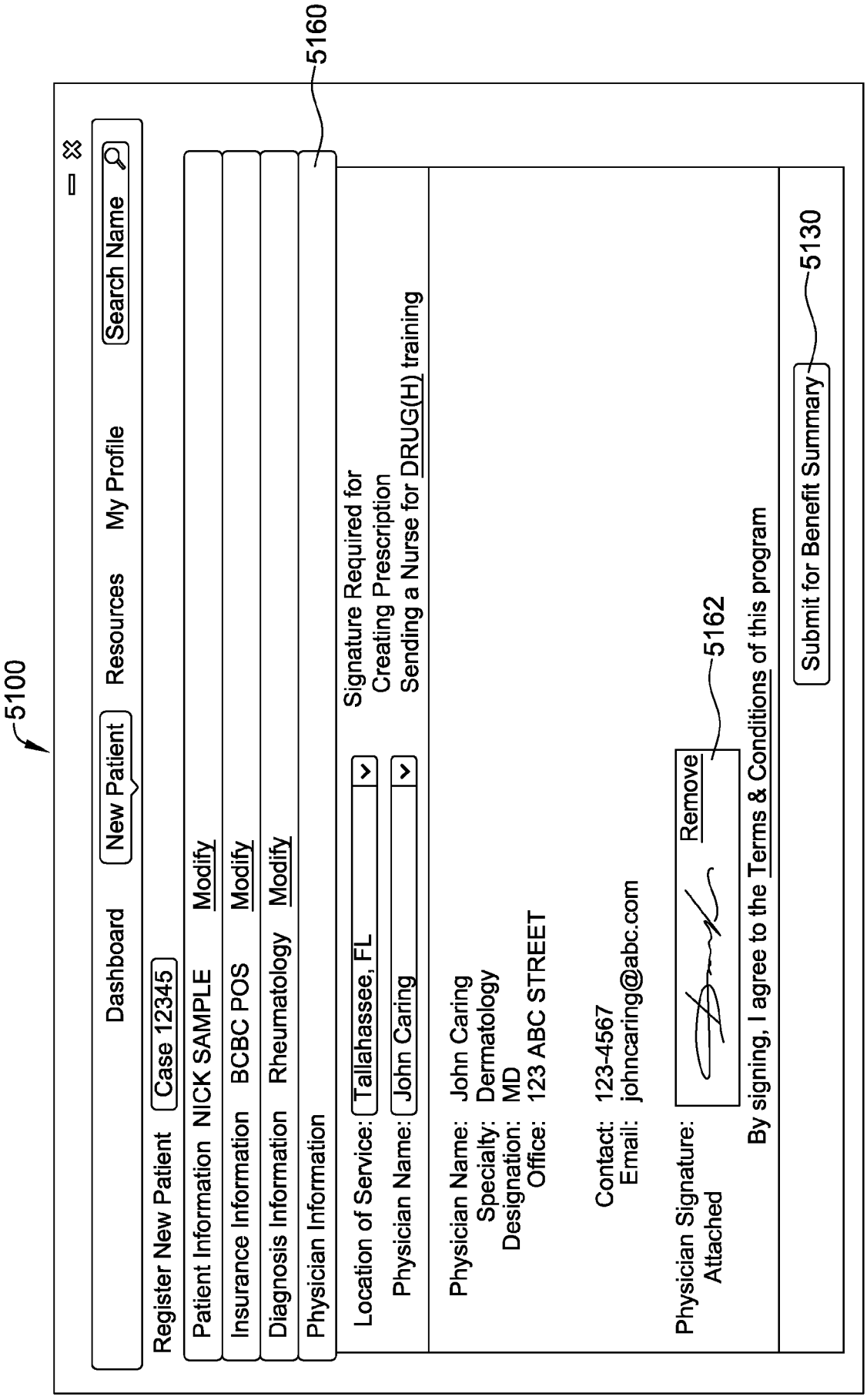

5100
Dashboard
New Patient
Resources
My Profile
Search Name
Register New Patient
Case 12345
Patient Information NICK SAMPLE Modify
Insurance Information BCBC POS Modify
Diagnosis Information Rheumatology Modify
Physician Information
5160
Location of Service: Tallahassee, FL
Physician Name: John Caring
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
5162
By signing, I agree to the Terms & Conditions of this program
Submit for Benefit Summary
5130

FIG. 63

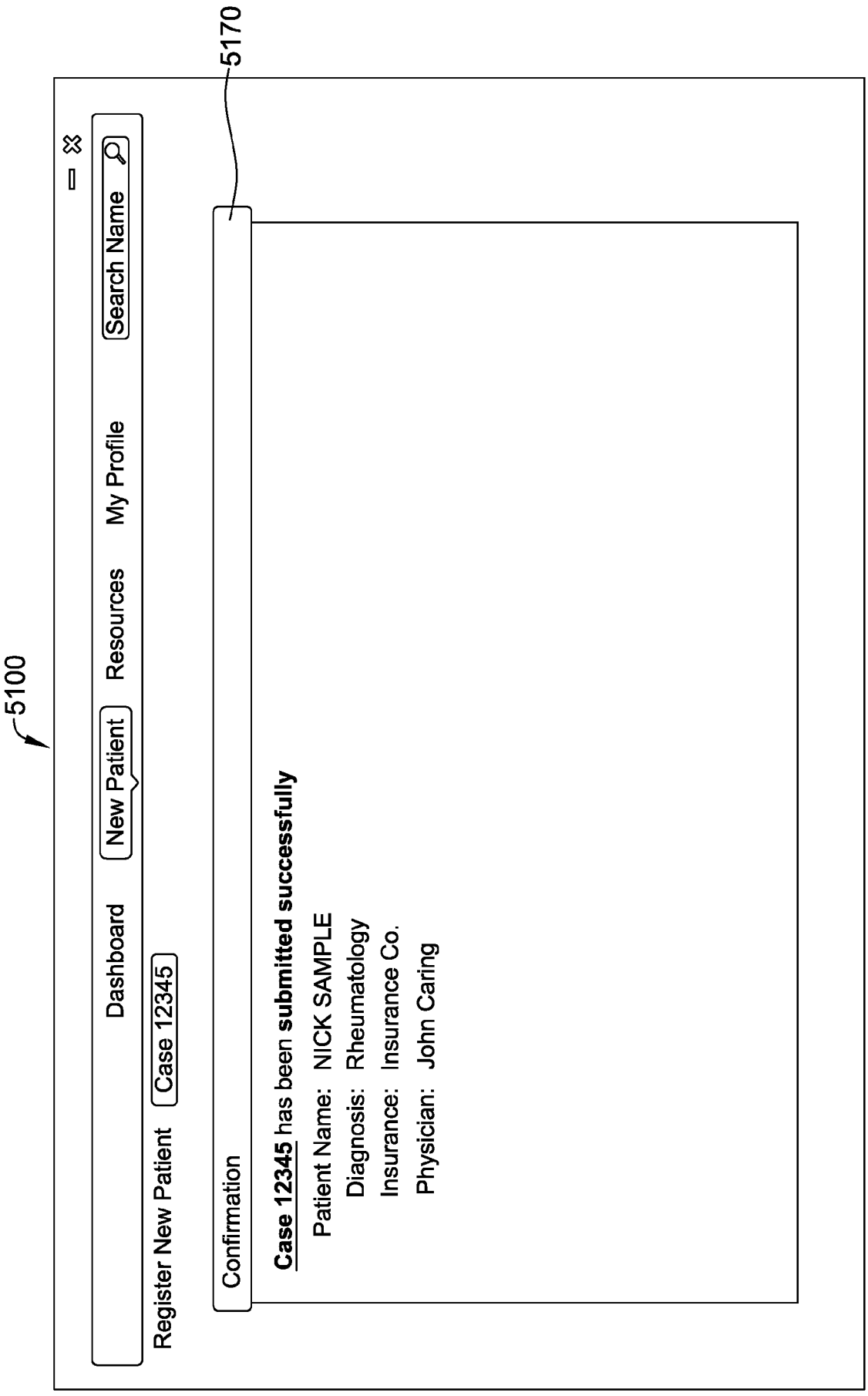

5100
5170
Dashboard
New Patient
Resources
My Profile
Search Name
Register New Patient
Case 12345
Confirmation
Case 12345 has been submitted successfully
Patient Name: NICK SAMPLE
Diagnosis: Rheumatology
Insurance: Insurance Co.
Physician: John Caring

FIG. 64

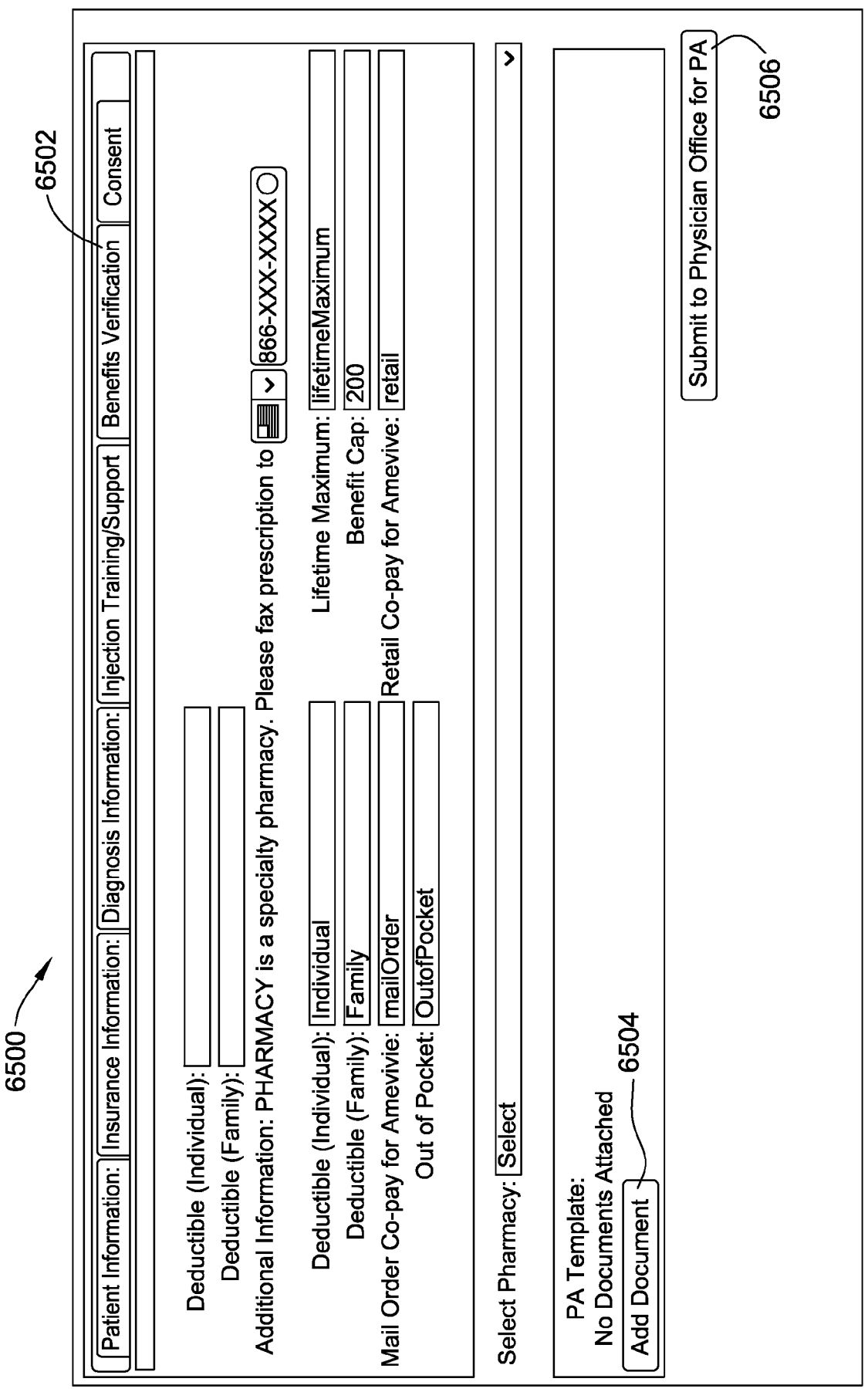

6500
6502
Patient Information:
Insurance Information:
Diagnosis Information:
Injection Training/Support
Benefits Verification
Consent
Deductible (Individual):
Deductible (Family):
Additional Information: PHARMACY is a specialty pharmacy. Please fax prescription to
866-XXX-XXXX
Deductible (Individual): Individual
Deductible (Family): Family
Mail Order Co-pay for Amevivie: mailOrder
Out of Pocket: OutofPocket
Lifetime Maximum: lifetimeMaximum
Benefit Cap: 200
Retail Co-pay for Amevive: retail
Select Pharmacy: Select
PA Template:
No Documents Attached
Add Document
6504
Submit to Physician Office for PA
6506

FIG. 65

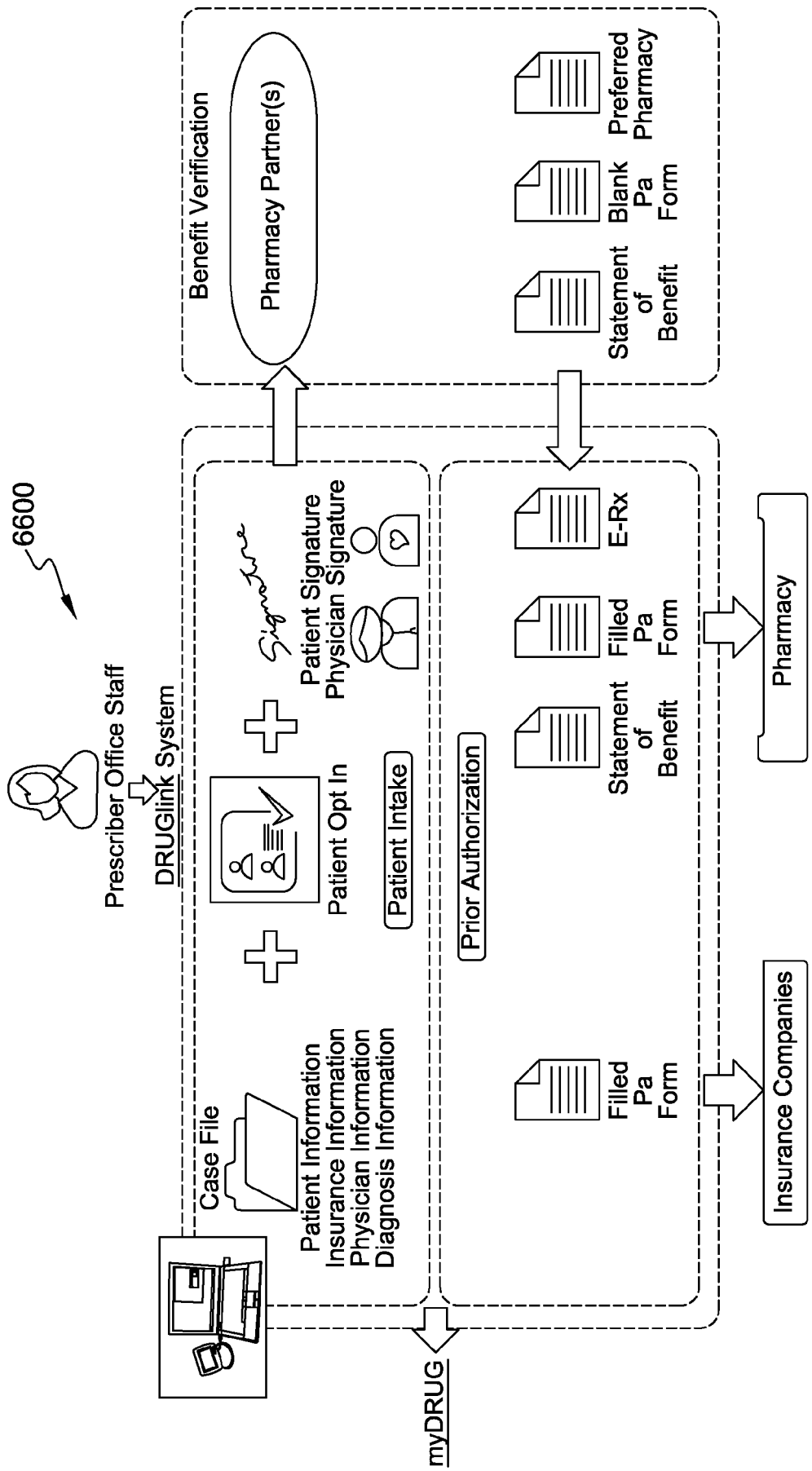

6600
Prescriber Office Staff
DRUGlink System
Benefit Verification
Pharmacy Partner(s)
Preferred Pharmacy
Blank Pa Form
Statement of Benefit
Patient Signature
Physician Signature
Patient Opt In
Patient Intake
Case File
Patient Information
Insurance Information
Physician Information
Diagnosis Information
Prior Authorization
E-Rx
Filled Pa Form
Statement of Benefit
Pharmacy
Filled Pa Form
Insurance Companies
myDRUG

FIG. 66

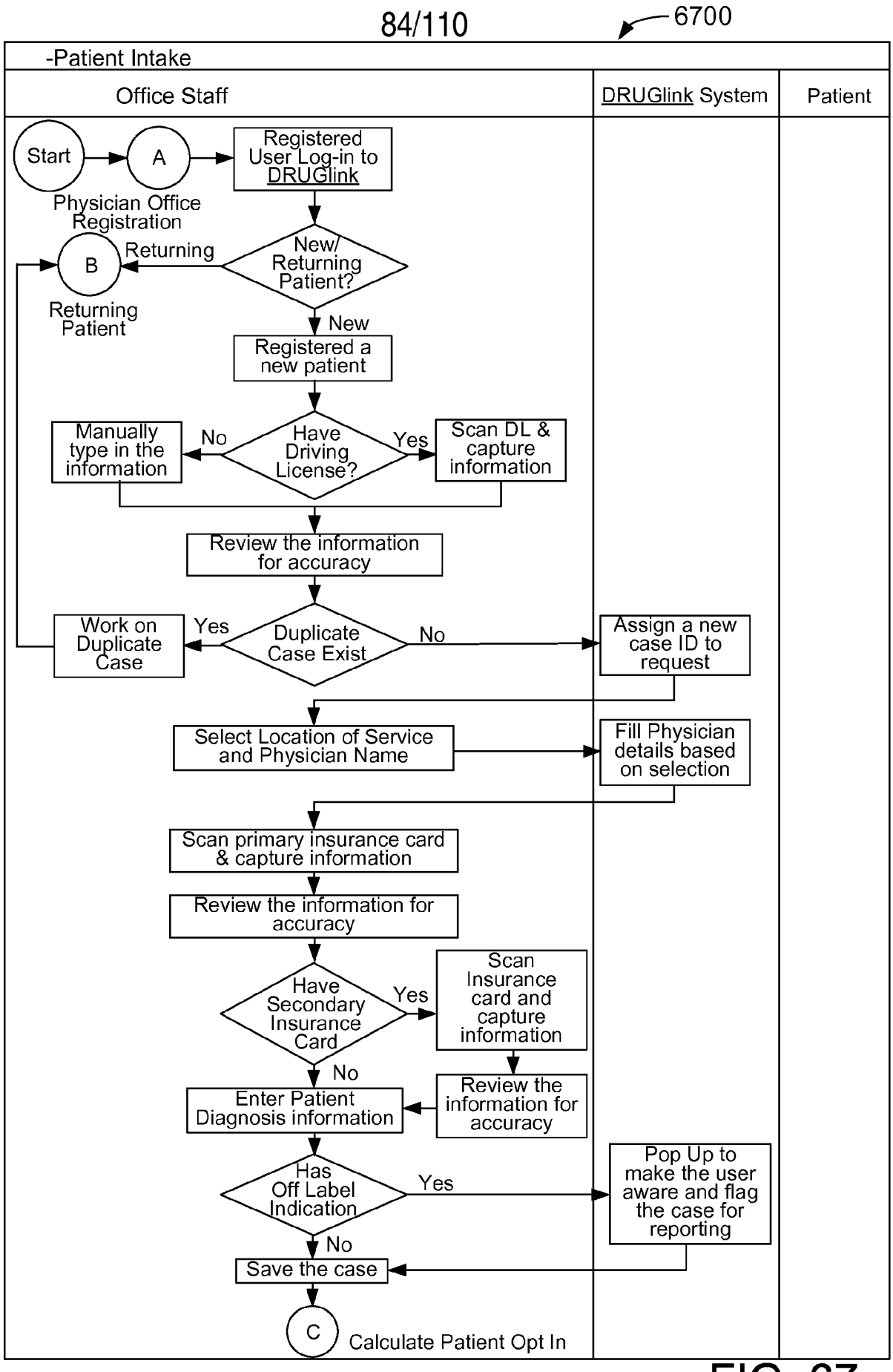

6700
-Patient Intake
Office Staff
DRUGlink System
Patient
Start
A
Registered User Log-in to DRUGlink
Physician Office Registration
B
Returning
New/ Returning Patient?
Returning Patient
New
Registered a new patient
Manually type in the information
No
Have Driving License?
Yes
Scan DL & capture information
Review the information for accuracy
Work on Duplicate Case
Yes
Duplicate Case Exist
No
Assign a new case ID to request
Select Location of Service and Physician Name
Fill Physician details based on selection
Scan primary insurance card & capture information
Review the information for accuracy
Have Secondary Insurance Card
Yes
Scan Insurance card and capture information
No
Enter Patient Diagnosis information
Review the information for accuracy
Has Off Label Indication
Yes
Pop Up to make the user aware and flag the case for reporting
No
Save the case
C
Calculate Patient Opt In

FIG. 67

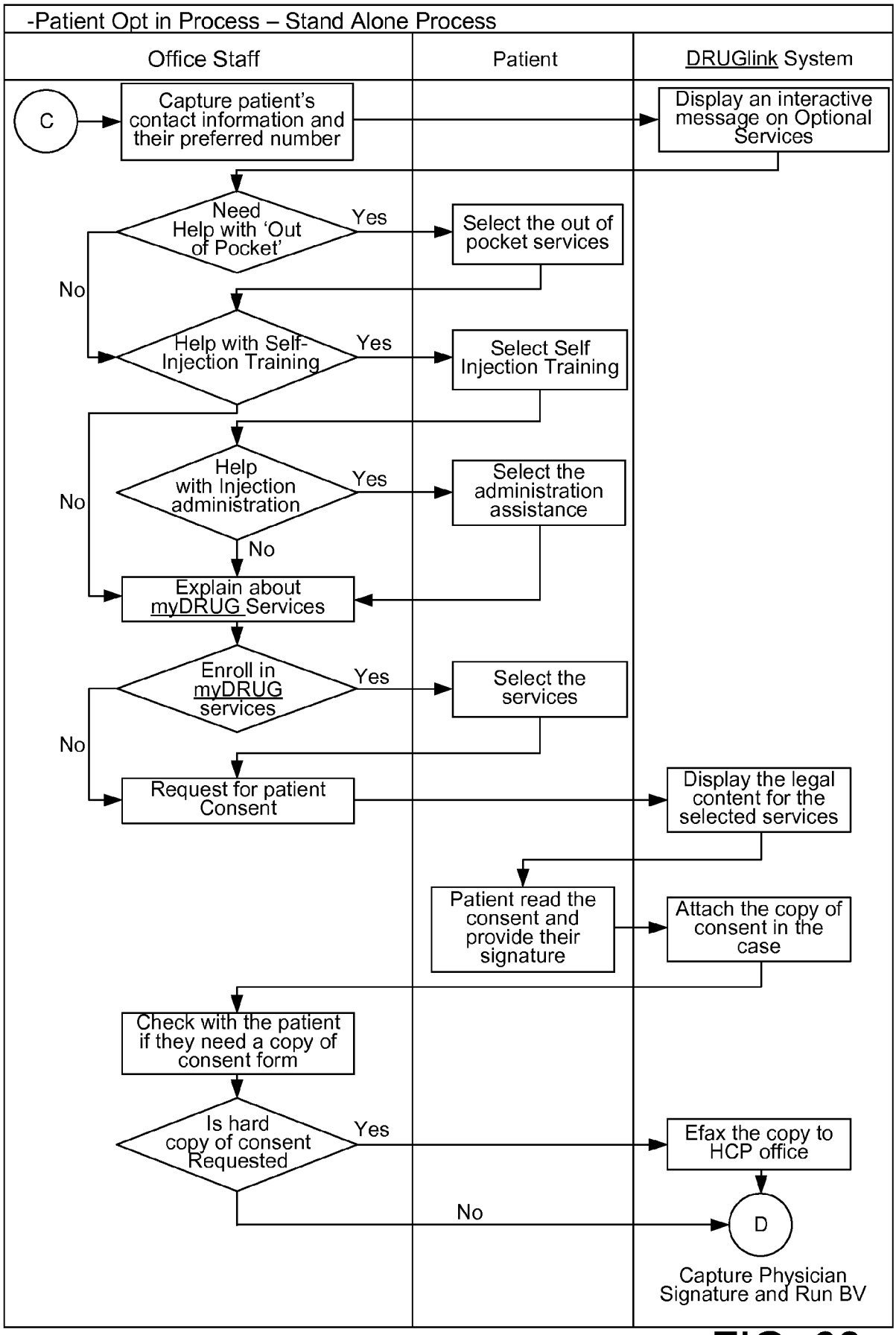

-Patient Opt in Process – Stand Alone Process
Office Staff
Patient
DRUGlink System
C
Capture patient's contact information and their preferred number
Display an interactive message on Optional Services
Need Help with 'Out of Pocket'
Yes
Select the out of pocket services
No
Help with Self-Injection Training
Yes
Select Self Injection Training
Help with Injection administration
Yes
Select the administration assistance
No
No
Explain about myDRUG Services
Enroll in myDRUG services
Yes
Select the services
No
Request for patient Consent
Display the legal content for the selected services
Patient read the consent and provide their signature
Attach the copy of consent in the case
Check with the patient if they need a copy of consent form
Is hard copy of consent Requested
Yes
Efax the copy to HCP office
No
D
Capture Physician Signature and Run BV

FIG. 68

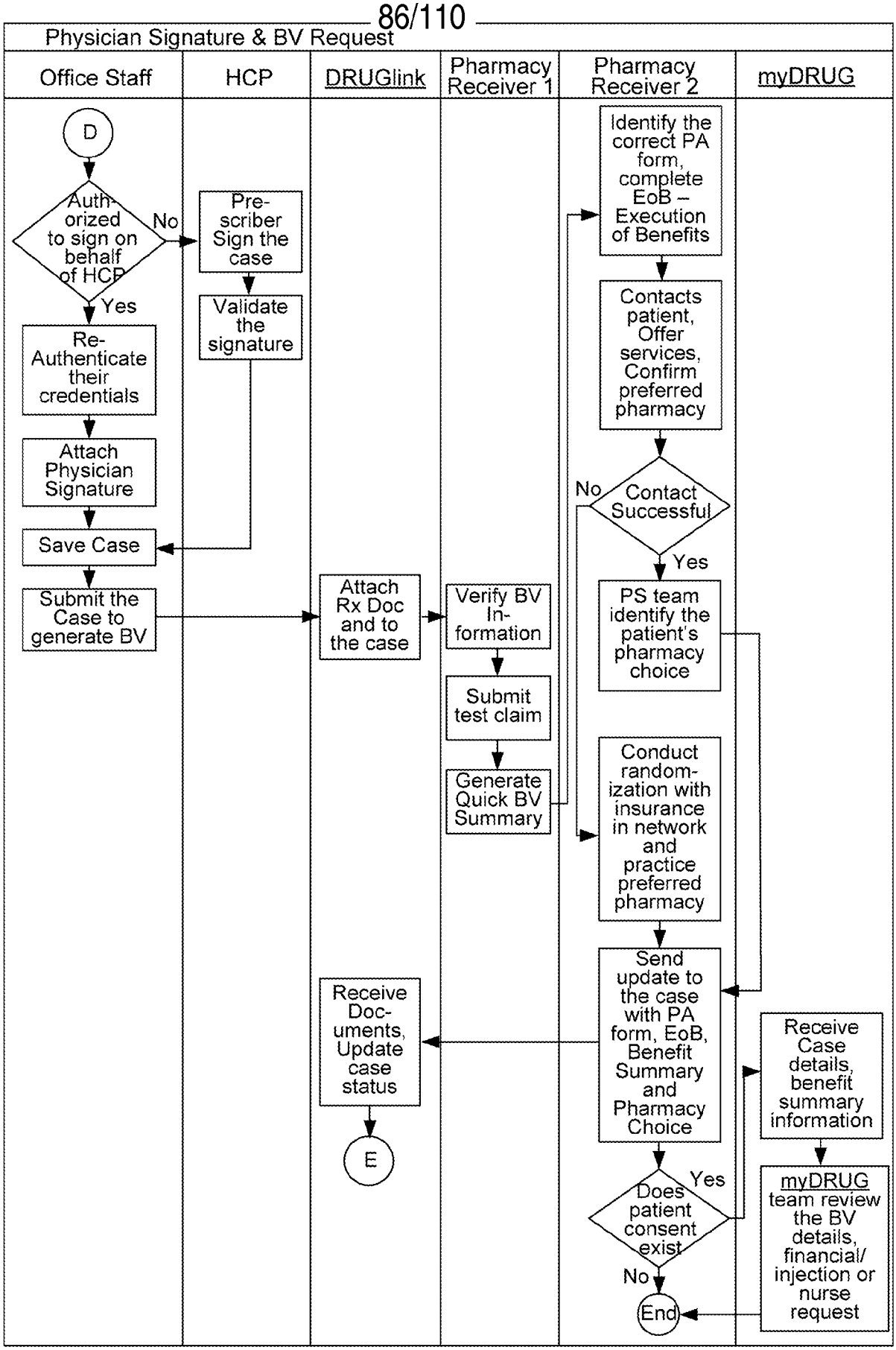

Physician Signature & BV Request
Office Staff
HCP
DRUGlink
Pharmacy Receiver 1
Pharmacy Receiver 2
myDRUG
D
Auth-orized to sign on behalf of HCP
No
Yes
Pre-scriber Sign the case
Validate the signature
Re-Authenticate their credentials
Attach Physician Signature
Save Case
Submit the Case to generate BV
Attach Rx Doc and to the case
Verify BV In-formation
Submit test claim
Generate Quick BV Summary
Identify the correct PA form, complete EoB – Execution of Benefits
Contacts patient, Offer services, Confirm preferred pharmacy
No
Contact Successful
Yes
PS team identify the patient's pharmacy choice
Conduct random-ization with insurance in network and practice preferred pharmacy
Send update to the case with PA form, EoB, Benefit Summary and Pharmacy Choice
Receive Doc-uments, Update case status
E
Yes
Does patient consent exist
No
End
Receive Case details, benefit summary information
myDRUG team review the BV details, financial/ injection or nurse request

FIG. 69

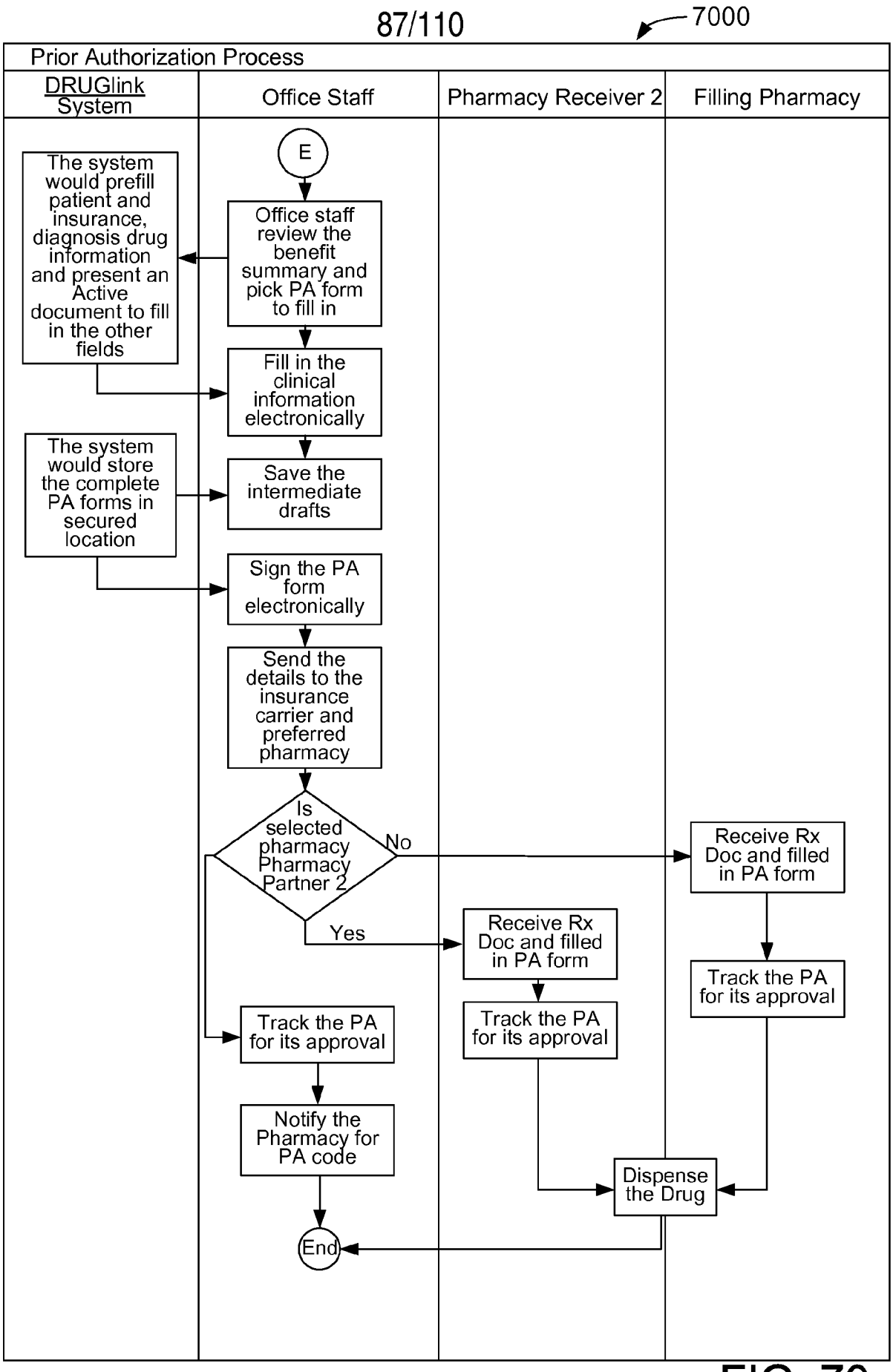

7000
Prior Authorization Process
DRUGlink System
Office Staff
Pharmacy Receiver 2
Filling Pharmacy
E
The system would prefill patient and insurance, diagnosis drug information and present an Active document to fill in the other fields
Office staff review the benefit summary and pick PA form to fill in
Fill in the clinical information electronically
The system would store the complete PA forms in secured location
Save the intermediate drafts
Sign the PA form electronically
Send the details to the insurance carrier and preferred pharmacy
Is selected pharmacy Pharmacy Partner 2
No
Yes
Receive Rx Doc and filled in PA form
Track the PA for its approval
Receive Rx Doc and filled in PA form
Track the PA for its approval
Track the PA for its approval
Notify the Pharmacy for PA code
Dispense the Drug
End

FIG. 70

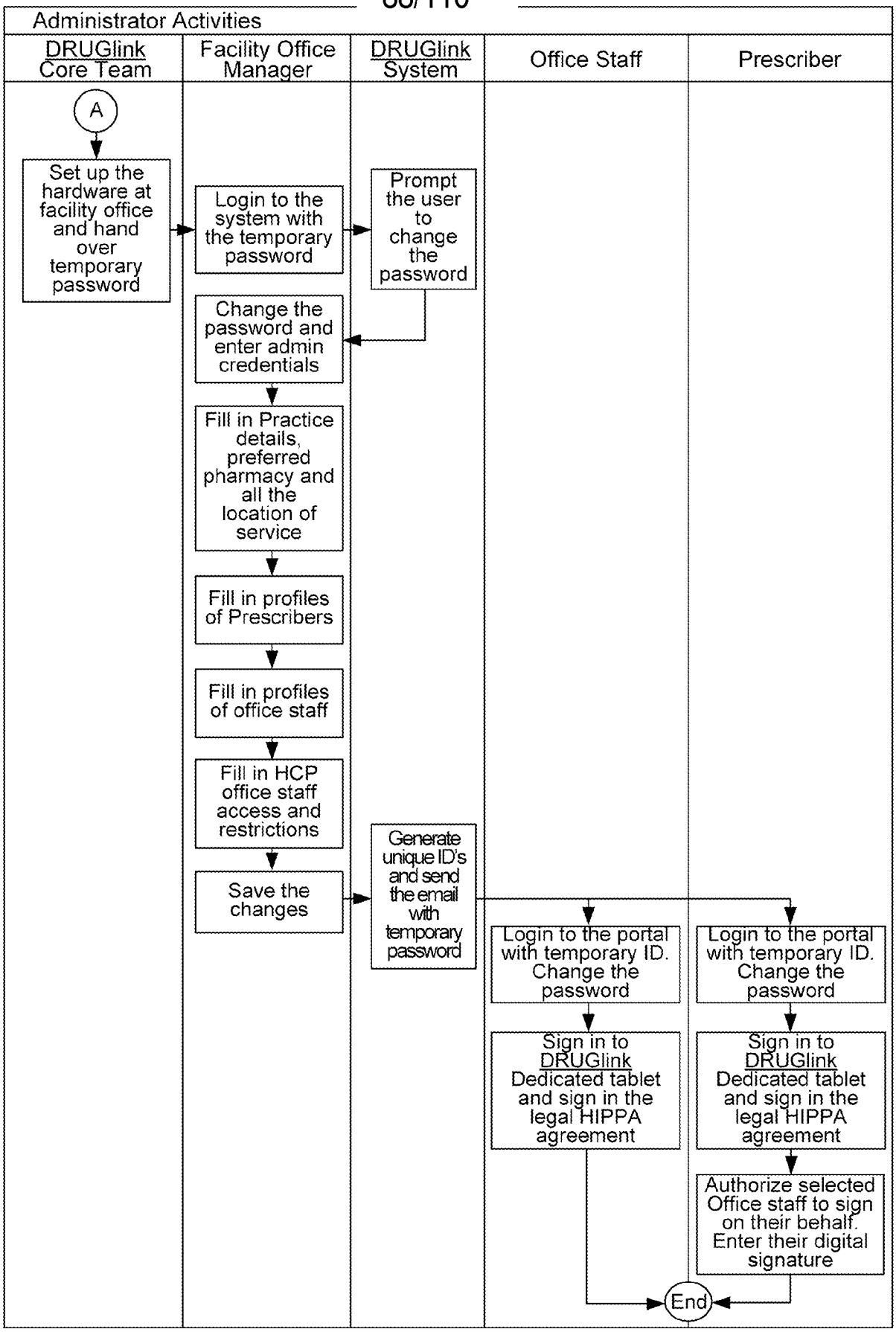

Administrator Activities
DRUGlink Core Team
Facility Office Manager
DRUGlink System
Office Staff
Prescriber
A
Set up the hardware at facility office and hand over temporary password
Login to the system with the temporary password
Prompt the user to change the password
Change the password and enter admin credentials
Fill in Practice details, preferred pharmacy and all the location of service
Fill in profiles of Prescribers
Fill in profiles of office staff
Fill in HCP office staff access and restrictions
Save the changes
Generate unique ID's and send the email with temporary password
Login to the portal with temporary ID. Change the password
Login to the portal with temporary ID. Change the password
Sign in to DRUGlink Dedicated tablet and sign in the legal HIPPA agreement
Sign in to DRUGlink Dedicated tablet and sign in the legal HIPPA agreement
Authorize selected Office staff to sign on their behalf. Enter their digital signature
End

FIG. 71

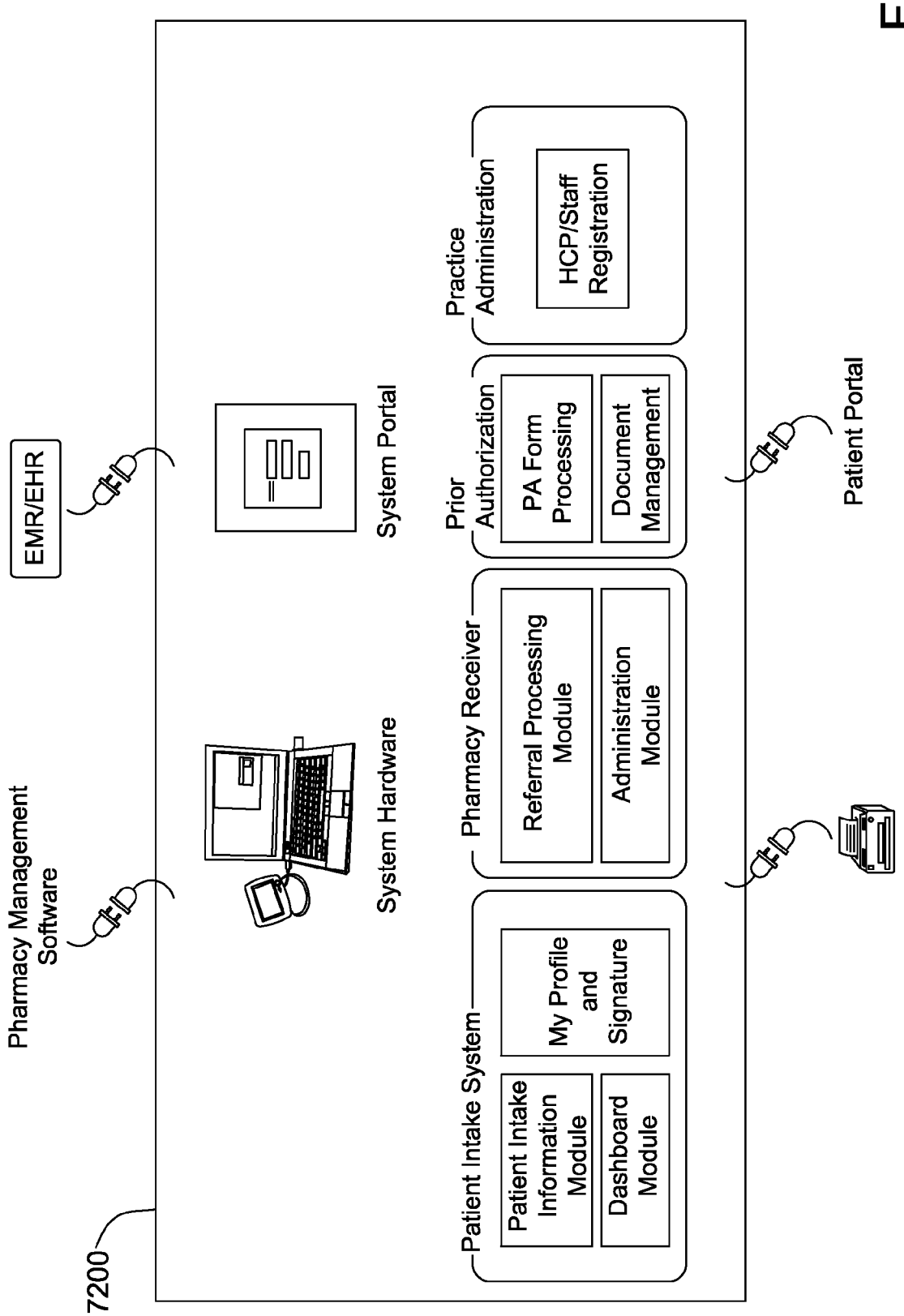

7200
Patient Intake System
Patient Intake Information Module
Dashboard Module
My Profile and Signature
Pharmacy Receiver
Referral Processing Module
Administration Module
Prior Authorization
PA Form Processing
Document Management
Practice Administration
HCP/Staff Registration
System Portal
System Hardware
Pharmacy Management Software
EMR/EHR
Patient Portal

FIG. 72

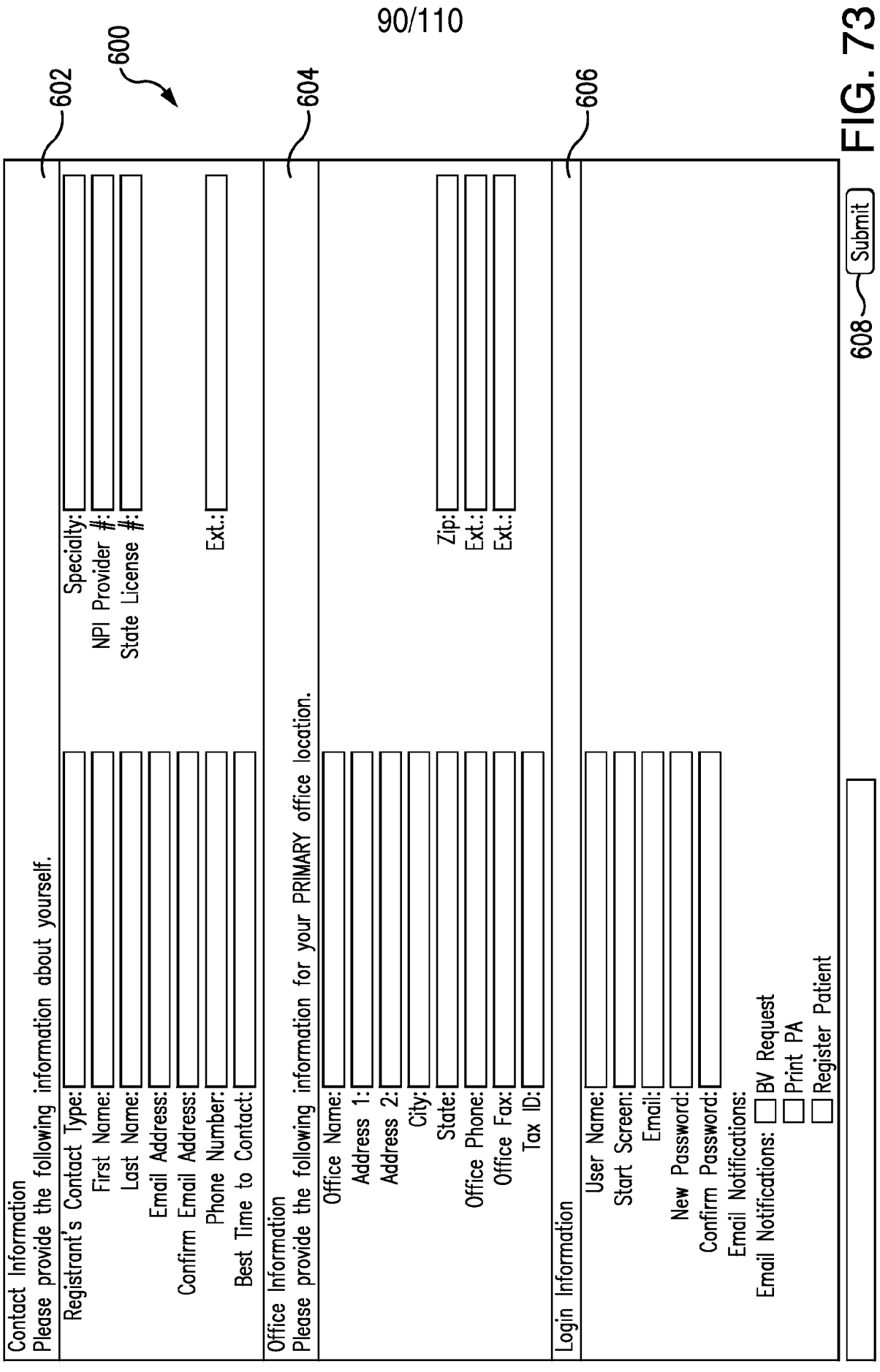

600
602
604
606
608
Contact Information
Please provide the following information about yourself.
Registrant's Contact Type:
First Name:
Last Name:
Email Address:
Confirm Email Address:
Phone Number:
Best Time to Contact:
Specialty:
NPI Provider #:
State License #:
Ext.:
Office Information
Please provide the following information for your PRIMARY office location.
Office Name:
Address 1:
Address 2:
City:
State:
Office Phone:
Office Fax:
Tax ID:
Zip:
Ext.:
Ext.:
Login Information
User Name:
Start Screen:
Email:
New Password:
Confirm Password:
Email Notifications:
Email Notifications:
BV Request
Print PA
Register Patient
Submit

FIG. 73

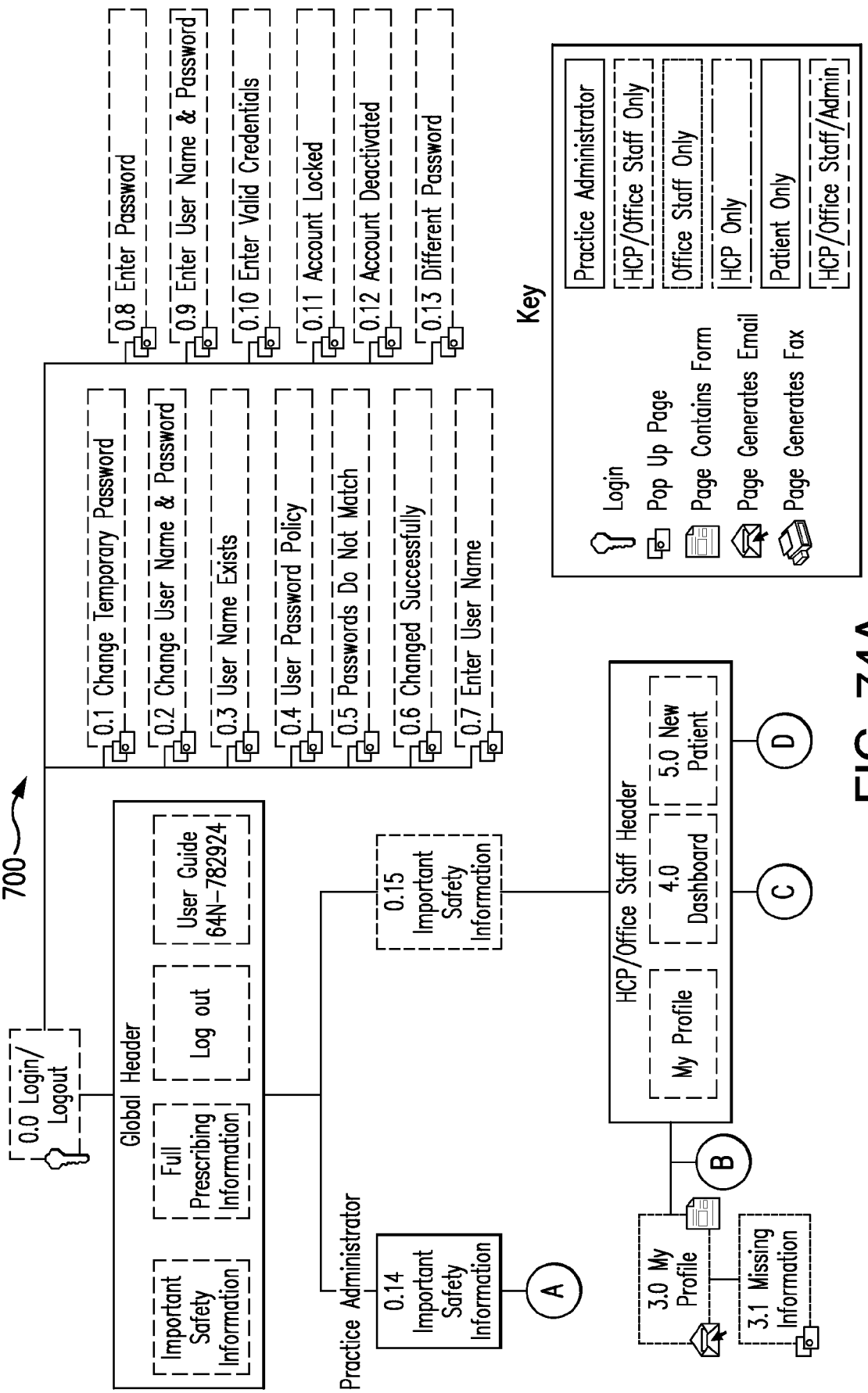

700
0.0 Login/ Logout
Global Header
Important Safety Information
Full Prescribing Information
Log out
User Guide 64N-782924
0.1 Change Temporary Password
0.2 Change User Name & Password
0.3 User Name Exists
0.4 User Password Policy
0.5 Passwords Do Not Match
0.6 Changed Successfully
0.7 Enter User Name
0.8 Enter Password
0.9 Enter User Name & Password
0.10 Enter Valid Credentials
0.11 Account Locked
0.12 Account Deactivated
0.13 Different Password
0.15 Important Safety Information
Practice Administrator
0.14 Important Safety Information
A
HCP/Office Staff Header
My Profile
4.0 Dashboard
5.0 New Patient
B
C
D
3.0 My Profile
3.1 Missing Information
Key
Practice Administrator
HCP/Office Staff Only
Office Staff Only
HCP Only
Patient Only
HCP/Office Staff/Admin
Login
Pop Up Page
Page Contains Form
Page Generates Email
Page Generates Fax

FIG. 74A

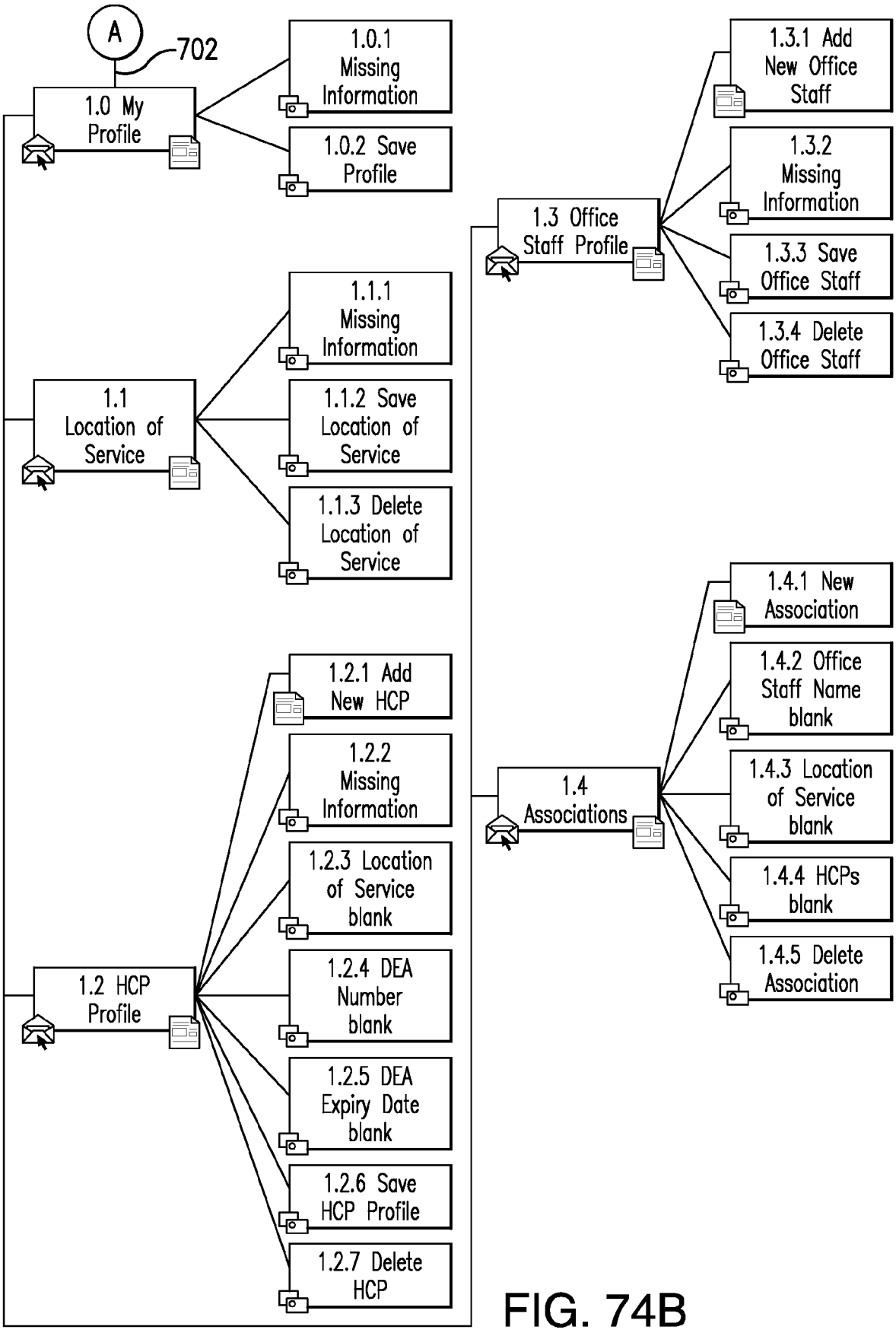

A
702
1.0 My Profile
1.0.1 Missing Information
1.0.2 Save Profile
1.1 Location of Service
1.1.1 Missing Information
1.1.2 Save Location of Service
1.1.3 Delete Location of Service
1.2 HCP Profile
1.2.1 Add New HCP
1.2.2 Missing Information
1.2.3 Location of Service blank
1.2.4 DEA Number blank
1.2.5 DEA Expiry Date blank
1.2.6 Save HCP Profile
1.2.7 Delete HCP
1.3 Office Staff Profile
1.3.1 Add New Office Staff
1.3.2 Missing Information
1.3.3 Save Office Staff
1.3.4 Delete Office Staff
1.4 Associations
1.4.1 New Association
1.4.2 Office Staff Name blank
1.4.3 Location of Service blank
1.4.4 HCPs blank
1.4.5 Delete Association

FIG. 74B

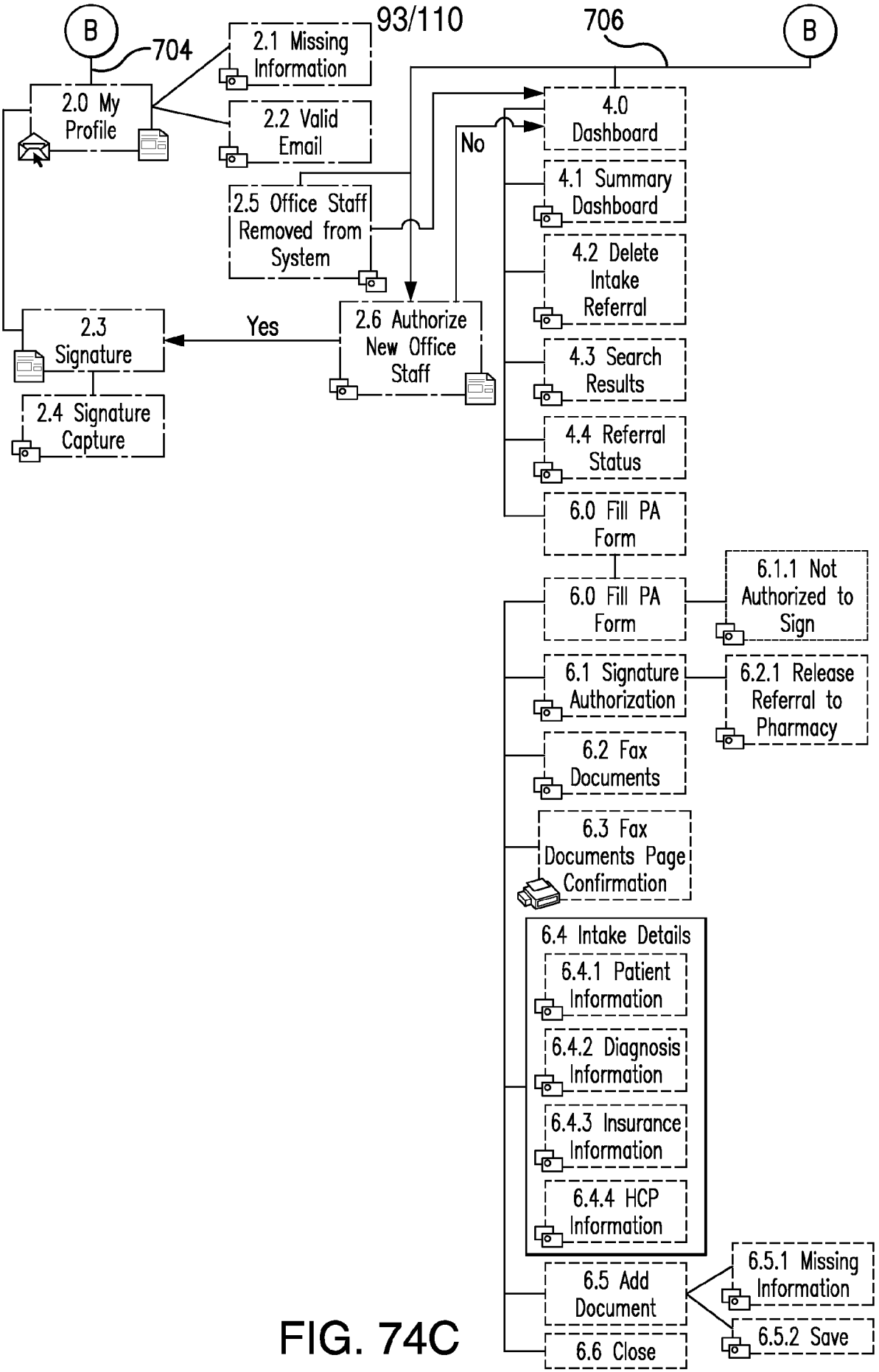

B
704
2.0 My Profile
2.1 Missing Information
2.2 Valid Email
93/110
2.5 Office Staff Removed from System
2.6 Authorize New Office Staff
Yes
No
2.3 Signature
2.4 Signature Capture
706
B
4.0 Dashboard
4.1 Summary Dashboard
4.2 Delete Intake Referral
4.3 Search Results
4.4 Referral Status
6.0 Fill PA Form
6.0 Fill PA Form
6.1.1 Not Authorized to Sign
6.1 Signature Authorization
6.2.1 Release Referral to Pharmacy
6.2 Fax Documents
6.3 Fax Documents Page Confirmation
6.4 Intake Details
6.4.1 Patient Information
6.4.2 Diagnosis Information
6.4.3 Insurance Information
6.4.4 HCP Information
6.5 Add Document
6.5.1 Missing Information
6.5.2 Save
6.6 Close

FIG. 74C

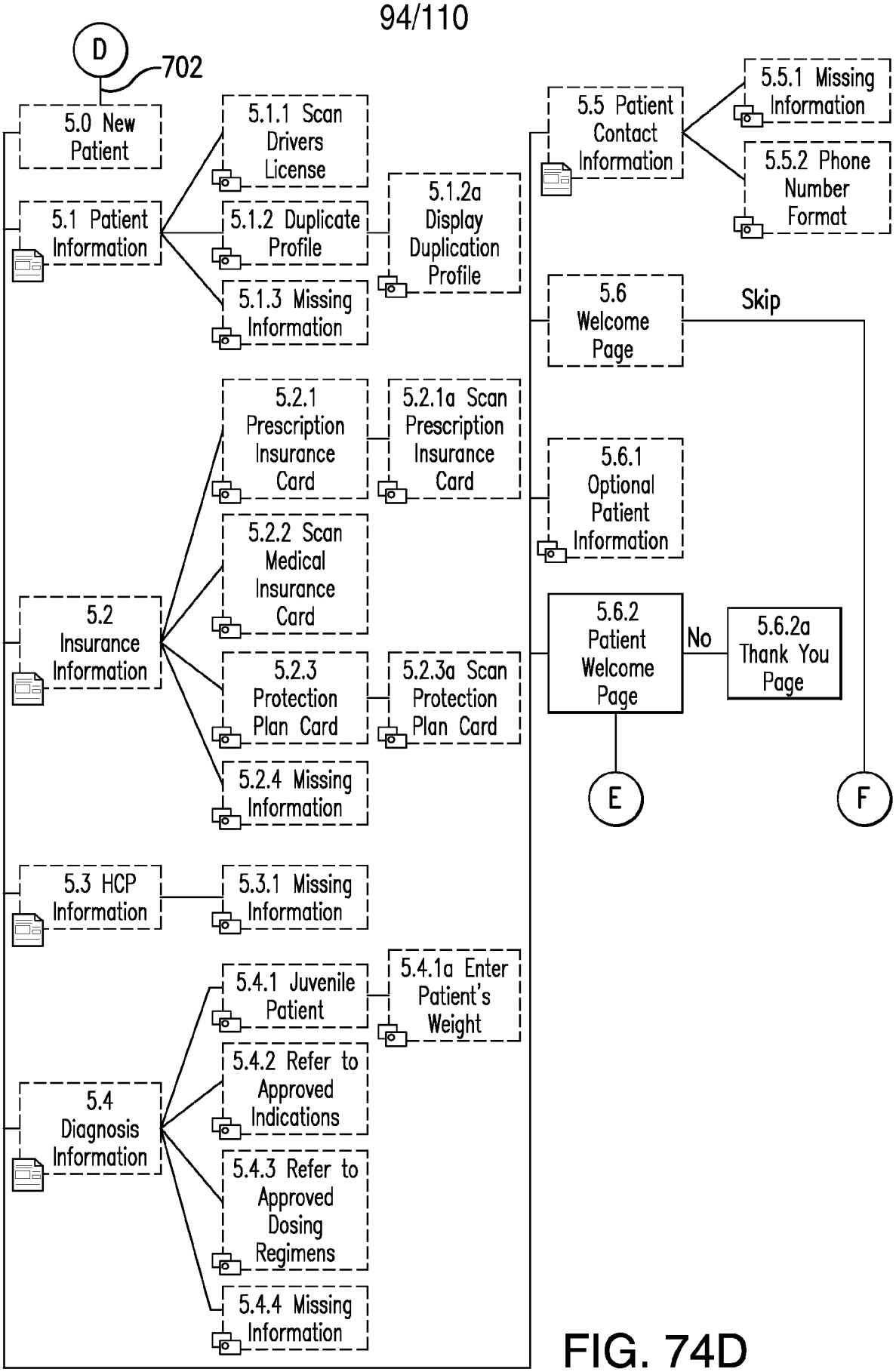

D
702
5.0 New Patient
5.1 Patient Information
5.1.1 Scan Drivers License
5.1.2 Duplicate Profile
5.1.3 Missing Information
5.1.2a Display Duplication Profile
5.2 Insurance Information
5.2.1 Prescription Insurance Card
5.2.2 Scan Medical Insurance Card
5.2.3 Protection Plan Card
5.2.4 Missing Information
5.2.1a Scan Prescription Insurance Card
5.2.3a Scan Protection Plan Card
5.3 HCP Information
5.3.1 Missing Information
5.4 Diagnosis Information
5.4.1 Juvenile Patient
5.4.2 Refer to Approved Indications
5.4.3 Refer to Approved Dosing Regimens
5.4.4 Missing Information
5.4.1a Enter Patient's Weight
5.5 Patient Contact Information
5.5.1 Missing Information
5.5.2 Phone Number Format
5.6 Welcome Page
Skip
5.6.1 Optional Patient Information
5.6.2 Patient Welcome Page
No
5.6.2a Thank You Page
E
F

FIG. 74D

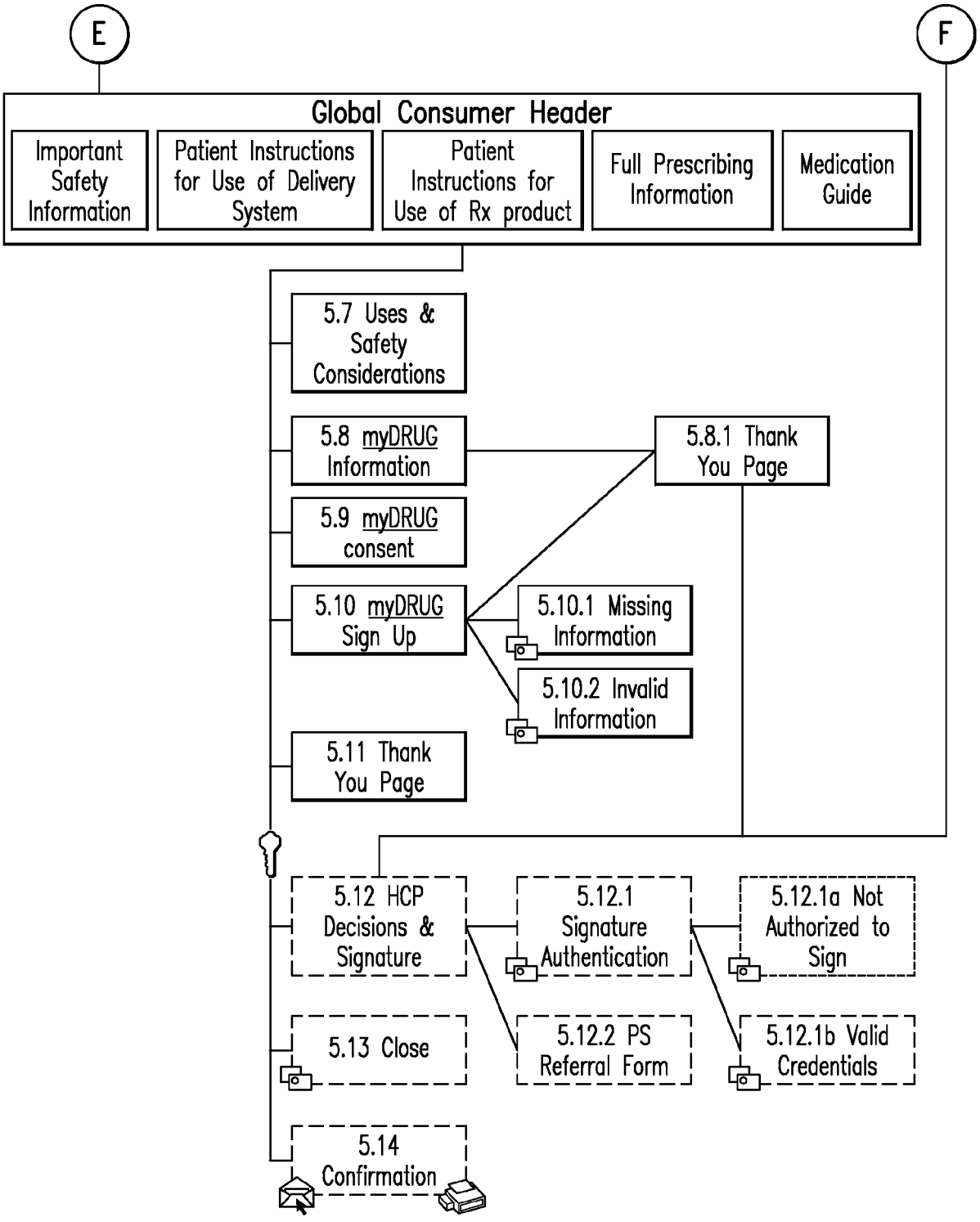

E
F
Global Consumer Header
Important Safety Information
Patient Instructions for Use of Delivery System
Patient Instructions for Use of Rx product
Full Prescribing Information
Medication Guide
5.7 Uses & Safety Considerations
5.8 myDRUG Information
5.8.1 Thank You Page
5.9 myDRUG consent
5.10 myDRUG Sign Up
5.10.1 Missing Information
5.10.2 Invalid Information
5.11 Thank You Page
5.12 HCP Decisions & Signature
5.12.1 Signature Authentication
5.12.1a Not Authorized to Sign
5.13 Close
5.12.2 PS Referral Form
5.12.1b Valid Credentials
5.14 Confirmation

FIG. 74E

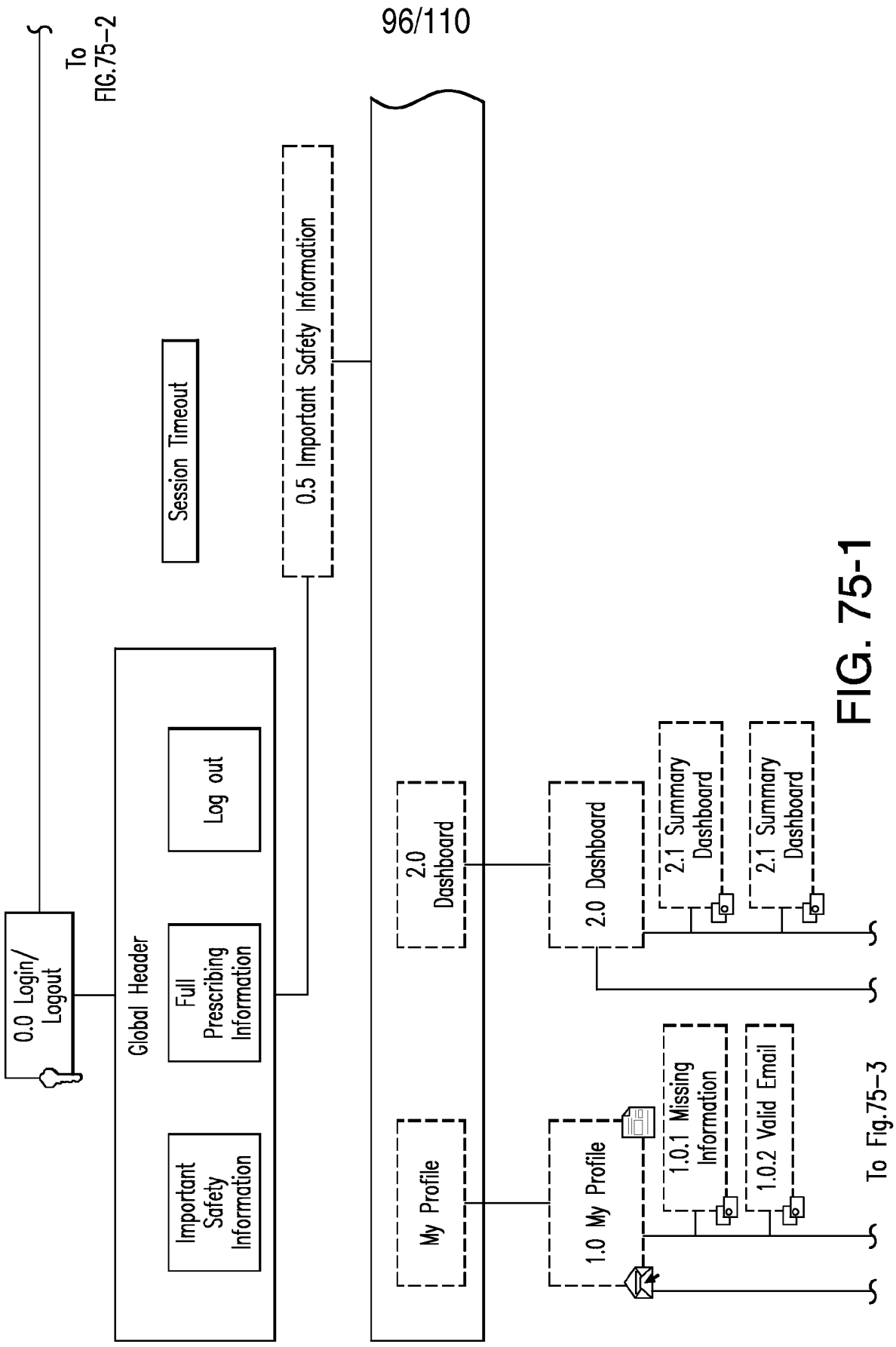

To FIG.75-2
0.0 Login/ Logout
Global Header
Important Safety Information
Full Prescribing Information
Log out
Session Timeout
0.5 Important Safety Information
2.0 Dashboard
My Profile
2.0 Dashboard
2.1 Summary Dashboard
2.1 Summary Dashboard
1.0 My Profile
1.0.1 Missing Information
1.0.2 Valid Email
To Fig.75-3

FIG. 75-1

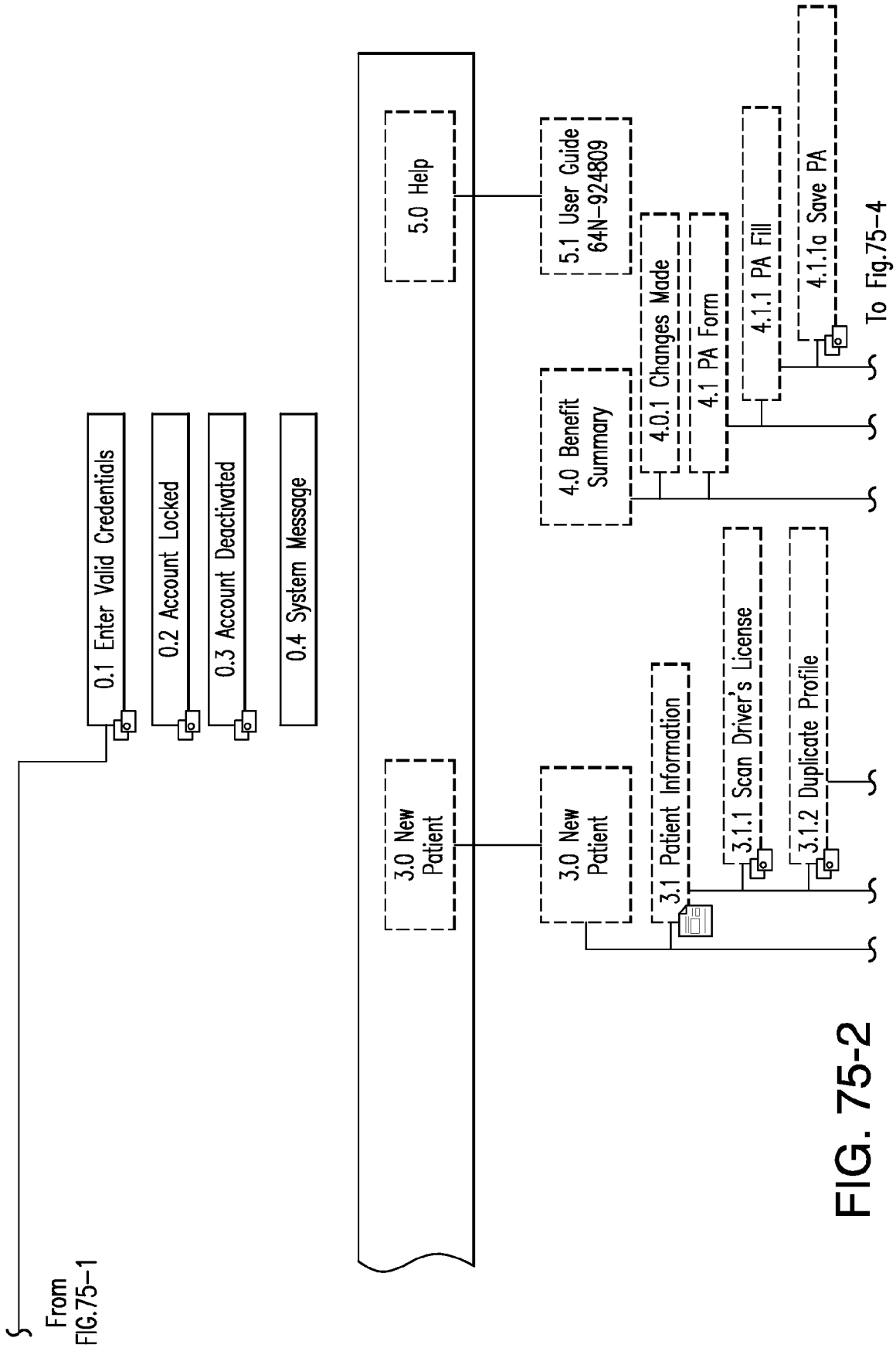

From FIG.75-1
0.1 Enter Valid Credentials
0.2 Account Locked
0.3 Account Deactivated
0.4 System Message
3.0 New Patient
3.0 New Patient
3.1 Patient Information
3.1.1 Scan Driver's License
3.1.2 Duplicate Profile
4.0 Benefit Summary
4.0.1 Changes Made
4.1 PA Form
4.1.1 PA Fill
4.1.1a Save PA
5.0 Help
5.1 User Guide 64N-924809
To Fig.75-4

FIG. 75-2

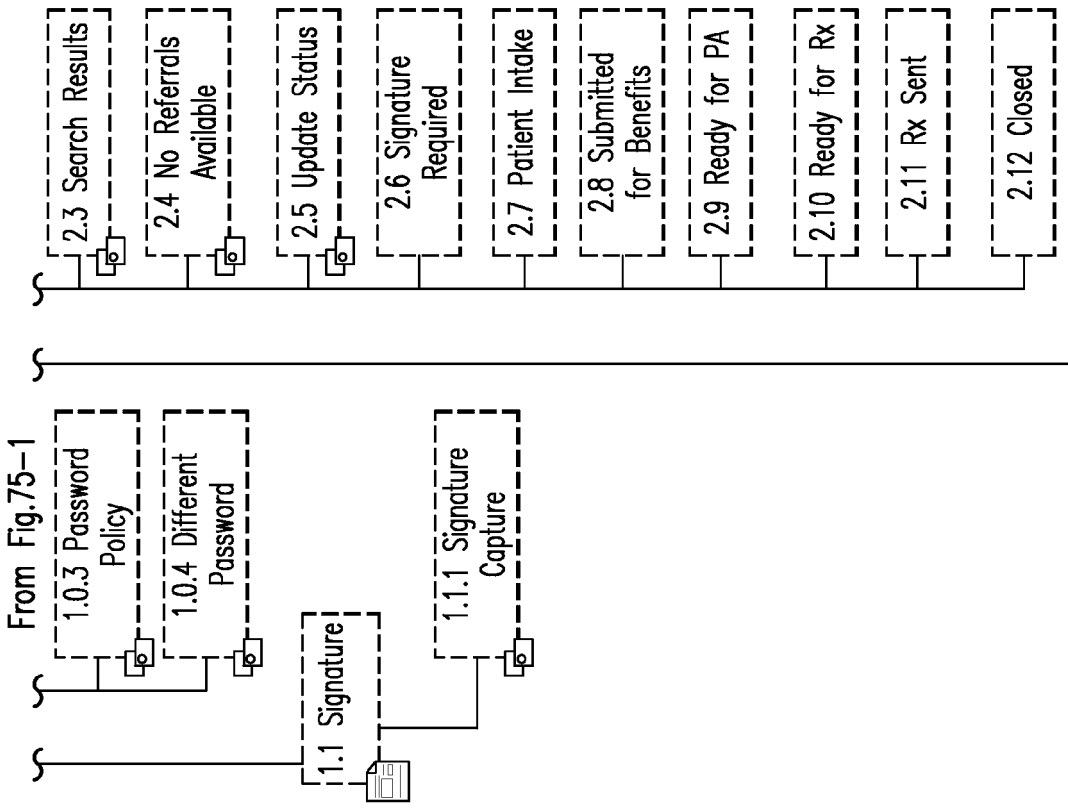

From Fig.75–1
1.0.3 Password Policy
1.0.4 Different Password
1.1 Signature
1.1.1 Signature Capture
2.3 Search Results
2.4 No Referrals Available
2.5 Update Status
2.6 Signature Required
2.7 Patient Intake
2.8 Submitted for Benefits
2.9 Ready for PA
2.10 Ready for Rx
2.11 Rx Sent
2.12 Closed
To Fig.75–5

FIG. 75-3

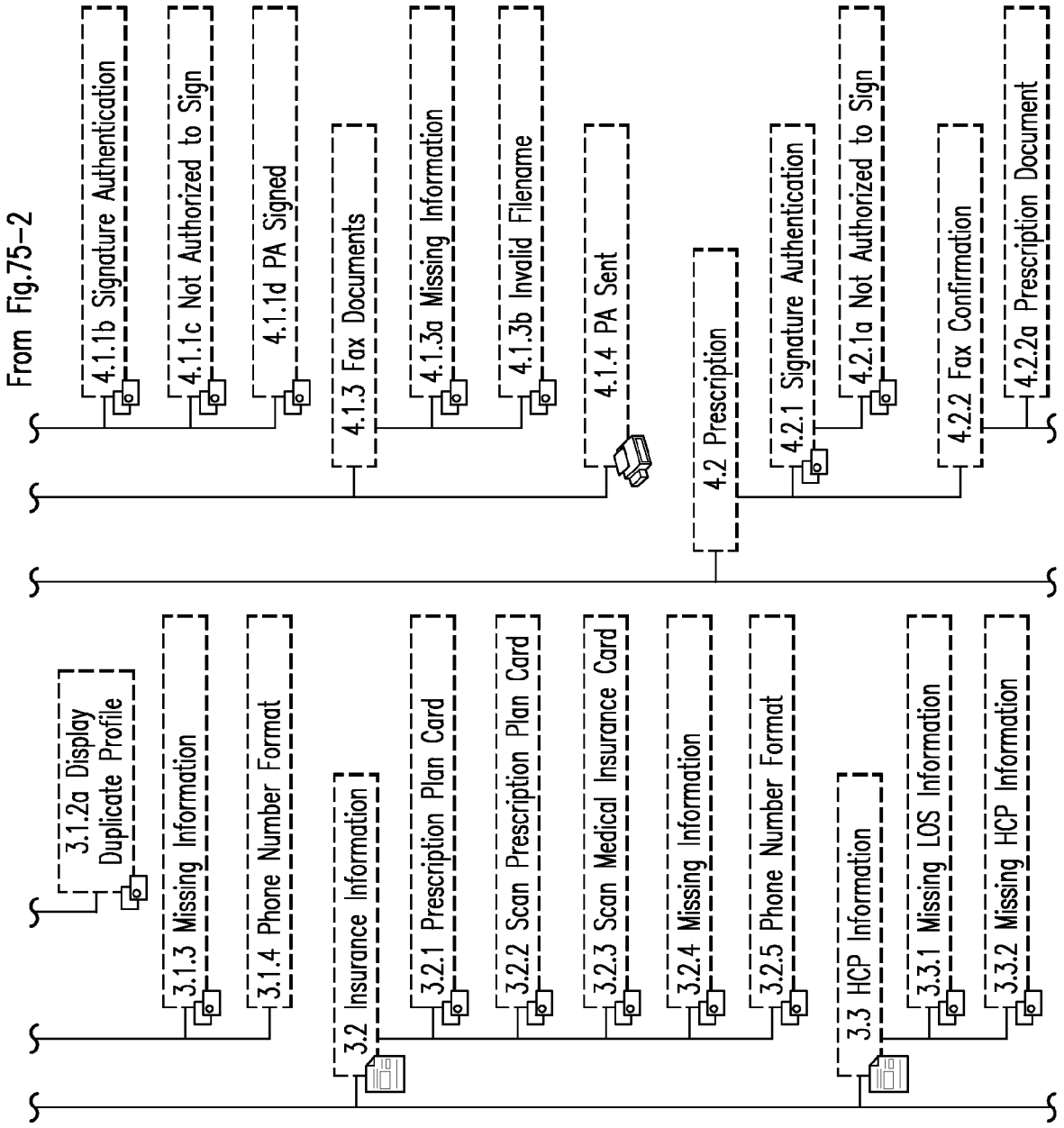


FIG. 75-4

To Fig.75-6

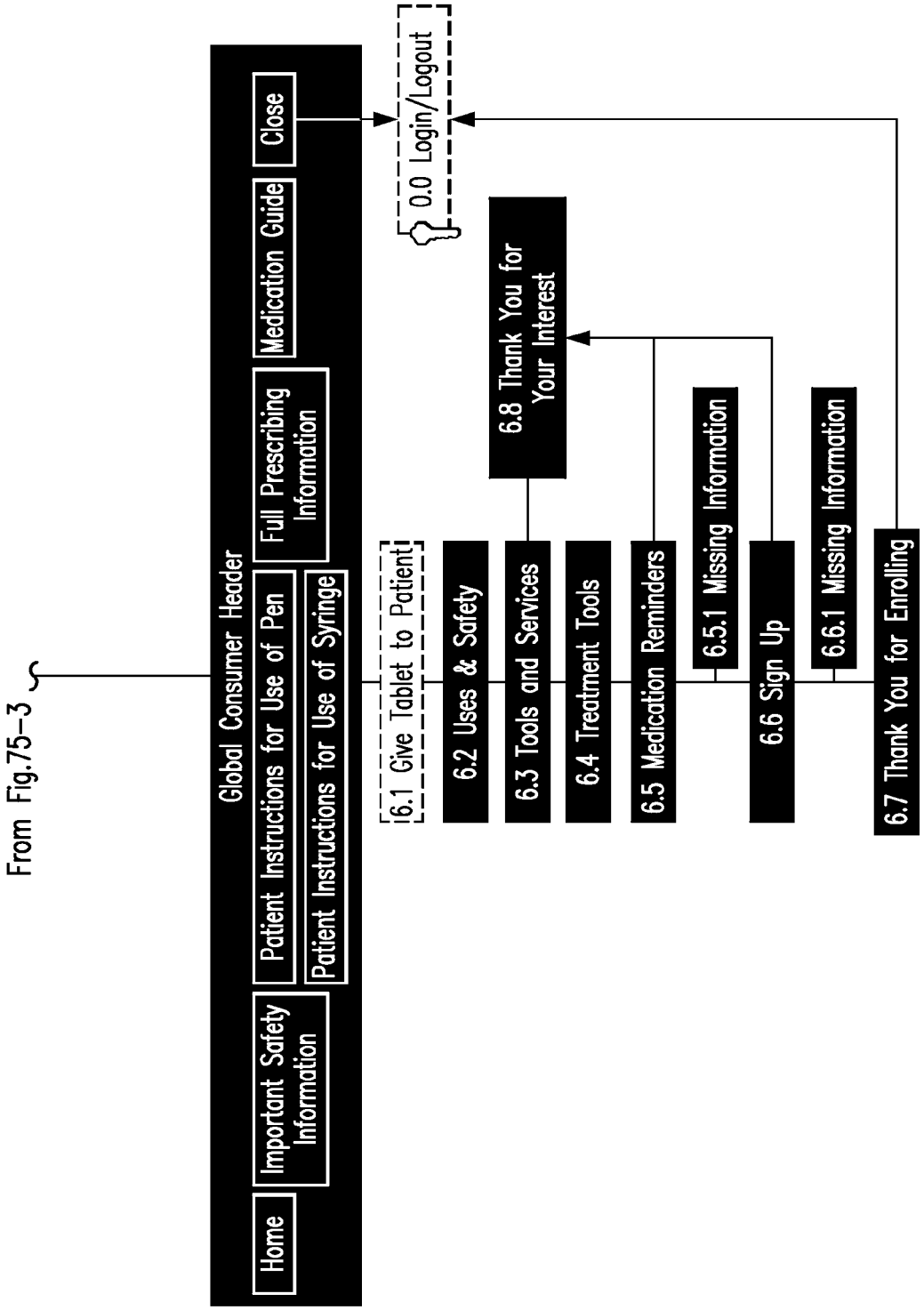

From Fig.75-3
Global Consumer Header
Home
Important Safety Information
Patient Instructions for Use of Pen
Patient Instructions for Use of Syringe
Full Prescribing Information
Medication Guide
Close
0.0 Login/Logout
6.1 Give Tablet to Patient
6.2 Uses & Safety
6.3 Tools and Services
6.4 Treatment Tools
6.5 Medication Reminders
6.5.1 Missing Information
6.6 Sign Up
6.6.1 Missing Information
6.7 Thank You for Enrolling
6.8 Thank You for Your Interest

FIG. 75-5

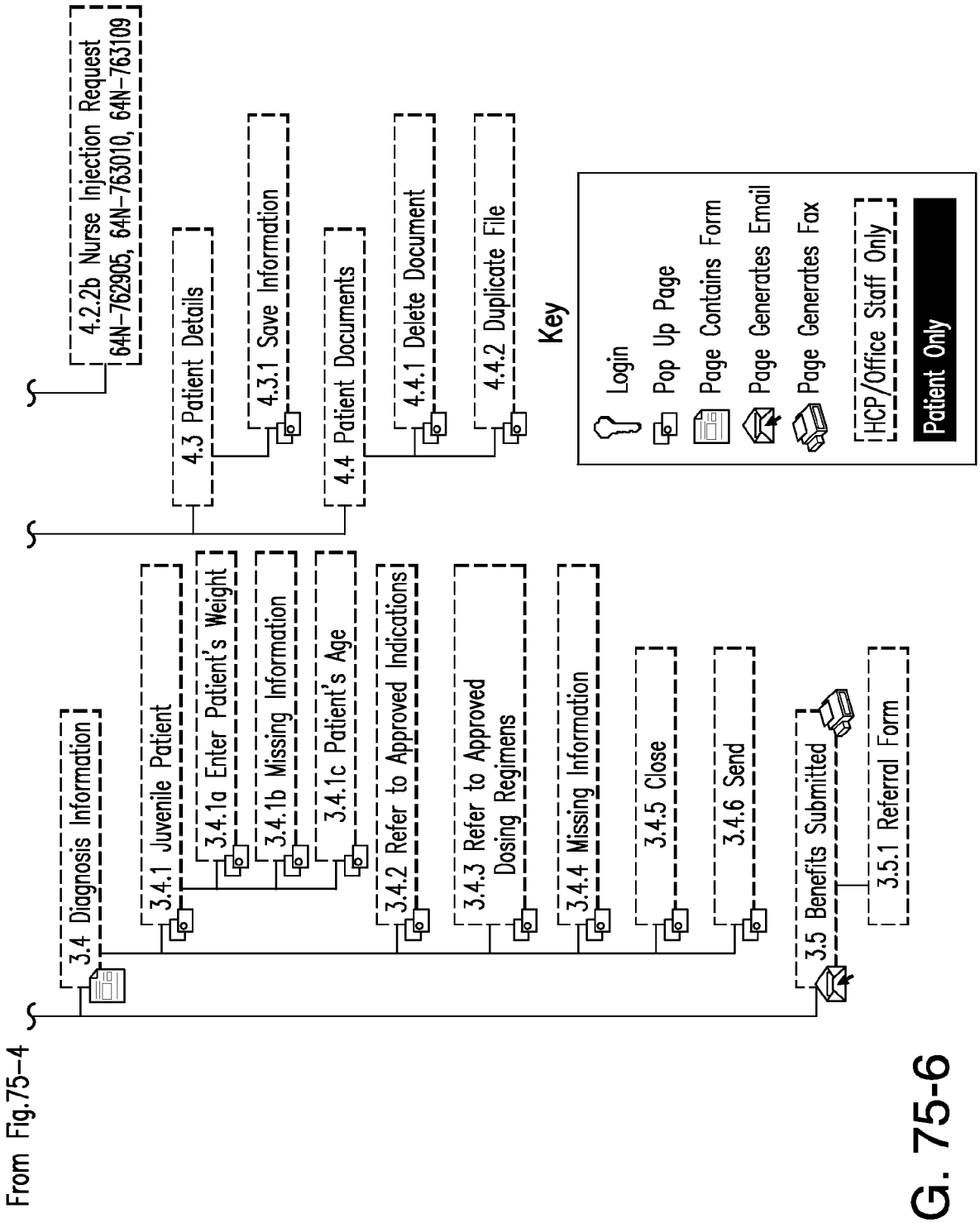

From Fig.75-4
3.4 Diagnosis Information
3.4.1 Juvenile Patient
3.4.1a Enter Patient's Weight
3.4.1b Missing Information
3.4.1c Patient's Age
3.4.2 Refer to Approved Indications
3.4.3 Refer to Approved Dosing Regimens
3.4.4 Missing Information
3.4.5 Close
3.4.6 Send
3.5 Benefits Submitted
3.5.1 Referral Form
4.3 Patient Details
4.3.1 Save Information
4.4 Patient Documents
4.4.1 Delete Document
4.4.2 Duplicate File
4.2.2b Nurse Injection Request 64N-762905, 64N-763010, 64N-763109
Key
Login
Pop Up Page
Page Contains Form
Page Generates Email
Page Generates Fax
HCP/Office Staff Only
Patient Only

FIG. 75-6

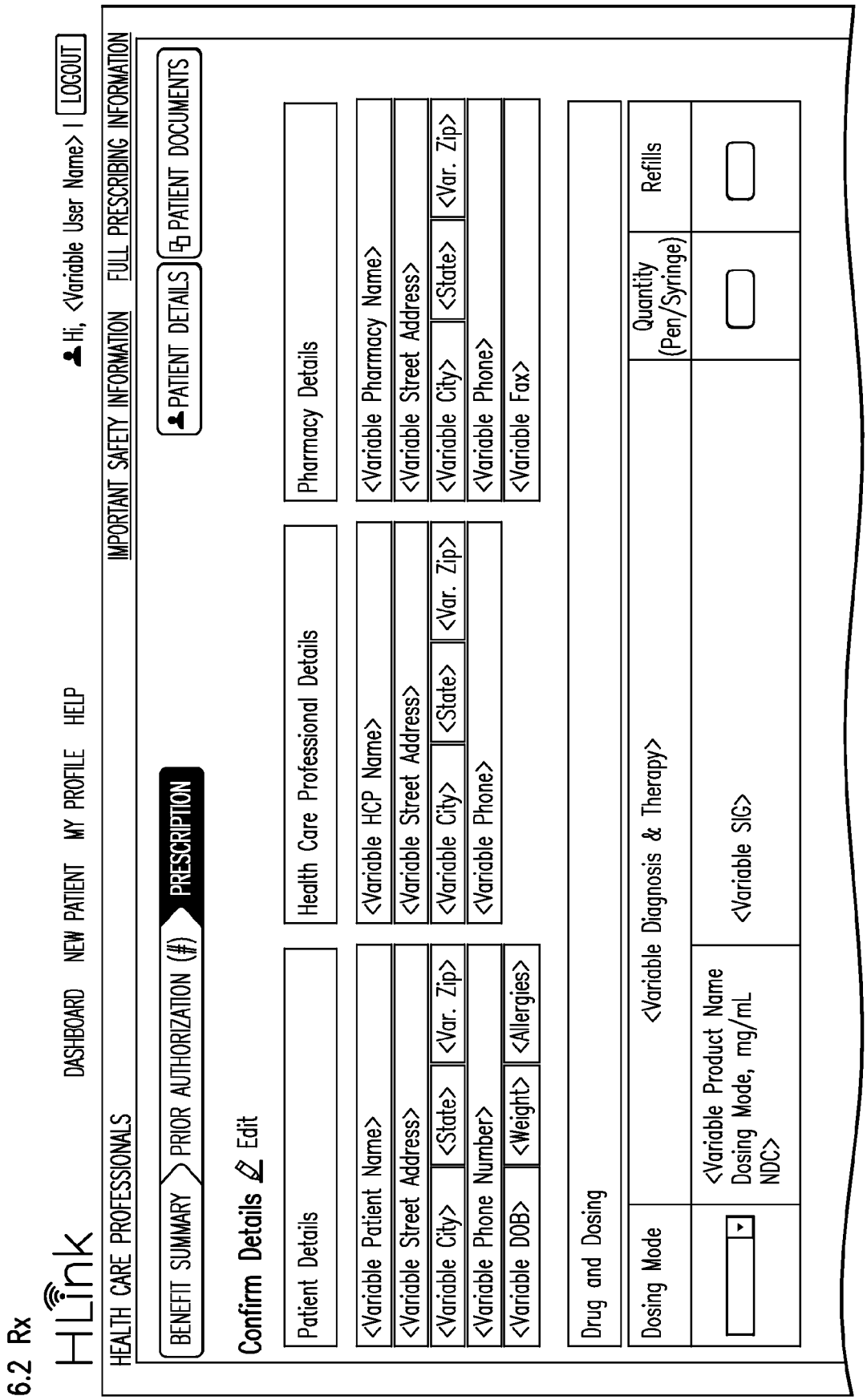

6.2 Rx
HLink
DASHBOARD NEW PATIENT MY PROFILE HELP
Hi, <Variable User Name> | LOGOUT
HEALTH CARE PROFESSIONALS
IMPORTANT SAFETY INFORMATION FULL PRESCRIBING INFORMATION
BENEFIT SUMMARY
PRIOR AUTHORIZATION (#)
PRESCRIPTION
PATIENT DETAILS
PATIENT DOCUMENTS
Confirm Details
Edit
Patient Details
<Variable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

FIG. 76-1

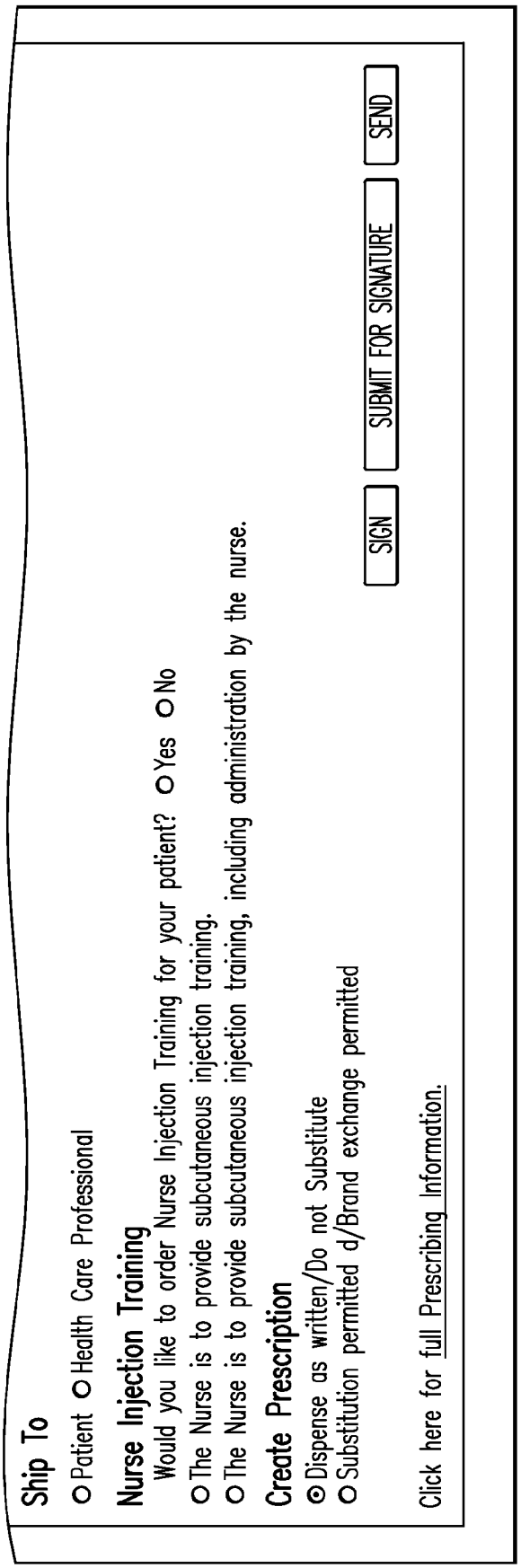

Ship To
O Patient O Health Care Professional
Nurse Injection Training
Would you like to order Nurse Injection Training for your patient? O Yes O No
O The Nurse is to provide subcutaneous injection training.
O The Nurse is to provide subcutaneous injection training, including administration by the nurse.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

FIG. 76-2

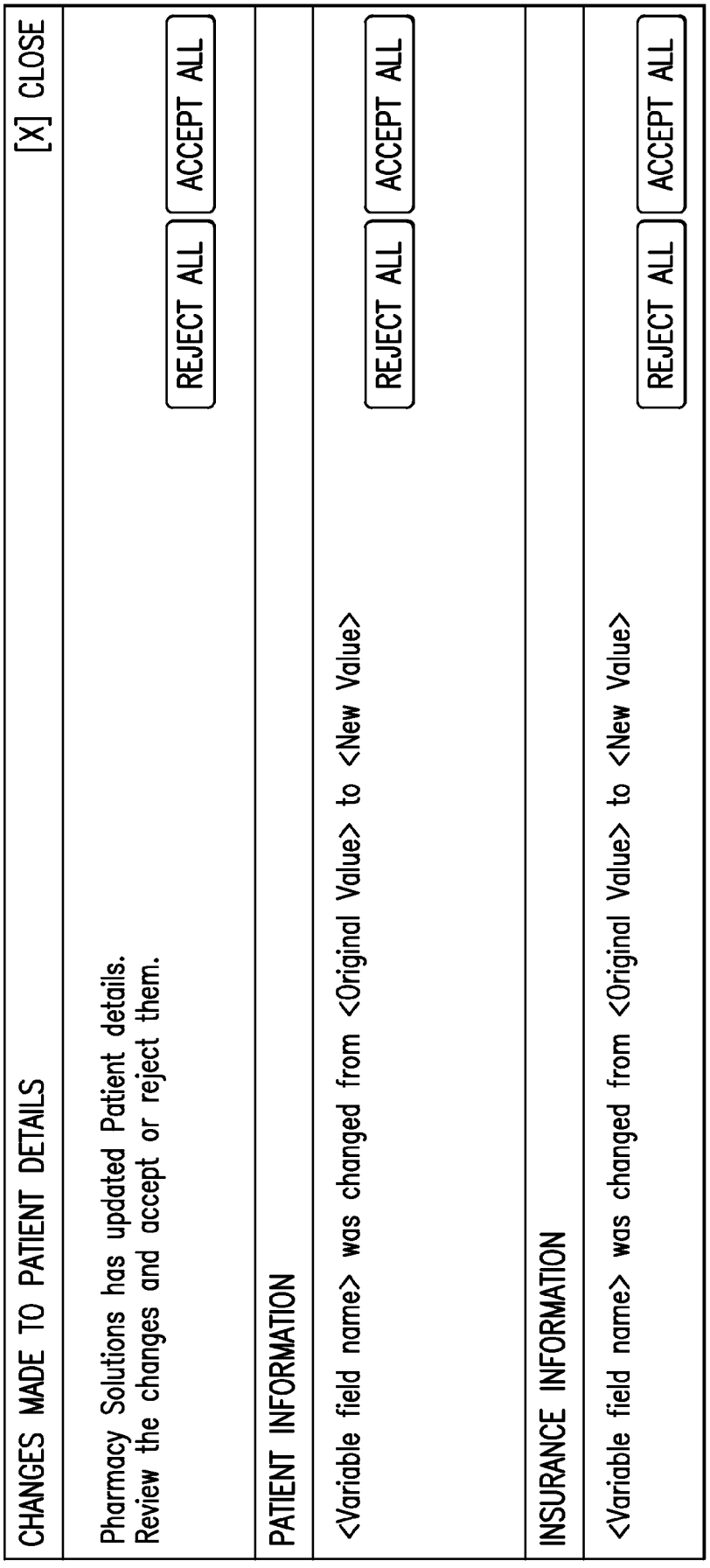

CHANGES MADE TO PATIENT DETAILS
[X] CLOSE
Pharmacy Solutions has updated Patient details.
Review the changes and accept or reject them.
REJECT ALL
ACCEPT ALL
PATIENT INFORMATION
<Variable field name> was changed from <Original Value> to <New Value>
REJECT ALL
ACCEPT ALL
INSURANCE INFORMATION
<Variable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

FIG. 77

HUMIRA® (adalimumab) Nursing Services Request Form Rheumatology

To FIG.78-1

Patient Information

Name: Shannon Sword

Sex (circle one): ■ F ☐ M Date of Birth: 2/25/1985

Address: 17689 W Running Creek Ct

City: Gurnee State: IL Zip: 60031

Day Phone: 1234567890 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: 10-08-2012

■ 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: Codeine

Pharmacy: WALGREENS

Physician Signature (no Stamps): Codeine Date: 10/8/2012

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

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

Physician Information

Physician Name: Crazy Santhosh (circle one): ■ MD ☐ DO ☐ Other:

Office Name: TCT

Address: Gandhi Nagar Bhuj

City: Bhopal State: NV Zip: 383058

State License #: 1234567890 1234567890 1234567890 1234567890 123456

NPI #: 1234567890 1234567890 1234567890 123456

Email Address: santhoshkumar.perumal@abbott.com

Office Contact: Crazy Santhosh

Phone: 4805280528 Fax: 093583058

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 oro ther 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

HLink | pharmacy SOLUTIONS | Referral In Progress | Referral Processed | Logout

Hi, Shannon Pharmacy Solutions
User Guide

Search for Patient

Practice Name	HCP Name	HCP State	Patient Name	myHUMIRA Enrollment	Created Date	Time Since Last Update
Formal Testing	Crazy Santhosh	Illinois	Michael Moore	No	Oct 08 2012, 18:08	0 days ago
Formal Testing	Crazy Santhosh	Illinois	Shannon Sword	No	Oct 08 2012, 17:34	0 days ago
Formal	VTP HCP	Louisiana	MOUNa DEa	No	Oct 05 2012, 06:54	1 days ago
Formal	VTP TWO	Louisiana	Jerry rich	No	Oct 05 2012, 03:30	1 days ago
V Care	HCPone Validation	New Mexico	Referral Four	No	Oct 05 2012, 02:22	1 days ago
V Care	HCPone Validation	New Mexico	Referral Three	No	Oct 05 2012, 02:18	1 days ago
V Care	HCPone Validation	New Mexico	Referral Two	No	Oct 05 2012, 02:16	1 days ago
V Care	HCPone Validation	New Mexico	Referral One	No	Oct 05 2012, 02:12	1 days ago
QA Formal	HCP Two VTP SixtyFour	Nevada	Patient Two	No	Oct 05 2012, 01:29	1 days ago
QA Formal	HCP One VTP SixtyFour	California	Patient One	No	Oct 05 2012, 00:54	1 days ago
Formal Testing	Crazy Santhosh	Maine	Abcdefghijklmnopqrstuvwxyz Abcdefghijklm Abcdefghijklmnopqrstuvwxyz Abcdefghijkl m	No	Oct 04 2012, 16:24	2 days ago
Sharn Swords	DOCTOR MARIAN	Kansas	Susan Jones	No	Oct 04 2012, 12:42	2 days ago

FIG. 79

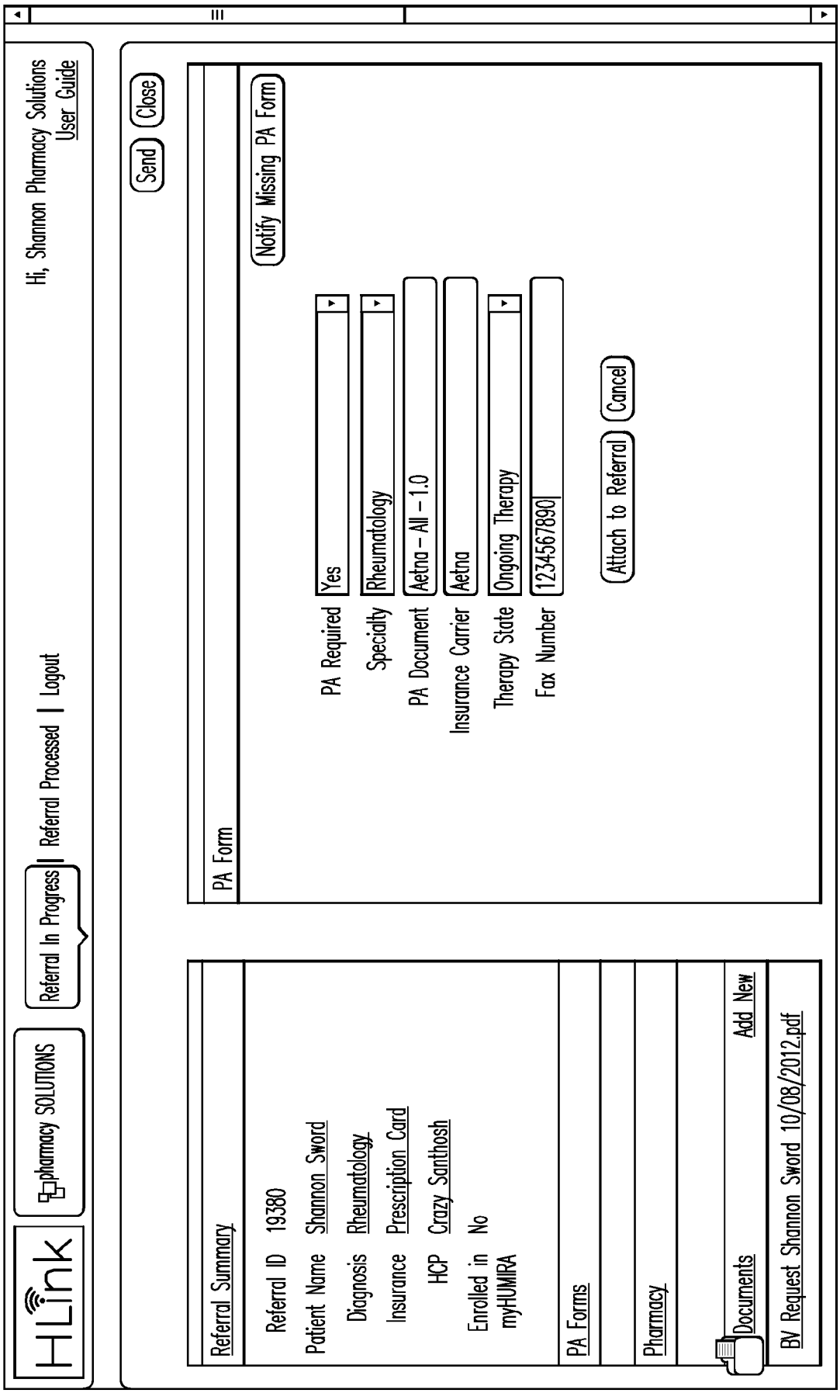

HLink
pharmacy SOLUTIONS
Referral In Progress
Referral Processed
Logout
Hi, Shannon Pharmacy Solutions
User Guide
Send
Close
Referral Summary
Referral ID 19380
Patient Name Shannon Sword
Diagnosis Rheumatology
Insurance Prescription Card
HCP Crazy Santhosh
Enrolled in myHUMIRA No
PA Forms
Pharmacy
Documents
Add New
BV Request Shannon Sword 10/08/2012.pdf
PA Form
Notify Missing PA Form
PA Required Yes
Specialty Rheumatology
PA Document Aetna – All – 1.0
Insurance Carrier Aetna
Therapy State Ongoing Therapy
Fax Number 1234567890
Attach to Referral
Cancel

FIG. 80

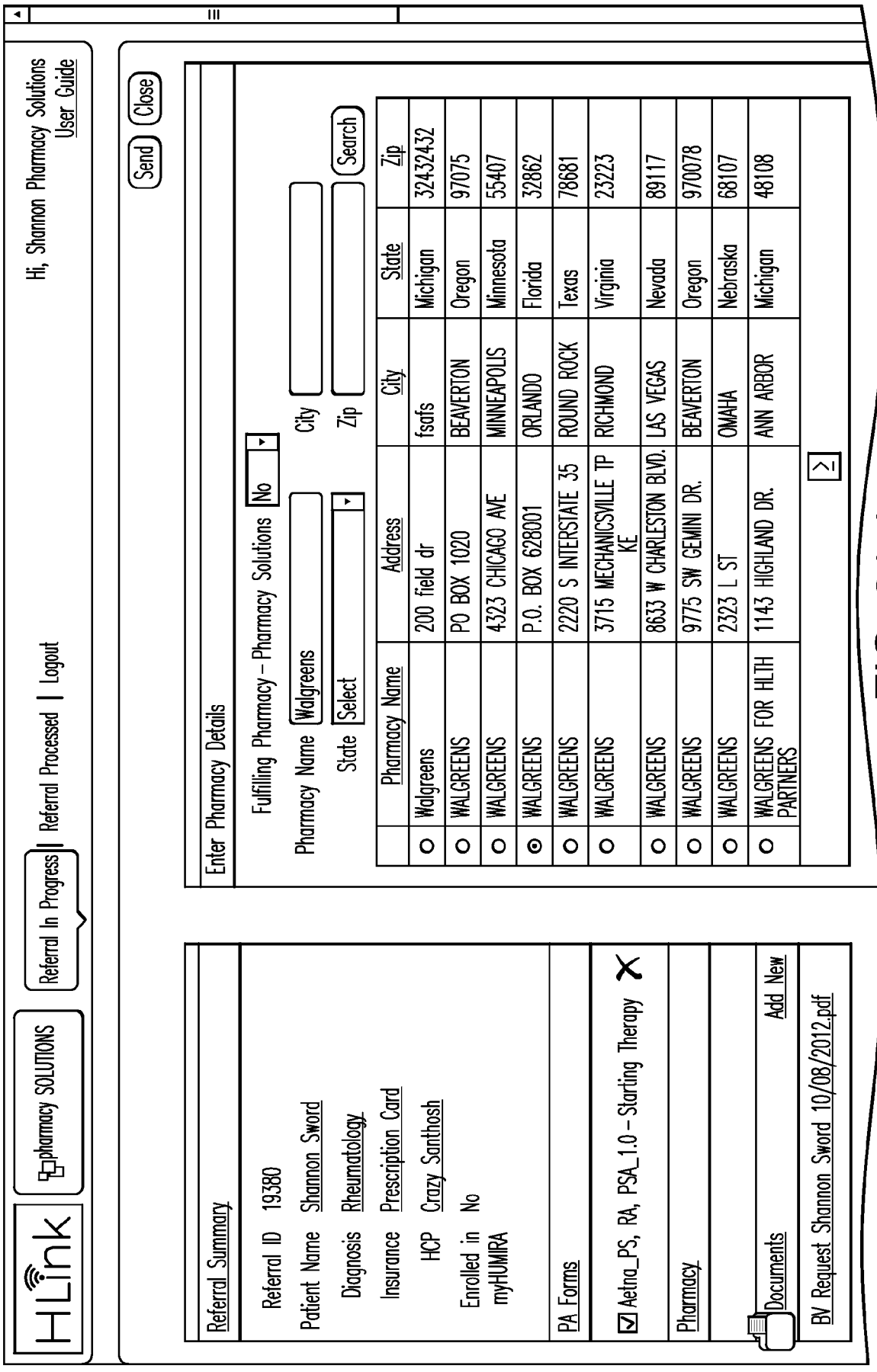

HLink
pharmacy SOLUTIONS
Referral In Progress
Referral Processed
Logout
Hi, Shannon Pharmacy Solutions
User Guide
Send
Close
Referral Summary
Referral ID 19380
Patient Name Shannon Sword
Diagnosis Rheumatology
Insurance Prescription Card
HCP Crazy Santhosh
Enrolled in myHUMIRA No
PA Forms
Aetna_PS, RA, PSA_1.0 – Starting Therapy
Pharmacy
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
Search
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

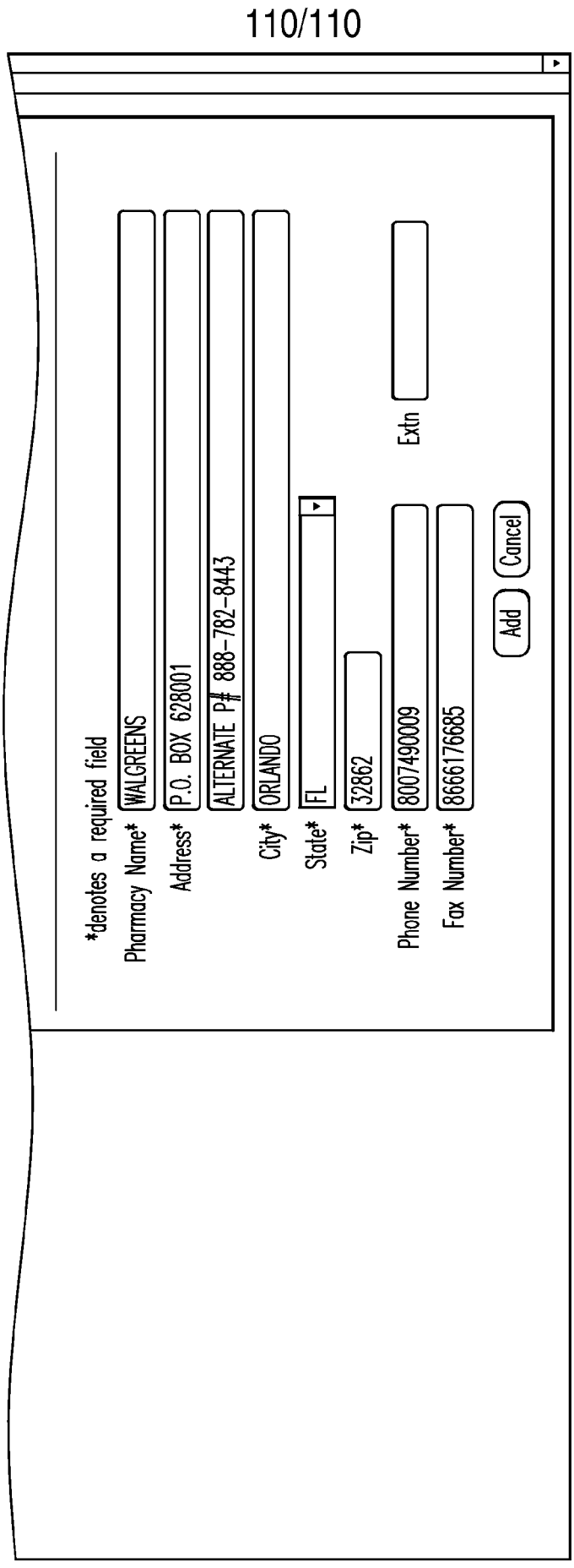

110/110
*denotes a required field
Pharmacy Name*
WALGREENS
Address*
P.O. BOX 628001
ALTERNATE P# 888-782-8443
City*
ORLANDO
State*
FL
Zip*
32862
Phone Number*
8007490009
Extn
Fax Number*
8666176685
Add
Cancel

FIG. 81-2