abbvie care with you

Support Program

Enrollment form for HUMIRA

Please fax the completed form to **1-866-270-1727**.
For any questions, or to register by phone, please call **1-866-848-6472**.

Please note that the only SECURE way to transfer this information is by Fax or Phone.

PATIENT INFORMATION

First name: **Last name:**

Date of birth (dd/mm/yyyy): _____ ☐ **M** ☐ **F**

Health card number:

Address:

City: | **Province:** Choose Province | **Postal code:**

Email:

Home phone: - -

Mobile: - -

Language preference: ☐ **English** ☐ **French** ☐ **Other:** _____

Enrolled in current or previous clinical study?
☐ **No** ☐ **Yes, study number:**

CONSENT INFORMATION AND PATIENT DISCLOSURE (to be completed by the patient)

I acknowledge that I have read the AbbVie Care Consent Information and Disclosure (see page 2), and that I consent to the collection, use, and disclosure of my personal information in accordance with these terms.

Patient signature:* _____

Date (dd/mm/yyyy): _____

Patient caregiver/legal guardian signature (if the patient is under 18 years old):

_____

Relationship to patient: _____

Date (dd/mm/yyyy): _____

☐ Please check here if you do not want to be contacted for market research purposes.

*** Valid patient consent requires patient signature.**

PHYSICIAN INFORMATION (to be completed by the physician)

Name: **License number:**

Address:

City: | **Province:** Choose Province | **Postal code:**

Phone: - - | **Fax:** - -

INJECTION TRAINING AND SUPPORT SERVICES

I require AbbVie Care to provide injection training: ☐ **No** ☐ **Yes**

Comments:

MEDICAL INFORMATION (to be completed by the physician)

TB TEST

☐ **Completed**
Date (dd/mm/yyyy): _____ **Result:** _____
☐ **Required**
☐ **Not required**

Has the patient ever suffered a severe allergic reaction?
☐ **No** ☐ **Yes**

Allergies:

Patient is cleared to start HUMIRA therapy.
☐ **No** ☐ **Yes**

℞ (check a format, diagnosis **and** dosage)

HUMIRA will be supplied in boxes of two units, in one of the following formats:

☐ **HUMIRA Pen** ☐ **HUMIRA pre-filled syringe** ☐ **HUMIRA vial (pediatric patients)**

☐ **Rheumatoid arthritis (RA)**
☐ **Psoriatic arthritis (PsA)**
☐ **Ankylosing spondylitis (AS)**
☐ 40 mg every other week subcutaneous (sc)

☐ **Adult Crohn's disease (CD)**
☐ **Ulcerative colitis (UC)**
☐ Week 0=160 mg, Week 2=80 mg, then 40 mg every other week, beginning Week 4 (sc)

☐ **Psoriasis (Ps)**
☐ **Uveitis**
☐ **Adolescent HS** (12 to 17 years of age weighing ≥30 kg)
☐ Week 0=80 mg, then 40 mg every other week, beginning Week 1 (sc)

☐ **Hidradenitis suppurativa (HS)**
☐ Week 0=160 mg, Week 2=80 mg, then 40 mg weekly, beginning Week 4 (sc)

☐ **Polyarticular juvenile idiopathic arthritis (JIA)**
☐ Patient weight 10 to <30 kg, 20 mg every other week (sc)
☐ Patient weight ≥30 kg, 40 mg every other week (sc)

☐ **Pediatric Crohn's disease (CD)**
☐ Week 0=160 mg, Week 2=80 mg, then 20 mg every other week, beginning Week 4 (sc)

☐ **Other dosing** (specify):

☐ **Pediatric uveitis**
☐ Patient weight <30 kg, 20 mg every other week (sc) in combination with methotrexate
☐ Patient weight ≥30 kg, 40 mg every other week (sc) in combination with methotrexate

Duration of treatment:
☐ **12 months** ☐ **6 months** ☐ **3 months** **Other:** _____

I hereby acknowledge that I am the patient's attending physician. I authorize AbbVie Care to be my designated agent to forward this prescription by fax, or other mode of delivery, to the pharmacy chosen by the above named. This prescription represents the original prescription drug order. The patient's chosen pharmacy is the only intended recipient and there are no others.

Physician signature: | **Date** (dd/mm/yyyy):

☐ An authorized representative/legal guardian may provide consent and sign this enrollment form on behalf of my patient.

Clinic stamp and/or additional comments:

Please refer to the HUMIRA Product Monograph for complete dosing information.

AbbVie Care consent information and patient disclosure

By signing this form requesting enrollment in AbbVie's patient support program (the AbbVie Care Program), you agree that AbbVie Corporation (AbbVie) or its affiliated companies or service providers appointed by AbbVie (collectively, the Program Administrators) may provide you with the AbbVie Care services as outlined in this enrollment form and provide you with relevant information to help better support you with your new therapy.

You understand the nature of your consent and that your enrollment is voluntary. You are free to withdraw your consent and discontinue participation in the AbbVie Care Program at any time, without giving any reason. Your medical care or legal rights will not be affected. Below we provide the key elements regarding the use of personal information by the Program Administrators.

What is the AbbVie Care Program?

The AbbVie Care Program is a support program for individuals prescribed an AbbVie Immunology product which includes:

- cost reimbursement assistance;
- education and training;
- therapy administration assistance;
- limited market research (for example conducting surveys of your experience with the Program).

The AbbVie Care Program does not provide medical advice and does not replace the need for you to speak with your treating physician for medical-related inquiries.

What categories of personal information does AbbVie process about you and why?

The Program Administrators will collect, process, and use your personal information for a range of different purposes.

What personal information is used?

The Program Administrators will use information gathered about you in this document as well as any additional personal information collected from you or your doctor, nurse, pharmacy or other healthcare providers, or insurers, such as:

- name, address, phone number, and other contact details;
- sensitive information, such as information regarding the use of our service and health-related information.

Why is your personal information used and by whom?

The Program Administrators may collect, use and disclose your personal information to your pharmacist, your insurer, your doctor, your nurse and other healthcare providers for the following purposes:

- administration of the AbbVie Care Program;
- delivery of products and services;
- helping you to access your medication, treatment;
- tailoring the AbbVie Care Program to your specific needs;
- contacting your healthcare providers and providing them with information about your AbbVie medication and participation in the AbbVie Care Program;
- reminding you to take your medication(s) as prescribed;
- providing you with materials relating to your medication, treatment and the AbbVie Care Program;
- contacting you to inform you of changes in the AbbVie Care Program and to collect your feedback on the AbbVie Care Program;
- for safety monitoring, reporting and auditing and responding to enquiries or issues in relation to your medication, or as otherwise may be required by law.

The Program Administrators may also use de-identified information gathered through the Program and pool your information with the information of other persons to:

- help us develop, evaluate or improve the AbbVie Care Program, our products, services, materials and treatment; and
- to conduct research, including future scientific research and publications.

Disclosures and transfers

AbbVie requires its service providers to process your personal information in accordance with this consent and for no other purpose.

AbbVie may provide metrics and analytical information about the Program to its affiliated companies and/or its parent company AbbVie Inc. regarding how the Program is working. This information is aggregated and does not identify you individually.

Your personal information may be transferred to another company or to a third party in connection with the sale or transfer of all or a portion of the Program Administrators' respective business.

Your personal information may be stored or processed outside of Canada. If this is the case, then your information would be subject to the laws of that country where it is stored. That country may have laws that require that your personal information be disclosed to the government under different circumstances than would Canada.

What rights do you have in respect of your personal information and who can you contact for questions?

You have a number of rights in relation to your information. These include a right to access and to correct, restrict, transfer and erase your information. To exercise these rights or to withdraw your consent, or opt out of any of the AbbVie Care services, or the data processing activities, you can contact us in writing at the address mentioned below or by going to https://www.abbvie.com/privacy-inquiry.html. Please understand that if you withdraw your consent you may no longer be able to participate in the AbbVie Care Program or receive certain of its services.

AbbVie collects, uses, discloses and protects your personal information in accordance with its privacy policies. You may obtain a copy of AbbVie's privacy policy by submitting a written request to Legal Services, 8401 Trans-Canada Highway, Saint-Laurent, Quebec, H4S 1Z1.

AbbVie has implemented appropriate technical and organizational security measures to protect your personal information against accidental or unlawful destruction or accidental loss, alteration, unauthorized disclosure, or access. Subject to consent and notice requirements, AbbVie reserves the right to change its policies and practices regarding personal information and its service providers.

You understand that AbbVie reserves the right to change or terminate the AbbVie Care Program or any of its patient support services, at any time, at AbbVie's sole discretion without notice to you.

This consent is valid for as long as you receive services from the AbbVie Care Program and for a reasonable time thereafter. Your personal information will be kept for the duration of your participation in the AbbVie Care Program and will thereafter be deleted in accordance with our document retention policies, subject to legal and regulatory requirements.

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