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**.

PATIENT INFORMATION (to be completed by the patient)

First name:	**Last name:**	
Date of birth (dd/mm/yyyy): / /		**M** ☐ **F** ☐
Health card number:		
Address:		
City:	**Province:** -	**Postal code:**
Call preference: ☐ **Home** ☐ **Mobile** ☐ **Other**		
Home phone: ( )	**Voice message OK:** ☐ **Yes** ☐ **No**	
Mobile: ( )	**Voice message OK:** ☐ **Yes** ☐ **No** ☐ **Or SMS**	
Best time to call: ☐ **9am–12pm** ☐ **12pm–5pm**		
Language preference: ☐ **English** ☐ **French** ☐ **Other:** _____		
Enrolled in current or previous HUMIRA study? ☐ **No** ☐ **Yes, study number:**		

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

I acknowledge that I have read and agreed to the AbbVie Care consent information and patient disclosure on the second page (page 2) of this form

Patient's signature: _____

Date (dd/mm/yyyy): _____

Parent/Guardian signature (if the patient is under 18 years old):

_____

Relation to patient: _____

Date (dd/mm/yyyy): _____

☐ Please check here if you do not wish to share your information with a third party for market research purposes

PHYSICIAN INFORMATION (to be completed by the physician)

Name:	**License number:**	
Address:		
City:	**Province:**	**Postal code:**
Phone: ( )	**Fax:** ( )	
Email:		

INJECTION SERVICES (check one)

☑ **Self-injection training requested:** I request that AbbVie Care provide injection training and support to this patient until they are comfortable with self-injection.

☐ **Nurse provides ongoing injections:** I request that AbbVie Care administer all injections for this patient until the attending physician deems patient self-sufficient.

MEDICAL INFORMATION (to be completed by the physician)

Chest X-ray required? ☐ **No** ☐ **Yes** **Result:** _____

TB test required? ☐ **No** ☐ **Yes** **Result:** _____

If TB test positive, is patient receiving anti-TB treatment?
☐ **No** ☐ **Yes, to be completed on** (dd/mm/yyyy): _____

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

Allergies:

Additional information:

Rx (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)** ☐ 40 mg every other week subcutaneous (sc)	☐ **Psoriatic arthritis (PsA)** ☐ 40 mg every other week (sc)
☐ **Ankylosing spondylitis (AS)** ☐ 40 mg every other week (sc)	☐ **Psoriasis** ☐ Week 0=80 mg, then 40 mg every other week, beginning Week 1 (sc)
☐ **Ulcerative colitis (UC)** ☐ Week 0=160 mg, Week 2=80 mg, then 40 mg every other week, beginning Week 4 (sc)	☑ **Adult Crohn's disease (CD)** ☐ Week 0=160 mg, Week 2=80 mg, then 40 mg every other week, beginning Week 4 (sc)
☐ **Pediatric Crohn's disease** ☐ Week 0=160 mg, Week 2=80 mg, then 20 mg every other week, beginning Week 4 (sc)	☐ **Polyarticular juvenile idiopathic arthritis (JIA)** ☐ 24 mg/m² body surface area, up to a maximum single dose of 40 mg, every other week (sc) **Dosage** (see page 2 for details): _____

☐ **Other dosing** (specify): _____

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

Clinic stamp and/or additional comments:

HBI =

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's signature:	**Date** (dd/mm/yyyy):

Please fax the completed form to **1-866-270-1727**.
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HUMIRA dose in millilitres (mL)* by height and weight of children for polyarticular JIA

Height (cm)	Total body weight (kg)												
	10	15	20	25	30	35	40	45	50	55	60	65	70
80	0.2	0.3	0.3	0.3									
90	0.2	0.3	0.3	0.4	0.4	0.4							
100	0.3	0.3	0.3	0.4	0.4	0.4	0.5	0.5					
110	0.3	0.3	0.4	0.4	0.4	0.5	0.5	0.5	0.5	0.6	0.6		
120	0.3	0.4	0.4	0.4	0.5	0.5	0.5	0.6	0.6	0.6	0.6	0.7	0.7
130		0.4	0.4	0.5	0.5	0.5	0.6	0.6	0.6	0.6	0.7	0.7	0.7
140		0.4	0.4	0.5	0.5	0.6	0.6	0.6	0.7	0.7	0.7	0.7	0.8†
150			0.5	0.5	0.6	0.6	0.6	0.7	0.7	0.7	0.7	0.8†	0.8†
160			0.5	0.5	0.6	0.6	0.7	0.7	0.7	0.8†	0.8†	0.8†	0.8†
170				0.6	0.6	0.6	0.7	0.7	0.8†	0.8†	0.8†	0.8†	0.8†
180					0.6	0.7	0.7	0.8†	0.8†	0.8†	0.8†	0.8†	0.8†

Please refer to the HUMIRA Product Monograph for complete dosing information.
sc=subcutaneous.
* Each mL provides 50 mg adalimumab (40 mg/0.8 mL).
† Maximum single dose is 40 mg (0.8 mL).

AbbVie Care consent information and patient disclosure

By signing this form, you consent and agree to the following:

The personal information that you provide in this document, as well as any additional personal information collected from you or your doctor, nurse, pharmacy or insurer, by AbbVie Corporation (AbbVie) or its affiliated companies or service providers appointed by AbbVie (collectively, the Program Administrators), will be used and disclosed for purposes relating to the administration of the AbbVie Care Program. The AbbVie Care Program includes a support program for patients prescribed HUMIRA, cost reimbursement assistance, therapy administration assistance and training, and limited market research activities (for example, conducting surveys of your experiences with the Program).

By enrolling in the AbbVie Care Program, you understand that any personal information that was previously collected by one of the Program Administrators may be disclosed to and used by all of the Program Administrators, for the above purposes. You agree that the Program Administrators may contact you for information required for the administration of the AbbVie Care Program, either by mail, email or by phone at the addresses and number(s) provided.

The Program Administrators may use or disclose your personal information, including your personal health information, to your pharmacist, your insurer, your doctor, nursing services providers, and other healthcare providers, for the purposes of administering the AbbVie Care Program and to help you access your HUMIRA therapy. In addition, AbbVie may collect, use and disclose your personal information to report any adverse drug event, or as otherwise may be required by law. We may also pool your information together with information of other persons to be used for market research. You won't be identified in this pooled information.

Your personal information will only be used for the above purposes or as otherwise permitted or required under the law. The Program Administrators may store or process your personal information 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.

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. For more information about AbbVie's policies and practices regarding its service providers, please submit a written request to the address indicated above.

You can request access to your personal information, correct any errors in that information, or withdraw your consent at any time by contacting AbbVie in writing at the address above. You understand that withdrawing your consent will result in the termination of your enrollment in the AbbVie Care Program.

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. If any one of the current Program Administrators discontinues its involvement with the AbbVie Care Program, your consent to the collection, use, storage and disclosure of your personal information remains in effect for the other Program Administrators, and you consent to the use and disclosure of your personal information by/to another service provider that is appointed by AbbVie to administer the AbbVie Care Program.

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