Skyrizi® COMPLETE

RESOURCES AND SUPPORT FOR HELPING YOUR PATIENTS START ON TREATMENT

Skyrizi Complete Enrollment & Prescription Form

ENROLL YOUR PATIENTS IN SKYRIZI COMPLETE TO ACTIVATE:



A dedicated **Field Reimbursement Manager** who provides expertise in insurance policies and case-by-case personalized support



360° Access Support that includes comprehensive access and reimbursement support, fulfillment coordination support for Intravenous (IV) Infusion and On-Body Injector, and educational resources



Patient **financial support options** for eligible, commercially insured patients who may pay as little as $0 per treatment, including administration and ongoing lab costs‡

3 ways to help your patients enroll in Skyrizi Complete

- Download, fill out, and fax the Skyrizi Complete Enrollment and Prescription Form to **1.678.727.0690**
- Enroll your patients directly on **CompletePro.com**
- Call **1.866.SKYRIZI** (1.866.759.7494) to enroll patients by phone

Give the **Skyrizi Complete Getting Started Checklist** to your patients

The SKYRIZI Express Start program* provides newly prescribed, commercially insured patients with a clinical urgent need to begin treatment the first month of SKYRIZI induction therapy at no cost

Eligible patients can get started in as little as 1 day with an On-Body Injector (OBI), depending on the prescribed indication, or in 5 days for IV treatment.†

1. **Eligible patients* must be:**
   - New, commercially insured adults (between the ages of 18 and 63)
   - Prescribed SKYRIZI for an approved indication
   - Identified by their provider as having an urgent clinical need to begin treatment quickly
2. Check the **SKYRIZI Express Start checkbox** in Section 4 of the **Skyrizi Complete Enrollment and Prescription Form** when you fill it out
3. Fax the completed form to **1.678.727.0690**; Skyrizi Complete will fax confirmation that your patient is enrolled
4. **For Infusion patients** - fax the participating **infusion center** an order for the SKYRIZI IV induction dose. Amerita and Option Care Health are participating in the SKYRIZI Express Start Program. **If approved, a single SKYRIZI IV induction dose for your patient will be shipped directly to the participating infusion center at no cost***

QUESTIONS? CALL SKYRIZI COMPLETE

1.866.SKYRIZI (1.866.759.7494)

*Please see abridged **SKYRIZI Express Start Terms and Conditions** on page 2.

†**Timing dependent on patient answering a confirmatory phone call from Pharmacy Solutions,** the AbbVie-authorized pharmacy administering the SKYRIZI Express Start program.

‡Please see abridged **SKYRIZI Complete Savings Card Terms and Conditions** on page 2.

Please see Indications and Important Safety Information on page 2.
Please see full Prescribing Information, or visit https://www.rxabbvie.com/pdf/skyrizi_pi.pdf.

US-SKZG-260382

Skyrizi®
risankizumab-rzaa

INDICATIONS AND IMPORTANT SAFETY INFORMATION
ABOUT SKYRIZI® (risankizumab-rzaa)[1] FOR HEALTHCARE PROFESSIONALS

SKYRIZI INDICATIONS[1]

Crohn's Disease: SKYRIZI is indicated for the treatment of moderately to severely active Crohn's disease in adults.
Ulcerative Colitis: SKYRIZI is indicated for the treatment of moderately to severely active ulcerative colitis in adults.

IMPORTANT SAFETY INFORMATION[1]

Hypersensitivity Reactions

SKYRIZI® (risankizumab-rzaa) is contraindicated in patients with a history of serious hypersensitivity reaction to risankizumab-rzaa or any of the excipients. Serious hypersensitivity reactions, including anaphylaxis, have been reported with the use of SKYRIZI. If a serious hypersensitivity reaction occurs, discontinue SKYRIZI and initiate appropriate therapy immediately.

Infection

SKYRIZI may increase the risk of infection. Do not initiate treatment with SKYRIZI in patients with a clinically important active infection until it resolves or is adequately treated.

In patients with a chronic infection or a history of recurrent infection, consider the risks and benefits prior to prescribing SKYRIZI. Instruct patients to seek medical advice if signs or symptoms of clinically important infection occur. If a patient develops such an infection or is not responding to standard therapy, closely monitor and discontinue SKYRIZI until the infection resolves.

Tuberculosis (TB)

Consider evaluating patients for TB infection prior to initiating treatment with SKYRIZI based on clinical judgement. Consider anti-TB therapy prior to initiating SKYRIZI in patients with a past history of latent or active TB in whom an adequate course of treatment cannot be confirmed. Monitor patients for signs and symptoms of active TB during and after SKYRIZI treatment. Avoid administering SKYRIZI to patients with active TB.

Hepatotoxicity

Drug-induced liver injury was reported in a patient with Crohn's disease who was hospitalized for a rash during induction dosing of SKYRIZI. For the treatment of Crohn's disease and ulcerative colitis, evaluate liver enzymes and bilirubin at baseline and during induction (12 weeks); monitor thereafter according to routine patient management. Consider an alternate treatment for patients with evidence of liver cirrhosis. Interrupt treatment if drug-induced liver injury is suspected, until this diagnosis is excluded. Instruct your patient to seek immediate medical attention if they experience symptoms suggestive of hepatic dysfunction.

Immunizations

Avoid use of live vaccines in patients treated with SKYRIZI. Drugs that interact with the immune system may increase the risk of infection following administration of live vaccines. Prior to initiating SKYRIZI, complete all age-appropriate vaccinations according to current immunization guidelines.

Adverse Reactions

Most common (>3%) adverse reactions associated with SKYRIZI in Crohn's disease are upper respiratory infections, headache, and arthralgia in induction, and arthralgia, abdominal pain, injection site reactions, anemia, pyrexia, back pain, arthropathy, and urinary tract infection in maintenance.

Most common (≥3%) adverse reactions associated with SKYRIZI in ulcerative colitis are arthralgia in induction, and arthralgia, pyrexia, injection site reactions, and rash in maintenance.

Lipid Elevations: Increases from baseline and increases relative to placebo were observed at Week 4 and remained stable to Week 12 in patients treated with SKYRIZI in Crohn's disease. Lipid elevations observed in patients with ulcerative colitis were similar to those in Crohn's disease.

Dosage Forms and Strengths: SKYRIZI (risankizumab-rzaa) is available in a 600 mg/10 mL single-dose vial for intravenous infusion and a 180 mg/1.2 mL or 360 mg/2.4 mL single-dose prefilled cartridge with on-body injector.

Reference: 1. SKYRIZI [package insert]. North Chicago, IL: AbbVie Inc.

SKYRIZI Express Start Program Terms and Conditions

One-time offer for new SKYRIZI® patients in the U.S. with commercial insurance and a valid prescription. Program not available to patients receiving prescription reimbursement under Medicare, Medicaid, or any other government healthcare program. Program solely intended to allow patients not currently taking SKYRIZI to access their prescribed treatment quickly due to urgent clinical need. There is no obligation to continue use of SKYRIZI after program concludes. Program does not guarantee insurance coverage. Additional limitations apply. **See full SKYRIZI Express Start Program Terms and Conditions at www.SkyriziExpressStart.com.**

SKYRIZI Savings Card Terms and Conditions

Eligibility: Available to patients with commercial insurance coverage for SKYRIZI® (risankizumab-rzaa) who meet eligibility criteria. This co-pay assistance program is not available to patients receiving prescription reimbursement under any federal, state, or government-funded insurance programs (for example, Medicare [including Part D], Medicare Advantage, Medigap, Medicaid, TRICARE, Department of Defense, or Veterans Affairs programs) or where prohibited by law. Offer subject to change or termination without notice. Restrictions, including monthly maximums, may apply. This is not health insurance.
For full Terms and Conditions, visit www.skyrizi.com/savings-card-terms or call 1.866.SKYRIZI for additional information. To learn about AbbVie's privacy practices and your privacy choices, visit https://abbv.ie/corpprivacy.

Please see full Prescribing Information, or visit https://www.rxabbvie.com/pdf/skyrizi_pi.pdf.

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US-SKZG-260382

Skyrizi®
risankizumab-rzaa

Skyrizi® COMPLETE

SGM-083126-A05

ENROLLMENT AND PRESCRIPTION FORM

Fax to Skyrizi Complete **1.678.727.0690** | Questions? Call **1.866.759.7494**

Skyrizi® risankizumab-rzaa

To enroll, fill out sections 1-4 and fax to Skyrizi Complete. Required fields are marked with an asterisk (*).

1. PATIENT INFORMATION

Privacy Notice: For information on how we collect and process your personal data, including the categories we collect, purposes for their collection, and disclosures to third parties, visit **https://abbv.ie/PrivacyPatient**.
Consent to process my sensitive personal information: Through my submission of the Skyrizi Complete Enrollment and Prescription form, I consent to the collection, use, and disclosure of my personal health data, as described in the Privacy Notice above and in AbbVie's Privacy Notice in the **"How We May Disclose Personal Data"** section. My consent is required to process sensitive personal data under certain privacy laws, and I have the right to withdraw my consent by visiting **"Your Privacy Choices"** on AbbVie's website.
By enrolling, you may receive your own Ambassador provided by AbbVie. Ambassadors do not work under the direction of your health care professional (HCP) or give medical advice. They are trained to direct patients to their HCP for treatment-related advice, including further referrals.

*First Name:	*Last Name:	*Date of Birth (MM/DD/YYYY): ____ /____ /_____

*Street Address:	City:	State:	*ZIP Code:

*Primary Phone:	Mobile Phone (if different):	*Email Address:

Sex (Assigned at Birth): ☐ Male ☐ Female	☐ Spanish interpreter needed

TB Test (Date): _____ /_____ /_____ ☐ Pos ☐ Neg	Prior Therapies:	Last Treatment Date: _____ /_____ /_____

Last Completed Treatment: Infusion Induction: ☐ 1 ☐ 2 ☐ 3 On-Body Injector (OBI) Induction (CD Only): ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ OBI Maintenance ☐ Not Yet Started

2. INSURANCE INFORMATION – Fill out below OR attach front and back copies of patient's medical and pharmacy insurance card(s)

☐ Copies (front and back) of the patient's medical and pharmacy insurance card(s) attached

*Primary Medical Insurance:	*Policy #:	*Group #:
*Primary Prescription Insurance:	*PCN #:	*Group RX #:
*RxID #:	*RxBIN #:	

3. PRESCRIBER INFORMATION

*Prescriber's First Name:	*Prescriber's Last Name:	*NPI #:	
*Office Phone:	*Office Fax:	Office Contact Name:	Office Email Address:

*Street Address:	City:	State:	*ZIP Code:

4. PRESCRIPTION INFORMATION – Fill out and sign corresponding prescription(s) below

☐ **SKYRIZI Express Start:** Yes, opt my newly prescribed, commercially insured patient with a clinical urgent need to begin treatment into receiving their first month of SKYRIZI induction therapy in as little as 1 day (OBI) or 5 days (IV infusion). **Please see abridged SKYRIZI Express Start Program Terms and Conditions on page 4.**

☐ ***Diagnosis: Crohn's Disease (CD)** ICD 10:	☐ ***Diagnosis: Ulcerative Colitis (UC)** ICD 10:
*CD Induction (Choose One): ☐ Intravenous (IV) ☐ On-Body Injector (OBI)	*UC Induction: ☐ Intravenous (IV)

INDUCTION THERAPY†	Directions	Quantity	Refills
SKYRIZI prefilled cartridge with SKYRIZI On-Body Injector			
☐ For CD SC Induction SC = subcutaneous	Inject 720 mg subcutaneously (given as two consecutive injections of 360 mg/2.4 mL each) at Weeks 0 and 2	2 Induction Packs	0
	Inject 720 mg subcutaneously (given as two consecutive injections of 360 mg/2.4 mL each) at Weeks 4 and 8	1 Induction Pack	1
SKYRIZI 600 mg/10 mL single-use vial			
☐ For CD Infusion	600 mg to be administered via intravenous infusion at Weeks 0, 4, and 8	1 vial	2
☐ For UC Infusion	1200 mg to be administered via intravenous infusion at Weeks 0, 4, and 8	2 vials	2
MAINTENANCE THERAPY‡	**Directions**	**Quantity**	**Refills**
SKYRIZI prefilled cartridge with SKYRIZI On-Body Injector			
For UC or CD: Select ONE ongoing therapy strength	☐ Inject 180 mg/1.2 mL subcutaneously every 8 Weeks	1 device with prefilled cartridge	
	☐ Inject 360 mg/2.4 mL subcutaneously every 8 Weeks		

†For the treatment of moderate to severe CD and moderate to severe UC, evaluate liver enzymes and bilirubin at baseline, and during induction at least up to 12 weeks of treatment, and consider evaluating patients for TB infection prior to initiating treatment with SKYRIZI based on clinical judgement. ‡The recommended maintenance dosage of SKYRIZI is 180 mg or 360 mg. Use the lowest effective dosage needed to maintain therapeutic response.

Skyrizi Complete Bridge Prescription

Required in the event a commercially insured patient with a valid Rx for SKYRIZI experiences an **insurance denial or delay** in coverage determination due to submission under medical benefit or appeal. Continued eligibility requires documentation of ongoing pursuit of coverage. See full SKYRIZI Complete Bridge Program Eligibility Criteria on page 4. Please complete the full form as well as this section and sign below. Prescription to be filled through an AbbVie-authorized pharmacy. By signing below, I understand that faxing this form to SKYRIZI Complete will result in the transmission of an original copy to the AbbVie-authorized pharmacy for dispensing.

PRESCRIBER CERTIFICATION: I certify that the above therapy is medically necessary and that the information provided is accurate to the best of my knowledge. I certify that I am the prescriber who has prescribed SKYRIZI to the previously identified patient and that I provided the patient with a description of the Skyrizi Complete patient support program. I authorize Skyrizi Complete to act on my behalf for the purposes of transmitting this prescription to the appropriate pharmacy. I understand that the no charge resource through Skyrizi Complete may support patients who are experiencing a delay in insurance coverage for SKYRIZI until coverage is obtained, and I confirm that I will support the above-identified patient in seeking to secure such coverage as I deem appropriate. I certify that I will not seek reimbursement from any third-party payor for any no charge product dispensed by an AbbVie-authorized pharmacy.

Prescriber's Signature (REQUIRED): _____ **Date (MM/DD/YYYY):** ____/____/_____

☐ May not substitute/Dispense as written

Pharmacy Prescription (Optional) – Rx will be forwarded to pharmacy listed below, or appropriate pharmacy if blank.

Patient's Preferred Specialty Pharmacy:

PRESCRIBER CERTIFICATION: I certify that the above therapy is medically necessary and that the information provided is accurate to the best of my knowledge. I certify that I am the prescriber who has prescribed SKYRIZI to the previously identified patient and that I provided the patient with a description of the Skyrizi Complete patient support program. I authorize Skyrizi Complete to act on my behalf for the purposes of transmitting this prescription to the appropriate pharmacy designated by the patient utilizing their benefit plan (if applicable).

Prescriber's Signature (REQUIRED): _____ **Date (MM/DD/YYYY):** ____/____/_____

☐ May not substitute/Dispense as written

PRESCRIBER PRIVACY NOTICE: For information on how we collect and process your personal data, including the categories we collect, purposes for their collection, and disclosure to third parties, visit https://abbv.ie/PrivacyHCP.

Skyrizi® COMPLETE

SGM-083126-A05

ENROLLMENT AND PRESCRIPTION FORM

Fax to Skyrizi Complete **1.678.727.0690** | Questions? Call **1.866.759.7494**

Skyrizi® risankizumab-rzaa

PATIENT INFORMATION – Carry over from page 1

*Patient First Name:	*Patient Last Name:	*Date of Birth (MM/DD/YY): ___/___/_____

5. INFUSION PROVIDER INFORMATION ONLY – Only to be filled out for UC/CD patients starting with infusion

SITE OF INFUSION INFORMATION

☐ Prescriber's Office (if checked, enter the Tax ID only and proceed to the next section)	☐ Non-prescribing MD's Office	☐ Hospital Outpatient
☐ Infusion Center	☐ Other:	

Practice/Facility Name:	Site of Infusion NPI #:	Tax ID:
Phone:	*Fax:	

Street Address:	City:	State:	ZIP Code:

6. NEWS AND UPDATES CONSENT

MARKETING CONSENT (OPTIONAL)

☐	I consent to the collection, use, and disclosure of my health-related personal data to receive communications from AbbVie regarding its products, programs, services, clinical trials, research opportunities and for online targeted advertising, as further described in the "**How we may use Personal Data**," "**How we disclose Personal Data**," and "**Cookies and similar tracking and data collection technologies**" sections of our **Privacy Notice**. My consent is required to process sensitive personal data under certain privacy laws, and I have the right to withdraw my consent by visiting "**Your Privacy Choices**" on AbbVie's website.

SMS PATIENT CONSENT (OPTIONAL)

☐	I consent to receive automated and recurring text messages from Complete Treatment Support program, including service updates, medication reminders and marketing messages, to the provided mobile number listed on front page of enrollment form. Message and data rates may apply. I am not required to consent as a condition of receiving goods or services. I can text HELP to 29279 for help, or call 1-866-759-7494. I can text STOP to 29279 to unsubscribe at any time. **View full Terms and Conditions**.

INDICATIONS[1]

Crohn's Disease: SKYRIZI is indicated for the treatment of moderately to severely active Crohn's disease in adults.
Ulcerative Colitis: SKYRIZI is indicated for the treatment of moderately to severely active ulcerative colitis in adults.

SAFETY CONSIDERATIONS[1]

SKYRIZI is contraindicated in patients with a history of serious hypersensitivity reaction to risankizumab-rzaa or any of its excipients. Serious hypersensitivity reactions, including anaphylaxis, have been reported with use of SKYRIZI. If a serious hypersensitivity reaction occurs, discontinue SKYRIZI and initiate appropriate therapy immediately. SKYRIZI may increase the risk of infection. Instruct patients to report signs or symptoms of clinically important infection during treatment. Should such an infection occur, discontinue SKYRIZI until infection resolves. Consider evaluating patients for tuberculosis infection prior to initiating treatment with SKYRIZI based on clinical judgement. Drug-induced liver injury was reported in a patient with Crohn's disease during induction dosing of SKYRIZI. For the treatment of Crohn's disease and ulcerative colitis, evaluate liver enzymes and bilirubin at baseline and during induction (12 weeks). Interrupt treatment with SKYRIZI if drug-induced liver injury is suspected, until this diagnosis is excluded. Avoid use of live vaccines in SKYRIZI patients.

SKYRIZI BRIDGE Terms and Conditions

SKYRIZI® Bridge Program Eligibility Criteria: Available to patients in the U.S., including Puerto Rico, aged 63 or younger with commercial insurance coverage and a valid prescription for SKYRIZI® (risankizumab-rzaa) for an FDA-approved indication, including confirmation that established clinical criteria have been met, as well as a denial of insurance coverage based on an initial coverage determination request on file (i.e., prior authorization or formulary exception request) and confirmation of the submission of an appeal of coverage denial. For medical benefit coverage, patients experiencing a delay of more than five (5) business days in resolution of an initial coverage determination request are eligible for this program. Continued eligibility for the program requires pursuit of coverage and confirmation of the submission of an appeal of coverage denial every 180 days. The program provides SKYRIZI at no charge to patients for up to three (3) years or until the patient receives insurance coverage approval, whichever occurs first, and is not contingent upon purchase requirements of any kind. The program is not available to patients receiving prescription reimbursement in whole or in part under Medicare, Medicaid, TRICARE, or any other federal-, state-, or government-funded healthcare programs. Offer subject to change or discontinuation without notice. This offer is not health insurance and participation in the program does not guarantee insurance coverage. No claims for payment may be submitted to any third party for product dispensed through the program. Additional limitations may apply.

SKYRIZI EXPRESS START Program Terms and Conditions

One-time offer. Not available to patients receiving prescription reimbursement under Medicare, Medicaid, or any other government healthcare program. Program solely intended to allow patients not currently taking SKYRIZI to access their prescribed treatment quickly due to urgent clinical need. No obligation to continue use after program concludes. Program does not guarantee insurance coverage. Additional limitations apply. **See full SKYRIZI Express Start Program Terms and Conditions at www.SkyriziExpressStart.com.**

Skyrizi® COMPLETE

SKYRIZI GETTING STARTED CHECKLIST

Now that you've been prescribed SKYRIZI, and enrolled into Skyrizi Complete, you have access to educational resources, potential savings options, and support from Skyrizi Complete. Use this checklist to help you start and stay on track with your prescribed treatment plan. Download the Complete App today.

1 GET INSURANCE SUPPORT AND SAVINGS OPTIONS

A Skyrizi Complete Ambassador* will call you to help you navigate your health insurance coverage and find ways you may be able to save. Savings may be available, for eligible commercially insured patients, on SKYRIZI infusions, infusion administration costs, SKYRIZI On-Body Injector (OBI), and required lab testing for eligible patients.†

- ☐ It's important to connect with an Ambassador to review coverage when they call within one business day of your enrollment. Or you can reach out to an Ambassador at **1.866.SKYRIZI** (1.866.759.7494)‡
- ☐ Find out about your savings options at **SKYRIZISavings.com**. You may be eligible to get SKYRIZI for as little as $0† per treatment.

2 GET READY FOR YOUR STARTER DOSES

Starting with Intravenous (IV) Infusion

For patients with either moderate to severe Crohn's disease (CD) or moderate to severe ulcerative colitis (UC)

You'll receive 3 infusions (1 every 4 weeks) administered by a healthcare provider



Review these resources and tips:

- ☐ Watch the Understanding Infusions Video at **InfusionPrepSKYRIZI.com**
- ☐ Review the Infusion Prep Guide, available at **SKYRIZIresources.com**
- ☐ Talk to your healthcare provider about lab tests before, during, and at least up to 12 weeks of treatment with SKYRIZI

Date of first IV starter dose: ____/____/____

Infusion center contact info: _____

OR

Starting with the On-Body Injector (OBI)

Only for patients with moderate to severe Crohn's disease (CD)

You'll self-administer each starter dose at home (2 injections per dose) at Weeks 0, 2, 4, and 8 after being trained by your healthcare provider



Review these resources and tips:

- ☐ Review information on starting with the OBI at **SKYRIZI.com/OBI**
- ☐ Watch the OBI Training Video at **InjectingSKYRIZI.com**
- ☐ Talk to your healthcare provider about lab tests before, during, and at least up to 12 weeks of treatment with SKYRIZI
- ☐ Reach out to your healthcare provider or a Skyrizi Complete Ambassador for additional training on using the OBI

Date of first OBI starter dose: ____/____/____

Specialty Pharmacy contact info: _____

3 GET READY FOR OBI MAINTENANCE DOSES

Both CD and UC patients will self-administer maintenance doses at home with the OBI. Before you continue your treatment at home with the OBI, you should receive an initial training on how to use it from your healthcare provider. You can also ask an Ambassador if in-person or virtual supplemental injection training is available.

- ☐ **Watch the OBI Training Video** at **InjectingSKYRIZI.com**
- ☐ **Talk to an Ambassador** about resources or get additional information at **SkyriziComplete.com**
- ☐ **Call your Specialty Pharmacy** to arrange delivery of your OBI 2 weeks before the date of your first injection at home

Date of first OBI maintenance dose: ____/____/____ Specialty Pharmacy contact info: _____

SKYRIZI USES

SKYRIZI is a prescription medicine used to treat adults with:

• moderately to severely active Crohn's disease. • moderately to severely active ulcerative colitis.

SAFETY CONSIDERATIONS

Do not use if you are allergic to SKYRIZI. SKYRIZI may cause serious side effects, including serious allergic reactions, an increased risk of infections, and liver problems. Stop using SKYRIZI and get emergency medical help right away if experiencing symptoms of a serious allergic reaction. Before starting treatment, your doctor may check for infections and tuberculosis. Tell your doctor right away about any infections or symptoms of infection and about planned or recent vaccines. Liver problems may happen while being treated for Crohn's disease or ulcerative colitis that can lead to hospitalization. Your doctor will do liver blood tests before and during treatment and may stop SKYRIZI if liver problems develop.

*Ambassadors are provided by AbbVie and do not work under the direction of your health care professional (HCP) or give medical advice. They are trained to direct patients to their HCP for treatment-related advice, including further referrals.

†For eligible, commercially insured patients only. See abridged **SKYRIZI Complete Savings Card Terms and Conditions** on page 6. If eligible, you'll receive your Savings Card in the mail. Call a Skyrizi Complete Ambassador if you do not receive your card.

‡Help is available Monday through Friday, from 8:00 AM to 8:00 PM ET, except for holidays.

Please see additional Important Safety Information on page 6.

Please see full Prescribing Information, including Medication Guide, or visit https://www.rxabbvie.com/pdf/skyrizi_pi.pdf, and discuss with your doctor.

US-SKZG-260382

Skyrizi® risankizumab-rzaa

USES AND IMPORTANT SAFETY INFORMATION
ABOUT SKYRIZI® (risankizumab-rzaa) FOR PATIENTS

SKYRIZI USES

SKYRIZI is a prescription medicine used to treat adults with:

- moderately to severely active Crohn's disease.
- moderately to severely active ulcerative colitis.

IMPORTANT SAFETY INFORMATION

What is the most important information I should know about SKYRIZI® (risankizumab-rzaa)?

SKYRIZI is a prescription medicine that may cause serious side effects, including:

Serious allergic reactions:

- Stop using SKYRIZI and get emergency medical help right away if you get any of the following symptoms of a serious allergic reaction:
  - fainting, dizziness, feeling lightheaded (low blood pressure)
  - swelling of your face, eyelids, lips, mouth, tongue, or throat
  - trouble breathing or throat tightness
  - chest tightness
  - skin rash, hives
  - itching

Infections:

SKYRIZI may lower the ability of your immune system to fight infections and may increase your risk of infections. Your healthcare provider may check you for infections and tuberculosis (TB) before starting treatment with SKYRIZI and may treat you for TB before you begin treatment with SKYRIZI if you have a history of TB or have active TB. Your healthcare provider should watch you closely for signs and symptoms of TB during and after treatment with SKYRIZI.

- Tell your healthcare provider right away if you have an infection or have symptoms of an infection, including:
  - fever, sweats, or chills
  - cough
  - shortness of breath
  - blood in your mucus (phlegm)
  - muscle aches
  - warm, red, or painful skin or sores on your body different from your psoriasis
  - weight loss
  - diarrhea or stomach pain
  - burning when you urinate or urinating more often than normal

Do not use SKYRIZI if you are allergic to risankizumab-rzaa or any of the ingredients in SKYRIZI. See the Medication Guide or Consumer Brief Summary for a complete list of ingredients.

Before using SKYRIZI, tell your healthcare provider about all of your medical conditions, including if you:

- have any of the conditions or symptoms listed in the section **"What is the most important information I should know about SKYRIZI?"**
- have an infection that does not go away or that keeps coming back.
- have TB or have been in close contact with someone with TB.
- have recently received or are scheduled to receive an immunization (vaccine). Medicines that interact with the immune system may increase your risk of getting an infection after receiving live vaccines. You should avoid receiving live vaccines right before, during, or right after treatment with SKYRIZI. Tell your healthcare provider that you are taking SKYRIZI before receiving a vaccine.
- are pregnant or plan to become pregnant. It is not known if SKYRIZI can harm your unborn baby.
- are breastfeeding or plan to breastfeed. It is not known if SKYRIZI passes into your breast milk.
- become pregnant while taking SKYRIZI. You are encouraged to enroll in the Pregnancy Registry, which is used to collect information about the health of you and your baby. Talk to your healthcare provider or call 1-877-302-2161 or visit https://glowpregnancyregistry.com to enroll in this registry.

Tell your healthcare provider about all the medicines you take, including prescription and over-the-counter medicines, vitamins, and herbal supplements.

What are the possible side effects of SKYRIZI?

SKYRIZI may cause serious side effects. See "What is the most important information I should know about SKYRIZI?"

Liver problems may happen while being treated for Crohn's disease or ulcerative colitis: A person with Crohn's disease who received SKYRIZI through a vein in the arm developed changes in liver blood tests with a rash that led to hospitalization. Your healthcare provider will do blood tests to check your liver before, during, and at least up to 12 weeks of treatment, and may stop treatment with SKYRIZI if you develop liver problems. Tell your healthcare provider right away if you notice any of the following symptoms: unexplained rash, nausea, vomiting, stomach (abdominal) pain, tiredness (fatigue), loss of appetite, yellowing of the skin and eyes (jaundice), and dark urine.

The most common side effects of SKYRIZI in people treated for Crohn's disease and ulcerative colitis include: upper respiratory infections, headache, joint pain, stomach (abdominal) pain, injection site reactions, low red blood cells (anemia), fever, back pain, urinary tract infection, and rash.

These are not all the possible side effects of SKYRIZI. Call your doctor for medical advice about side effects.

Use SKYRIZI exactly as your healthcare provider tells you to use it.

Dosage forms: SKYRIZI (risankizumab-rzaa) is available in a 600 mg/10 mL vial for intravenous infusion and a 180 mg/1.2 mL or 360 mg/2.4 mL single-dose prefilled cartridge with on-body injector.

You are encouraged to report negative side effects of prescription drugs to the FDA. Visit www.fda.gov/medwatch or call 1-800-FDA-1088.

If you are having difficulty paying for your medicine, AbbVie may be able to help. Visit AbbVie.com/PatientAccessSupport to learn more.

SKYRIZI COMPLETE SAVINGS CARD TERMS & CONDITIONS

Eligibility: Available to patients with commercial insurance coverage for SKYRIZI® (risankizumab-rzaa) who meet eligibility criteria. This co-pay assistance program is not available to patients receiving prescription reimbursement under any federal, state, or government-funded insurance programs (for example, Medicare [including Part D], Medicare Advantage, Medigap, Medicaid, TRICARE, Department of Defense, or Veterans Affairs programs) or where prohibited by law. Offer subject to change or termination without notice. Restrictions, including monthly maximums, may apply. This is not health insurance. **For full Terms and Conditions, visit www.skyrizi.com/savings-card-terms or call 1.866.SKYRIZI for additional information. To learn about AbbVie's privacy practices and your privacy choices, visit https://abbv.ie/corpprivacy.**

Please see full Prescribing Information, including Medication Guide, or visit https://www.rxabbvie.com/pdf/skyrizi_pi.pdf, and discuss with your doctor.

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