HADLIMA®
(adalimumab-bwwd)
injection, 40 mg/0.4 mL, 40 mg/0.8 mL

Please read the Medication Guide for HADLIMA, including the information about serious infections and cancers, and discuss it with your doctor. The Instructions for Use and Physician Prescribing Information also are available.

ORGANON Helps

ORGANON PATIENT ASSISTANCE PROGRAM

Please fax or mail the completed, signed, and dated enrollment form to:
FAX: 1-866-806-0775 • **MAIL:** Organon Patient Assistance Program, PO Box 2355, Morristown, NJ 07962
For any questions, please call 1-866-809-9515

PATIENT MUST COMPLETE PAGES 1, 3, 4, 5 AND SIGN IN ALL PLACES WITH A SIGN HERE | **USE A BLACK OR BLUE PEN**

Section 1: Patient and Insurance Information

Patient Information

Patient's First Name: _____ Patient's Last Name: _____

US Resident* ☐ Yes ☐ No **You do not have to be a US citizen to participate.* Patient's Gender: _____

Address Line 1: _____

Address Line 2 (Apartment/Unit Number): _____

City: _____ State: _____ Zip: _____

Date of Birth: _____/_____/_____ ☐ I am enrolling for the first time ☐ I am re-enrolling

Provide an email address and a mobile phone number so we may contact you with program notifications and updates

Mobile Phone: _____ Home Phone: _____

Email: _____

I would like my product shipped to: ☐ My Home ☐ My Physician's Office

☐ Other Address: _____

Special delivery instructions: _____

Section 1: Patient and Insurance Information continues on page 3.

What is HADLIMA?

HADLIMA is a prescription medicine used:

- **To reduce the signs and symptoms of:**
  - **Moderate to severe rheumatoid arthritis (RA) in adults.** HADLIMA can be used alone, with methotrexate, or with certain other medicines.
  - **Moderate to severe polyarticular juvenile idiopathic arthritis (JIA) in children** 2 years of age and older. HADLIMA can be used alone or with methotrexate.
  - **Psoriatic arthritis (PsA) in adults.** HADLIMA can be used alone or with certain other medicines.
  - **Ankylosing spondylitis (AS) in adults.**
  - **Moderate to severe hidradenitis suppurativa (HS) in adults.**
- **To treat moderate to severe Crohn's disease (CD) in adults and children 6 years of age and older.**
- **To treat moderate to severe ulcerative colitis (UC) in adults.** It is not known if adalimumab products are effective in people who stopped responding to or could not tolerate tumor necrosis factor (TNF) blocker medicines.
- **To treat moderate to severe chronic (lasting a long time) plaque psoriasis (Ps) in adults** who have the condition in many areas of their body and who may benefit from taking injections or pills (systemic therapy) or phototherapy (treatment using ultraviolet light alone or with pills).
- **To treat non-infectious intermediate** (middle part of the eye), **posterior** (back of the eye), and **panuveitis** (all parts of the eye) **in adults**.

IMPORTANT SAFETY INFORMATION

What is the most important information I should know about HADLIMA?

You should discuss the potential benefits and risks of HADLIMA with your doctor. HADLIMA is a tumor necrosis factor (TNF) blocker medicine that can lower the ability of your immune system to fight infections. You should not start taking HADLIMA if you have any kind of infection unless your doctor says it is okay.

Serious infections have happened in people taking adalimumab products. These serious infections include tuberculosis (TB) and infections caused by viruses, fungi, or bacteria that have spread throughout the body. Some people have died from these infections. Your doctor should test you for TB before starting HADLIMA, and check you closely for signs and symptoms of TB during treatment with HADLIMA, even if your TB test was negative. If your doctor feels you are at risk, you may be treated with medicine for TB.

Cancer. For children and adults taking TNF blockers, including HADLIMA, the chance of getting lymphoma or other cancers may increase. There have been cases of unusual cancers in children, teenagers, and young adults using TNF blockers. Some people have developed a rare type of cancer called hepatosplenic T-cell lymphoma. This type of cancer often results in death. If using TNF blockers, including HADLIMA, your chance of getting 2 types of skin cancer (basal cell and squamous cell) may increase. These types are generally not life threatening if treated; tell your doctor if you have a bump or open sore that does not heal.

What should I tell my doctor BEFORE starting HADLIMA?

Tell your doctor about all of your health conditions, including if you:

- Have an infection, are being treated for infection, or have symptoms of an infection.
- Get a lot of infections or infections that keep coming back.
- Have diabetes.
- Have TB or have been in close contact with someone with TB, or were born in, lived in, or traveled where there is more risk for getting TB.
- Live or have lived in an area (such as the Ohio and Mississippi River valleys) where there is an increased risk for getting certain kinds of fungal infections, such as histoplasmosis, coccidioidomycosis, or blastomycosis. These infections may happen or become more severe if you use HADLIMA. Ask your doctor if you are unsure if you have lived in these areas.
- Have or have had hepatitis B.
- Are scheduled for major surgery.
- Have or have had cancer.
- Have numbness or tingling or a nervous system disease, such as multiple sclerosis or Guillain-Barré syndrome.
- Have or had heart failure.
- Have recently received or are scheduled to receive a vaccine. HADLIMA patients may receive vaccines, except for live vaccines. Children should be brought up to date on all vaccines before starting HADLIMA.
- Are allergic to HADLIMA or any of its ingredients.
- Are pregnant, planning to become pregnant, breastfeeding, or planning to breastfeed.
- Have a baby and were using HADLIMA during your pregnancy. Tell your baby's doctor before your baby receives any vaccines.

Also tell your doctor about all the medicines you take. You should not take HADLIMA with ORENCIA® (abatacept), KINERET® (anakinra), REMICADE® (infliximab), ENBREL® (etanercept), CIMZIA® (certolizumab pegol), or SIMPONI® (golimumab). Tell your doctor if you have ever used RITUXAN® (rituximab), IMURAN® (azathioprine), or PURINETHOL® (mercaptopurine, 6-MP).

What should I watch for after starting HADLIMA?

HADLIMA can cause serious side effects, including:

- **Serious infections.** These include TB and infections caused by viruses, fungi, or bacteria. Symptoms related to TB include a cough, low-grade fever, weight loss, or loss of body fat and muscle.
- **Hepatitis B infection in carriers of the virus.** Symptoms include muscle aches, feeling very tired, dark urine, skin or eyes that look yellow, little or no appetite, vomiting, clay-colored bowel movements, fever, chills, stomach discomfort, and skin rash.
- **Allergic reactions.** Symptoms of a serious allergic reaction include hives, trouble breathing, and swelling of your face, eyes, lips, or mouth.
- **Nervous system problems.** Signs and symptoms include numbness or tingling, problems with your vision, weakness in your arms or legs, and dizziness.
- **Blood problems** (decreased blood cells that help fight infections or stop bleeding). Symptoms include a fever that does not go away, bruising or bleeding very easily, or looking very pale.
- **Heart failure** (new or worsening). Symptoms include shortness of breath, swelling of your ankles or feet, and sudden weight gain.
- **Immune reactions including a lupus-like syndrome.** Symptoms include chest discomfort or pain that does not go away, shortness of breath, joint pain, or rash on your cheeks or arms that gets worse in the sun.
- **Liver problems.** Symptoms include feeling very tired, skin or eyes that look yellow, poor appetite or vomiting, and pain on the right side of your stomach (abdomen). These problems can lead to liver failure and death.
- **Psoriasis** (new or worsening). Symptoms include red scaly patches or raised bumps that are filled with pus.

Call your doctor or get medical care right away if you develop any of the above symptoms.

Common side effects of HADLIMA include injection site reactions (pain, redness, rash, swelling, itching, or bruising), upper respiratory infections (sinus infections), headaches, rash, and nausea. These are not all of the possible side effects with HADLIMA. Tell your doctor if you have any side effect that bothers you or that does not go away.

Remember, tell your doctor right away if you have an infection or symptoms of an infection, including:

- Fever, sweats, or chills
- Muscle aches
- Cough
- Shortness of breath
- Blood in phlegm
- Weight loss
- Warm, red, or painful skin or sores on your body
- Diarrhea or stomach pain
- Burning when you urinate
- Urinating more often than normal
- Feeling very tired

HADLIMA is given by injection under the skin.

This is the most important information to know about HADLIMA. For more information, talk to your health care provider.

Please read the Medication Guide for HADLIMA, including the information about serious infections and cancers, and discuss it with your doctor. The Instructions for Use and Physician Prescribing Information also are available.

HADLIMA®
(adalimumab-bwwd)
injection, 40 mg/0.4 mL, 40 mg/0.8 mL

Patient's First Name: _____ Patient's Last Name: _____

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Section 1 (continued): Patient and Insurance Information

Insurance Information

PLEASE COMPLETE ALL THAT APPLY AND **INCLUDE A FRONT AND BACK COPY OF INSURANCE CARD** FOR EACH TYPE OF INSURANCE

INSURANCE TYPE

☐ No Insurance ☐ Commercial/Private/Employer-Funded: _____

☐ Medicare ☐ Medicaid

PRESCRIPTION INSURANCE

Insurance Company: _____ Insurance Company Phone: _____

Policy ID #: _____ Group #: _____

BIN #: _____ PCN #: _____

MEDICAL INSURER (including Medicaid, Medicare, veterans benefits, and private insurers)

Insurance Company: _____ Insurance Company Phone: _____

Policy ID #: _____ Group #: _____

Policyholder Name: _____ Relationship: _____

Has your employer, insurance company, or another third party directed you to apply to the Organon Patient Assistance Program? ☐ Yes ☐ No

Patients with insurance plans or employers participating in or involved in any way with an alternate funding or similar program (including, but not limited to, patient advocacy programs, specialty networks, SHARx, Paydhealth, or Payer Matrix) requiring or encouraging patients to apply to a manufacturer's patient assistance program or otherwise pursue specialty drug prescription coverage through an alternate funding vendor as a condition of, requirement for, or prerequisite to coverage of relevant Organon products, or that otherwise denies, restricts, eliminates, delays, alters, or withholds any insurance benefits or coverage contingent upon application to, or denial of eligibility for, specialty drug prescription coverage through the alternate funding or similar program are not eligible for the Organon Patient Assistance Program.

Section 2: Authorization for Electronic Income Verification

I, the applicant named above, understand that I am providing "written instructions" to Organon under the Fair Credit Reporting Act authorizing Organon or its designated agent to obtain information from my credit profile to verify my annual income. I authorize Organon to obtain such information solely for the purpose of determining financial qualifications for the Organon Patient Assistance Program. I also agree to provide additional financial documentation in a timely manner to Organon to the extent it is necessary for determining my financial qualification for the Program, if so requested. I understand that I am entitled to a copy of this authorization upon request. This authorization shall be valid for three (3) years from the date of the signature on this form (unless a shorter period is prescribed by law). I understand that I may cancel this authorization at any time by mailing a letter requesting such cancellation to Organon at PO Box 2355, Morristown, NJ 07962. I understand that if I cancel my authorization, no new information will be collected from me; however, information collected prior to such cancellation may continue to be used or kept to fulfill the services described (if the patient is under 18 years of age or a legal guardian has been appointed, a legal representative should sign and print their name).

SIGN HERE **Patient's Original Signature** _____ **Date** M M D D Y Y Y Y

Legal Representative Signature _____ **Print Name** _____

Patient's First Name: _____ Patient's Last Name: _____

PATIENT MUST COMPLETE PAGES 1, 3, 4, 5 AND SIGN IN ALL PLACES WITH A SIGN HERE | **USE A BLACK OR BLUE PEN**

Section 3: Patient Authorization for Use/Disclosure of HIPAA Protected Health Information

By signing below, I authorize my physicians, pharmacists, and other health care providers ("Providers") and my health insurers ("Insurers") to disclose information about my medical condition and treatment, health insurance and policy number, and any other information provided in this enrollment form, as well as further information needed to process my enrollment (HIPAA "Protected Health Information" or "PHI"), to Organon Patient Assistance Program Inc., the sponsor of the Organon Patient Assistance Program ("Program"), and its agents, service providers, contractors, and representatives ("Organon"), so that Organon may operate the Program. This includes to: (i) verify my eligibility and enroll me in the Program for which I qualify; (ii) provide the services requested in this enrollment form, which may require the disclosure of my PHI by Organon to my Providers, Insurers, and Medicare; (iii) contact me via email, text message, telephone, or US postal mail and other communication channels I opt in to for Program-related purposes; (iv) ensure compliance with applicable laws and monitor, audit, and evaluate the Program's implementation and effectiveness; (v) use de-identified information for data analysis purposes; (vi) disclose my PHI to third parties relating to a corporate reorganization, merger, sale, joint venture, assignment, transfer, or other disposition of all or any portion of our business, assets, or stock, including regarding any bankruptcy or similar proceedings. I further authorize Organon to use and disclose my PHI for these Program purposes.

I understand that I do not need to sign this Authorization in order to receive health care treatment or insurance benefits, but that if I do not sign the Authorization, I will not be able to obtain assistance from the Program. I also understand that once PHI is disclosed to Organon pursuant to this authorization, it may no longer be protected by HIPAA.

I understand that I may cancel this Authorization at any time by calling 1-866-809-9515 or by mailing a written request to: The Organon Access Program, PO Box 2355, Morristown, NJ 07962. I understand that cancelling this Authorization will not invalidate uses and disclosures of my PHI made in reliance on the Authorization before Organon received notice of my cancellation. Unless canceled earlier, the Authorization will remain in effect for 3 years from the date of signature, or for the maximum period allowed by applicable state law, if less than 3 years. Organon will retain the information I have submitted in accordance with its records retention policy. I understand that I am entitled to receive a copy of this authorization once it has been signed.

I have read this authorization or have had it explained to me.

If the patient is under 18 years of age or a legal guardian has been appointed, a legal representative should sign and print their name.

SIGN HERE **Patient's Original Signature** _____ **Date** M M D D Y Y Y Y

Legal Representative Signature _____ **Print Name** _____

Patient's First Name: _____ Patient's Last Name: _____

PATIENT MUST COMPLETE PAGES 1, 3, 4, 5 AND SIGN IN ALL PLACES WITH A SIGN HERE | **USE A BLACK OR BLUE PEN**

Section 4: Consent to Collection and Use of Personal Information, Preferred Communications

By signing below, I consent to Organon's collection and use of my personal information, including information related to my health, for the Program purposes described above and to contact me via email, text message, telephone, or US postal mail for Program-related purposes. I understand that I can revoke this consent at any time, but doing so will mean that I will no longer be able to receive the Program services. Further information concerning Organon's collection and processing of personal information, including the rights of individuals with respect to such processing, is available at www.organon.com/privacy/.

☐ (Optional) By checking this box, I consent to receive Program-related texts, including communications which may be considered to be marketing, from and on behalf of the Organon Co-pay Assistance Program, made with an automatic text messaging system, at the cell phone number for me (the patient) provided on this form. I understand that I do not need to provide this consent in order to purchase any Organon products. I understand that text message and data rates may apply. Frequency may vary. Reply STOP to cancel, HELP for help. Terms and Conditions and Privacy Policy apply. To view the Privacy Policy, go to: www.organon.com/privacy/. See Terms and Conditions for the SMS Terms.

Mobile Phone #: _____

☐ (Optional) By checking this box, I consent to receive Program-related calls, including communications which may be considered to be marketing, from and on behalf of The Organon Access Program at the cell phone number for me (the patient) provided on this form. I understand that these calls may be autodialed and/or include prerecorded content or an artificial voice. I understand that I do not need to provide this consent in order to purchase any Organon products and that I can revoke this consent at any time by calling 1-866-809-9515 or by mailing a written request to: The Organon Access Program, PO Box 2355, Morristown, NJ 07962.

The Organon Access Program SMS (text) messages are recurring automated savings program messages, which include a digital savings card and refill reminder messages. These SMS messages are sent through PSKW, LLC, dba ConnectiveRx, a service provider partner operating on behalf of Organon, LLC ("Organon"). When you opt in to the service, we will send you an SMS message to confirm your sign-up. By providing your cell phone number, you represent that you are the authorized user of the wireless device you use to receive the messages and that you are authorized to approve any changes. Organon reserves the right to alter these Terms and Conditions or discontinue the messaging at any time and, at its sole discretion, may add or delete a cellular carrier from this program at any time, without notice. Text messages you receive as part of this program are automated, and your responses are not read by any person. Consent to receiving SMS messages is not a requirement to participate in The Organon Access Program, and you may opt out at any time. Please visit Organon's privacy policy at www.organon.com/privacy/ or contact us for additional information. Please visit the full Terms and Conditions regarding participation eligibility in The Organon Access Program. Message and data rates may apply. While we do not charge you for the messages, your mobile service provider may charge you for SMS messages as a part of your contract or service. Please contact your mobile service provider for details. Message frequency varies. To stop receiving messages, reply STOP at any time. For help, reply HELP or call 1-866-809-9515. We are able to deliver on most of the major and minor carriers, eg, Verizon, Sprint, AT&T, T-Mobile, and MetroPCS. If you are unsure whether your carrier supports short codes, please contact your wireless provider directly. Carriers are not liable for delayed or undelivered messages.

If the patient is under 18 years of age or a legal guardian has been appointed, a legal representative should sign and print their name.

SIGN HERE **Patient's Original Signature** _____ **Date** M M D D Y Y Y Y

Legal Representative Signature _____ **Print Name** _____

PHYSICIAN/PRESCRIBER MUST COMPLETE THIS PAGE AND SIGN IN ALL PLACES WITH A SIGN HERE | USE A BLACK OR BLUE PEN

Section 4: Prescription Information

THIS IS THE PRESCRIPTION. PLEASE DO NOT SUBMIT A PRESCRIPTION SEPARATE FROM THIS APPLICATION.

Patient's First Name: _____ Patient's Last Name: _____

Date of Birth: ____/____/_____ Weight: _____

Allergies: ☐ No Known ☐ Other: _____

Medical Conditions: ☐ No Known ☐ Other: _____

Current Medications: _____

HADLIMA® (adalimumab-bwwd) THERAPY OPTIONS:

Prefilled Autoinjector Pen (HADLIMA® PushTouch®)

☐ HADLIMA 40 mg/0.4 mL (high concentration, citrate-free)

☐ HADLIMA 40 mg/0.8 mL (low concentration, citrate-containing)

Prefilled Syringe

☐ HADLIMA 40 mg/0.4 mL (high concentration, citrate-free)

☐ HADLIMA 40 mg/0.8 mL (low concentration, citrate-containing)

Directions for Use _____

QUANTITY: ☐ 84-Day Supply (Program Standard) ☐ Other: _____ REFILLS: ☐ 1 year ☐ Other: _____

☐ Dispense as written

SIGN HERE **Physician/Prescriber's Original Signature** _____ **Date** M M D D Y Y Y Y

Section 5: Physician/Prescriber Information

Prescriber's First Name: _____ M.I.: _____

Prescriber's Last Name: _____ Professional Designation: _____

Physician/Prescriber NPI Number: _____

Name of Facility/Site: _____

Mailing Address (PO boxes not permitted): _____ Suite/Bldg/Floor: _____

City: _____ State: _____ Zip: _____

Office Phone: _____ Ext: _____ Secure Fax: _____

Office Contact Name: _____ Email Address: _____

Physician/Prescriber Attestation

I certify that this prescription is medically appropriate for this patient and that I will be supervising the patient's treatments. I verify that the information provided is complete and accurate to the best of my knowledge. I authorize the Organon Patient Assistance Program (Organon PAP), its affiliated companies, or its subcontractors to forward this prescription to a dispensing pharmacy on behalf of me and my patient. I understand that Organon PAP reserves the right to modify or discontinue this program at this facility/practice or terminate assistance at any time and without notice. I certify that I will not seek reimbursement or credit for this prescription from any insurer, health plan, or government program. I understand that Organon PAP reserves the right to conduct periodic audits and to request documentation to verify the information provided in this application as it relates to Organon PAP for purposes of determining eligibility of the patient.

SIGN HERE **Physician/Prescriber's Original Signature** _____ **Date** M M D D Y Y Y Y