ADULT PRESCRIPTION AND SERVICE REQUEST FORM
SIMLANDI® (adalimumab-ryvk) injection

teva | Shared Solutions® for Biosimilars

ENROLLMENT FORM
PLEASE FAX COMPLETED FORM TO **866-676-4073**
FOR QUESTIONS, CALL **888-587-3263**
MONDAY–FRIDAY 9AM EST TO 7PM EST

Requested Services: ☐ Benefits Verification ☐ Pharmacy Triage and Tracking ☐ Prior Authorization Support ☐ Commercial Copay Program ☐ Appeals Support ☐ Nurse Injection Training

1 PATIENT INFORMATION (PATIENT TO COMPLETE SECTIONS 1-3)

Patient Name (First MI Last):		DOB (mm/dd/yyyy):
Primary Phone: ☐ Cell ☐ Home	Other Phone: ☐ Cell ☐ Home	Gender: ☐ Male ☐ Female ☐ Other
Email:	Preferred Time of contact: ☐ Morning ☐ Afternoon	Preferred Language: ☐ English ☐ Spanish ☐ Other

May we leave a detailed voicemail on your personal cell phone about the status of your application, prescription, or shipments? ☐ Yes ☐ No

Is it okay to send text messages to your mobile device regarding the status of your application, prescription, or shipments? ☐ Yes ☐ No

By selecting Yes, I agree to receive text messages as allowed by this Form to the cell phone number provided. Message and data rates may apply.

Address:	City:	State:	ZIP:
Caregiver/Legal Rep Name (if applicable):	Contact Phone (if applicable):		

2 INSURANCE INFORMATION

☐ Private Commercial ☐ Medicare ☐ Medicaid ☐ VA ***PLEASE INCLUDE COPIES OF INSURANCE CARDS, FRONT AND BACK**

Primary Insurance Name:		Rx Insurance Name:	
Insurance ID #:	Group #:	Rx ID#:	Group #:
Primary Insurance Phone:		Rx Insurance Phone:	
Subscriber: ☐ Self ☐ Other – Name:		Date of Birth:	Relationship to Patient:
Secondary Insurance Name (if applicable):		Secondary Insurance ID# (if applicable):	
Secondary Insurance Phone:		Group #:	
Subscriber: ☐ Self ☐ Other – Name:		Date of Birth:	Relationship to Patient:

3 PATIENT OR PERSONAL REPRESENTATIVE SIGNATURE(S)

PATIENT AUTHORIZATION

I authorize my healthcare providers, pharmacies, and health plan(s) to disclose my personal health information on this form as well as information related to my medical condition, treatment, care management, prescriptions, and health insurance to Teva Pharmaceuticals, Inc. and its affiliates, contractors and agents, including their third party patient support program service provider (collectively "Teva") for the purposes described below.

I understand that the purpose of this Authorization is to provide me with access to services related to my prescribed medication and/or medical condition ("Program"), including (i) enrollment in the Program; (ii) conducting benefits investigation and coordinating my insurance coverage, which may include allowing a Teva field based representative to access my information and engage with my healthcare provider directly, if necessary; (iii) if needed, determining my eligibility for and coordinating financial assistance; (iv) coordinating prescription fulfillment and product replacement; (v) providing nursing support; (vi) facilitating quality and adverse event reporting activities; (vii) conducting data analytics, market research, and Program related business activities; (viii) contacting me by direct mail or by electronic or telephonic means to the contact information on this form or to any future contact information provided by me or on my behalf in connection with carrying out the Program services, including adherence related communications, reminders, and support, for which the third party service provider may receive financial remuneration from the manufacturer of your medication.

I understand that I may cancel this Authorization at any time, by writing to Teva, Attn: Authorizations, P.O. Box 501847, San Diego, CA 92150-1847, but my cancellation will not apply to any information already disclosed pursuant to this Authorization. This Authorization will remain in effect until the Program ends. I understand that once my information is disclosed, it may be subject to redisclosure by the recipients and no longer protected by federal privacy law. I understand that my treatment, payment for treatment, insurance enrollment, or eligibility for insurance benefits will not be directly affected if I do not sign this Authorization. However, if I do not sign this Authorization, I may not be able to receive Program services. I am also entitled to a copy of this signed Authorization.

Patient/Legal Rep Signature:	Date:

If signed by someone other than the patient, describe legal authority to do so:

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4 PHYSICIAN INFORMATION (PHYSICIAN TO COMPLETE SECTIONS 4-7)

Physician Name:	NPI #:	Tax ID #:	
Office Contact Name:	Contact Phone:	Contact Fax:	
Practice/Facility Name:	Contact Email:		
Address:	City:	State:	ZIP:

5 PRESCRIPTION INFORMATION

Patient Name (First MI Last): | DOB (mm/dd/yyyy):

☐ New ☐ Switch ☐ Restart

DIAGNOSIS ☐ Rheumatoid Arthritis (RA) ☐ Psoriatic Arthritis (PsA) ☐ Ankylosing Spondylitis (AS) ☐ Plaque Psoriasis (Ps)
☐ Uveitis ☐ Crohn's Disease (CD) ☐ Ulcerative Colitis (UC) ☐ Hidradenitis Suppurativa (HS)

PHARMACY PRESCRIPTION Please select the medication, and complete and sign the corresponding pharmacy prescription

Patient's preferred Specialty Pharmacy*_____ ☐ Do not send to Specialty Pharmacy

*Prescription will be triaged to preferred pharmacy unless otherwise dictated by insurance mandate and/or patient preference.

Pharmacy Phone: _____ Pharmacy Fax: _____

INDICATION	Initial Dose	Maintenance Dose
Available SIMLANDI Adult Formulations: Autoinjector 40 mg and 80 mg, Prefilled Syringe 40 mg		
Rheumatoid Arthritis (RA), Psoriatic Arthritis (PsA), Ankylosing Spondylitis (AS)	Initial dose not required. Indicate maintenance dose.	☐ 40 mg SC every other week ☐ 40 mg SC every week (for patients not receiving methotrexate) ☐ 80 mg SC every other week (for patients not receiving methotrexate) ☐ Autoinjector ☐ Prefilled Syringe Refills: _____
Plaque Psoriasis (Ps) or Uveitis	☐ 80 mg SC ☐ Autoinjector ☐ Prefilled Syringe	☐ 40 mg SC every other week starting one week after SIMLANDI initial 80 mg SC dose ☐ Autoinjector ☐ Prefilled Syringe Refills: _____
Hidradenitis Suppurativa (HS)	☐ 160 mg SC on Day 1, followed by 80 mg SC on Day 15 ☐ Autoinjector ☐ Prefilled Syringe	☐ 40 mg SC every week starting on Day 29 ☐ 80 mg SC every other week starting on Day 29 ☐ Autoinjector ☐ Prefilled Syringe Refills: _____
Crohn's Disease (CD) or Ulcerative Colitis (UC)	☐ 160 mg SC on Day 1, followed by 80 mg SC on Day 15 ☐ Autoinjector ☐ Prefilled Syringe	☐ 40 mg SC every other week starting on Day 29 ☐ Autoinjector ☐ Prefilled Syringe Refills: _____

6 PRESCRIBER SIGNATURE

After discussing the Program for my prescribed medication and/or medical condition (including its agents, service providers, and dispensing pharmacies) with the patient, the patient has elected to participate in the Program. I authorize the release of medical and/or other patient information relating to therapy to this Program, Teva Pharmaceuticals, Inc., its affiliates and its designated agents and service providers (collectively, "Teva"), to use and disclose as needed for fulfillment of the prescription related to this Program, and furnish any information in this form to the insurer of the above-named patient. I understand that Teva reserves the right to modify or terminate this Program at any time for any reason without any prior notice. I understand that I am under no obligation to prescribe a specific drug and I have not received, nor will I receive any benefit, for prescribing a specific drug. I certify that I have a signed copy on file of my patient's current and completed Patient Authorization so that I may share this patient's health information with Teva.

STAMP SIGNATURE NOT PERMITTED – INK SIGNATURE ONLY. Please attach all prescriptions on Official State Prescription form if mandated by individual state laws

The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, or hard copy prescription, etc.

Prescriber Signature: | Date:

Dispense as Written

Prescriber Signature: | Date:

Substitution Permitted