Patient Assistance Program APPLICATION

CELLTRION CONNECT® PATIENT SUPPORT PROGRAM

Adalimumab-aaty

Monday - Friday, 8 AM - 8 PM ET | Phone: (877) 812-6662 | Fax: (833) 912-3707 | www.CelltrionConnect.com

Patient Information - All fields marked with an * are required.

*First Name _____ MI _____ *Last Name _____

*Address _____ *City _____ *State _____ *Zip _____

*Date of Birth _____ Sex ☐ Male ☐ Female ☐ Prefer Not to Answer *Weight _____ lb or _____ kg

*Email _____ Preferred Language ☐ English ☐ Other _____

*Primary Phone _____ ☐ Cell ☐ Home Secondary Phone _____ ☐ Cell ☐ Home

Preferred Contact ☐ Patient ☐ Alternate Contact *By providing alternate contact information, I hereby authorize the release of my protected health information to the authorized alternate contact.*

Alternate Contact Name _____ Relationship to Patient _____

Primary Phone _____ ☐ Cell ☐ Home Secondary Phone _____ ☐ Cell ☐ Home

The Celltrion CONNECT® Patient Assistance Program is for uninsured patients only. Please confirm the patient does not have insurance. ☐

Patient Authorization to Share Health Information

By signing this form, the patient gives their permission for their physicians, pharmacies, laboratories, and other healthcare providers ("Healthcare Providers") and their health insurers to share their individually identifiable health information with Celltrion USA, Inc., the Celltrion Patient Assistance Foundation, and Celltrion affiliates and its vendors (collectively, "Celltrion").

The patient understands that their individually identifiable health information may include their full name, address, date of birth, demographic information, financial information, insurance information, and information related to their medical condition, treatment, care management, medication history, and prescriptions (collectively, "Health Information"), whether in written or verbal form, including portions of their medical record.

The patient's Health Information will be shared with Celltrion so that Celltrion may provide them with various support and information to help them access a Celltrion medicine, which may include the following, depending on the program (collectively, "Patient Support Activities"):

- Processing this application
- Verifying the information provided in this application
- Providing benefit investigation/verification and reimbursement support, including:
  - Assisting with identification of prior authorization requirements
  - Assisting with the identification of requirements of their insurer for appeal of a denied claim
- Determining their eligibility for and helping them access co-pay support or free drug programs
- Communicating with their Healthcare Providers about a Celltrion medicine and Patient Support Activities
- Coordinating the dispensing and delivery of medication
- Providing them with financial assistance resources and information if they are eligible
- Providing them with disease management and other educational materials, as well as information about Celltrion's products, services, and programs, may include sending them surveys about their experience with Celltrion products, services, and programs
- Providing them with access to Nurse Connectors™ who can assist in educational support communications

Celltrion also may use their Health Information for auditing for compliance with Program requirements, for quality assurance purposes, and to evaluate and improve our operations and services.

The patient understands that Celltrion may de-identify their Health Information and use it in performing research, education, business analytics, marketing studies, or for other commercial purposes, including linkage with other de-identified data Celltrion receives from other sources.

The patient understands that they do not have to sign this form, and choosing not to sign will not affect their ability to receive treatment from their Healthcare Providers or payment from their health insurer. However, if they do not sign this form, Celltrion may not be able to provide them with assistance.

The patient understands that once their Health Information is shared, it may no longer be protected by federal privacy law. However, Celltrion agrees to protect their Health Information and to use it for the purposes described in this form or as required or permitted by law. Select pharmacies may receive remuneration from Celltrion in exchange for their Health Information and/or for any Patient Support Activities provided to them. The patient understands that this form will remain in effect for six (6) years from the date of their signature or shall otherwise expire at a shorter duration as required under applicable state law unless they provide written notice that they would like to withdraw their approval to share their Health Information sooner. If the patient would like to withdraw their approval, they may contact Celltrion at **(877) 812-6662**. This withdrawal will not affect the use or sharing of their Health Information that took place before they withdraw their approval. The patient understands that they may receive a copy of this form.

SIGN & DATE

Patient or Patient Authorized Representative Signature _____ **Date** _____

Patient Representative First and Last Name (print) _____ Relationship to Patient _____

☐ **By checking this box**, the patient elects to opt out of Nurse Connectors™ educational support communications.

Please see Important Safety Information on page 5 and full Prescribing Information, including BOXED WARNING.

Celltrion CONNECT does not guarantee coverage or reimbursement. Coverage and reimbursement decisions are made by insurance companies following the receipt of claims.

Patient Name _____ Patient Date of Birth _____

Patient Assistance Program (PAP) Consent

I certify that I cannot afford my medication, and I affirm that my answers and my proof-of-income documents are complete, true, and accurate to the best of my knowledge. I will promptly contact the Celltrion Patient Assistance Program within thirty (30) days if my financial status or health insurance coverage changes. I will not seek to have this medicine or any cost from it counted in my Medicare Part D out-of-pocket expenses for prescription drugs. I will not seek reimbursement or credit for the medicine(s) from my prescription insurance provider, payor, or government health benefit program, including Medicare Part D plans, for Celltrion medications that I receive from the Celltrion Patient Assistance Foundation. I will notify my insurance provider of the receipt of any medicines through the Celltrion Patient Assistance Program. I have a signed copy of a current and completed Patient Authorization to Share Health Information on record with my healthcare provider so that my healthcare provider may share health information about me with Celltrion's assistance programs, Celltrion USA, Inc., and the Celltrion Patient Assistance Foundation.

I understand that the information I provide will be used by Celltrion, the Celltrion Patient Assistance Foundation, and parties acting on their behalf to determine eligibility, to manage and improve Celltrion's assistance programs, to communicate with me about my experience with Celltrion's assistance programs, to help me understand my insurance coverage and help me access certain Celltrion medicines through my insurance, and/or to send materials and other helpful information and updates relating to Celltrion programs.

I understand that: Completing this enrollment form does not guarantee that I will qualify for Celltrion's assistance programs. Celltrion may contact my insurer, to help me understand my insurance coverage for certain products and may provide me with support to obtain coverage through my insurer, including prior authorization and appeals support (if necessary and available). Celltrion may verify the accuracy of the information I have provided and may ask for more financial and insurance information. Any medicines supplied by Celltrion's assistance programs shall not be sold, traded, bartered, or transferred. Celltrion reserves the right to change or cancel Celltrion's assistance programs, or terminate my enrollment, at any time. The support provided through this program is not contingent on any future purchase. If I decide to enroll in a Medicare Part D plan and am eligible for the Celltrion Patient Assistance Program, I will inform the Celltrion Patient Assistance Foundation by calling 1-877-81CONNC (1-877-812-6662). If I receive notice that I have been auto enrolled in a Medicare Part D plan, I will immediately notify the Celltrion Patient Assistance Foundation.

☐ **By checking this box**, the patient agrees to PAP consent and agrees to the Terms and Conditions specified here.

Patient Authorization to Telephone Consumer Protection Act (TCPA) Information

By signing up for text messages from Celltrion, the patient agrees that they are the primary owner of the phone number(s) provided and consent to receiving promotional communications in the form of phone calls or text messages relating to Celltrion products and services and/or their condition or treatment at the phone number(s) provided. These communications may be sent from an automated system for the selection and dialing of telephone numbers, including an automatic telephone dialing system, or may use an artificial or pre-recorded voice, including recording messages or pre-recorded voicemails.

Your agreement and consent is not required as a condition for the purchase of any goods or services. Message and data rates may apply. Unsubscribe at any time by replying STOP or clicking the unsubscribe link (where available). Text HELP for help. Message frequency varies. To the maximum extent permitted by law: (i) all information contained in SMS text messages is provided "as is" without warranty of any kind, either express or implied, including but not limited to the implied warranties of merchantability, fitness for a particular purpose, or noninfringement; and (ii) Celltrion expressly excludes any liability for any direct, indirect, or consequential loss or damage incurred by any user in connection with the receipt, use, failure of, or inability to use SMS text messages.

The patient also gives their permission to receive communications from Celltrion and parties acting on its behalf, including calls or messages made with an automated system for the selection and dialing of telephone numbers, including an automatic telephone dialing system, or may use an artificial or pre-recorded voice, including recorded messages or prerecorded voicemails at the phone number(s) provided to determine their eligibility and provide benefits verification, prior authorization/appeals assistance, and financial assistance resources and information, such as co-pay support or free drug programs Nurse ConnectorsTM educational support communications, and/or other nonmarketing purposes. The patient understands that they can opt out of these telephonic communications concerning Patient Support Activities at any time by contacting Celltrion at **(877) 812-6662**, Monday - Friday, 8 AM - 8 PM ET.

Celltrion CONNECT®: View our privacy policy: **https://www.celltrionconnect.com/patient-privacy-policy** | View our terms of use: **https://www.celltrionconnect.com/terms-of-use/**

By signing below, the patient expressly consents to the terms of this section.

SIGN & DATE **Patient or Patient Authorized Representative Signature** _____ **Date** _____

Cell Phone _____ ☐ **By checking this box**, the patient accepts receiving SMS messages with the cell phone number(s) provided in the Patient Information section.

Patient Financial Verification Authorization

I understand that by checking the "I Agree" box immediately following this notice, I am providing "written instructions" to Celltrion CONNECT® and/or its agents and contractors under applicable federal and/or state law authorizing them to perform electronic income verification by obtaining information from my personal credit profile or other information from Experian Health. I authorize Celltrion CONNECT® and/or their agents and contractors to obtain such information solely to validate my income for the purposes of determining my eligibility for patient assistance. As a soft credit check, it will not impact my credit score.

☐ **I AGREE** to the terms above for electronic income verification using Experian Health.

☐ **I DO NOT AGREE** with the terms above and do not wish to have my income verified by using Experian Health. I understand that I will be asked to provide supporting documentation to authenticate my income and eligibility. If additional income documentation is required, the following documents are acceptable for income verification:

- Social Security/Disability benefit statement, monthly check, or 1099
- Previous year tax return or W-2 statement
- Unemployment or disability determination letter

Patient Income Verification

Annual Gross Income (Including salary/wages, Social Security income, disability income, and any other income): _____ **Household Size** (Number of members including you): _____

☐ **By checking this box**, the patient agrees to income information specified here.

Patient Name | Patient Date of Birth

Prescriber Information - All fields required.

Prescriber First Name | MI | Prescriber Last Name | Prescriber NPI

Tax ID # | Medicare PTAN # | Prescriber Address

City | State | Zip | Phone | Fax

Practice Name | Practice Contact Name

Practice Contact Title | Phone | Practice Contact Email Address

Adalimumab-aaty Prescribing Information - All fields required.

Patient's Preferred Pharmacy/Specialty Pharmacy

Patient's Therapy: Patient Weight (kg) (if under 18): | Treatment Start Date: | Diagnosis ICD-10 Code:

Crohn's Disease Adults and Pediatric Patients 6 years of age or older: ≥40 kg (88 lbs) Please select a starting/loading dose and maintenance dose.

☐ **Starting Dose: Adalimumab-aaty 80 mg/0.8 mL:** Administer 2 injections (160 mg) SQ on Day 1 (given in 1 day or split over 2 consecutive days). Then administer 1 injection (80 mg) SQ on Day 15. Then start Maintenance prescription. Quantity (1 month): 3 injections, Refills: 0

☐ **Maintenance Dose: Adalimumab-aaty 40 mg/0.4 mL:** Starting on Day 29: Administer 1 injection (40 mg) SQ every other week. Quantity (1 month): 2 injections

Crohn's Disease Pediatric Patients 6 years of age or older: 17 kg (37 lbs) to <40 kg (88 lbs) Please select a starting/loading dose and maintenance dose.

☐ **Starting Dose: Adalimumab-aaty 40 mg/0.4 mL:** Administer 2 injections (80 mg) SQ on Day 1. Then administer 1 injection (40 mg) SQ on Day 15. Then start Maintenance prescription. Quantity (1 month): 3 injections, Refills: 0

☐ **Maintenance Dose: Adalimumab-aaty 20 mg/0.2 mL:** Starting on Day 29: Administer 1 injection (20 mg) SQ every other week. Quantity (1 month): 2 injections

Hidradenitis Suppurativa Please select a starting/loading dose and maintenance dose.

☐ **Starting Dose: Adalimumab-aaty 80 mg/0.8 mL:** Administer 2 injections (160 mg) SQ on Day 1 (given in 1 day or split over 2 consecutive days). Then administer 1 injection (80 mg) SQ on Day 15. Then start Maintenance prescription. Quantity (1 month): 3 injections, Refills: 0

☐ **Maintenance Dose: Adalimumab-aaty 40 mg/0.4 mL:** Starting on Day 29: Administer 1 injection (40 mg) SQ every week. Quantity (1 month): 4 injections

☐ **Maintenance Dose: Adalimumab-aaty 80 mg/0.8 mL:** Starting on Day 29: Administer 1 injection (80 mg) SQ every other week. Quantity (1 month): 2 injections

Pediatric Hidradenitis Suppurativa ≥12 years of age and 30 kg (66 lbs) to <60 kg (132 lbs)

☐ **Adalimumab-aaty 40 mg/0.4 mL:** Day 1 administer 2 injections (80 mg) Then administer 1 injection (40 mg) Day 8 and SQ doses every other week.

Pediatric Hidradenitis Suppurativa ≥12 years of age and ≥60 kg (132 lbs)

☐ **Adalimumab-aaty 80 mg/0.8 mL:** Administer 2 injections (160 mg) SQ on Day 1 (given in 1 day or split over 2 consecutive days). Then administer 1 injection (80 mg) SQ on Day 15.Then 40 mg/0.4 mL on Day 29 and every week or 80 mg every other week.

Plaque Psoriasis or Adult Uveitis Please select a starting/loading dose and maintenance dose.

☐ **Starting Dose: Adalimumab-aaty 40 mg/0.4 mL:** Administer 2 injections (80 mg) SQ on Day 1. Then administer 1 injection (40 mg) SQ on Day 8 and Day 22. Then start Maintenance prescription. Quantity (1 month): 4 injections, Refills: 0

☐ **Maintenance Dose:** Adalimumab-aaty 40 mg/0.4 mL: Starting on Day 36: Administer 1 injection (40 mg) SQ every other week. Quantity (1 month): 2 injections*

Ulcerative Colitis (Adult) Please select a starting/loading dose and maintenance dose.

☐ **Starting Dose: Adalimumab-aaty 80 mg/0.8 mL:** Administer 2 injections (160 mg) SQ on Day 1 (given in 1 day or split over 2 consecutive days). Then administer 1 injection (80 mg) SQ on Day 15.Then start Maintenance prescription. Quantity (1 month): 3 injections, Refills: 0

☐ **Maintenance Dose:** Adalimumab-aaty 40 mg/0.4 mL: Starting on Day 29: Administer 1 injection (40 mg) SQ every other week. Quantity (1 month): 2 injections*

Juvenile Idiopathic Arthritis or Pediatric Patients with Uveitis ≥2 years of age and 15 kg (33 lbs) to <30 kg (66 lbs)

☐ **Adalimumab-aaty 20 mg/0.2 mL:** Administer 1 injection (20 mg) SQ every other week. Quantity (1 month): 2 injections

Juvenile Idiopathic Arthritis or Pediatric Patients with Uveitis ≥2 years of age and >30 kg (66 lbs)

☐ **Adalimumab-aaty 40 mg/0.4 mL:** Administer 1 injection (40 mg) SQ every other week. Quantity (1 month): 2 injections

Rheumatoid Arthritis, Psoriatic Arthritis, Ankylosing Spondylitis (Adults)

☐ Adalimumab-aaty 40 mg/0.4 mL: Administer 1 injection (40 mg) SQ every other week. Quantity (1 month): 2 injections
☐ Adalimumab-aaty 40 mg/0.4 mL: Administer 1 injection (40 mg) SQ every week.† Quantity (1 month): 4 injections
☐ Adalimumab-aaty 80 mg/0.8 mL: Administer 1 injection (80 mg) SQ every other week.† Quantity (1 month): 2 injections

*Discontinue in patients without evidence of clinical remission by 8 weeks (Day 57).
†Some patients with rheumatoid arthritis not receiving methotrexate may benefit from increasing the dosage to 40 mg every week or 80 mg every other week

Select Supply ☐ Adalimumab-aaty Prefilled Auto-Injector ☐ Adalimumab-aaty Prefilled Syringe with Safety Guard **Select Refills** Maintenance Refills:

Prescriber Attestation/Authorization

By signing this document the prescriber attests that they have obtained any and all authorizations and consents from the patient or the patient's authorized personal representative necessary under HIPAA and state law to release protected health information, including that contained on this form, to Celltrion and its employees or agents for the purposes relating to Celltrion's patient support program, including, assisting the patient with benefits verification, prior authorization/appeals assistance, dispensing and delivery of the medication, financial assistance resources and information, such as co-pay support or free drug programs, for which the patient may be eligible, and other support for Celltrion's medication.

The provider certifies that they have obtained consent from the patient or the patient's caregiver to be contacted by Celltrion, Celltrion CONNECT®, and parties acting on their behalf at the phone number(s) provided regarding the purposes described above and for other non-marketing purposes.

The provider certifies that they are the prescriber of Adalimumab-aaty to the patient and that the therapy is medically necessary. The provider authorizes Celltrion to act on their behalf to transmit this prescription by any means necessary to the pharmacy chosen by the patient.

SIGN & DATE **Prescriber Signature and Date (no stamps)** Dispense as Written/Brand Medically Necessary | Date

May Substitute/Product Selection Permitted | Date

CA, MA, NC, and PR: Interchange is mandated unless the prescriber writes the words "No Substitution" HERE

ATTN: Please submit the electronic prescription as required by your state law

Please see Important Safety Information on page 5 and full Prescribing Information, including BOXED WARNING.

Celltrion CONNECT does not guarantee coverage or reimbursement. Coverage and reimbursement decisions are made by insurance companies following the receipt of claims.

Patients Eligible for the Celltrion CONNECT® Patient Assistance Program (PAP)

The Celltrion CONNECT PAP is designed to provide free product to qualified individuals who are uninsured. Celltrion CONNECT will help activate the PAP for eligible participants.

To receive PAP benefits, the patient must enroll in the program and meet the following eligibility requirements:

- Patient has no insurance:
  - Uninsured includes all payor types
  - The patient must have tried all other insurance options for coverage. Some examples of other insurance coverage include private insurance, HMOs, Medicaid, Medicare, state pharmacy assistance programs, veterans assistance, and any other social service agency support.
  - This program excludes patients whose medication is reimbursed in whole or in part by any type of government insurance (eg, Medicare, Medicaid, TRICARE, or any other federal or state program). Patients who have Medicare Parts A and B only (no Medicare Part D) are still excluded.
- Patient must have a valid prescription from a licensed healthcare provider (HCP) for an on-label indication.
- Patient must have an adjusted annual household income of ≤400% of the federal poverty level (FPL).
- Income verification:
  - Electronic income verification (eIV) will be conducted by the program. No asset review will be required; however, patients will need to provide proof of income if eIV does not match what the patient has reported (proof of income could include one of the following: W-2s, tax returns (1040, 1099), 3 months of pay stubs).
- Patient must show proof of residency by providing a valid United States or the Commonwealth of Puerto Rico address, and product must be administered and shipped to locations in the United States or the Commonwealth of Puerto Rico. Patient must have lived in the United States or the Commonwealth of Puerto Rico for at least 6 months.
- Diagnosis and dosing are consistent with FDA-approved indication for Adalimumab-aaty.
- Patients with insurance plans or employers participating in an alternate funding program (also sometimes referred to as patient advocacy programs, specialty networks, SHARx, Paydhealth, or Payer Matrix, among other names) are not eligible for PAP.
  - These programs require patients to apply to a manufacturer's PAP or otherwise pursue specialty drug prescription coverage through an alternate funding vendor as a condition of, requirement for, or prerequisite to coverage of relevant 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 program.
  - Patients must promptly contact the Celltrion CONNECT PAP if their financial status or insurance coverage changes.
- Electronic benefits verification (eBV) will be conducted by the program every 6 months to determine coverage changes.
- You may not seek payment for the value of medicines received from this program from any health plan, patient assistance foundation, flexible spending account, or healthcare savings account.
- This program offer may not be used with any other coupon, discount, prescription savings card, free trial, or other offer. Offer good only in the United States or the Commonwealth of Puerto Rico. Void where prohibited, taxed, or limited by law.
- Program terms will expire at the end of each calendar year and may change or end without notice.
- Eligibility rules are subject to change at any time.

Indications and Important Safety Information for Adalimumab-aaty

IMPORTANT SAFETY INFORMATION

What is the most important information I should know about Adalimumab-aaty?

You should discuss treatment characteristics of Adalimumab-aaty with your doctor, including potential benefits and risks. Adalimumab-aaty is a TNF blocker medicine that can lower the ability of your immune system to fight infections. Notify your doctor if you have any kind of infection before you start taking Adalimumab-aaty.

Serious infections have happened in people taking adalimumab products, including tuberculosis (TB) and infections caused by viruses, fungi, or bacteria that have spread throughout the body. Some of these infections have been fatal. Your doctor should test you for TB prior to treatment with Adalimumab-aaty, and monitor closely for signs and symptoms of TB throughout treatment with Adalimumab-aaty, regardless of your TB test results. Your doctor may choose to treat you with a medicine for TB if they feel you are at risk.

Cancer. The chance of getting cancer may increase for children and adults taking TNF blockers, including adalimumab, including cases of unusual cancers. Some people have developed a rare type of cancer called hepatosplenic T-cell lymphoma, which is often fatal. Your chance of getting two types of skin cancer (basal cell and squamous cell) may increase while using TNF blockers, including adalimumab. Basal cell and squamous cell skin cancer are typically not life-threatening if treated. You should tell your doctor if you notice a bump or open sore that doesn't heal.

What should I tell my doctor BEFORE starting Adalimumab-aaty?

Give your doctor a complete description of your health, including the following:

- Current infection, treatment for infection, or symptoms of an infection
- Frequent infections or infections that don't resolve with treatment
- Diabetes
- Confirmed TB or close contact with someone who has TB, or were born in, lived in, or traveled where there is more risk for getting TB
- Current or prior residence in major river valleys where risk for getting certain kinds of fungal infections(histoplasmosis, coccidioidomycosis, or blastomycosis) is increased. These infections may happen or become more severe if you use Adalimumab-aaty.

Also, tell your doctor about all the medicines you take. You should not take Adalimumab-aaty 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 Adalimumab-aaty?

Adalimumab products, including Adalimumab-aaty, can cause serious side effects, including the following:

- **Serious infections.** Any infection caused by viruses, fungi, or bacteria, including TB. Common TB symptoms include cough, low-grade fever, weight loss, or loss of body fat and muscle.
- **Hepatitis B infection in carriers of the virus.** Common hepatitis B 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.** Common symptoms of a serious allergic reaction include hives, trouble breathing, and swelling of the face, eyes, lips, or mouth.
- **Nervous system problems.** Common signs and symptoms include numbness or tingling, problems with vision, weakness in your arms or legs, and dizziness.
- **Blood problems (decreased blood cells that help fight infections or stop bleeding).** Common symptoms include a fever that does not go away, bruising or bleeding very easily, or very pale skin tone.
- **Heart failure (new or worsening).** Common symptoms include shortness of breath, swelling in the ankles or feet, and sudden weight gain.
- **Immune reactions including a lupus-like syndrome.** Common symptoms include chest discomfort or pain that does not go away, shortness of breath, joint pain, or a rash on cheeks or arms that gets worse in the sun.
- **Liver problems.** Common symptoms include feeling very tired, skin or eyes that look yellow, poor appetite or vomiting, and pain on the right side of the stomach (abdomen). These problems can lead to liver failure and death.
- **Psoriasis (new or worsening).** Common symptoms include red scaly patches or raised, pus-filled bumps.

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

Common side effects of adalimumab products include injection site reactions (redness, rash, swelling, itching, or bruising), upper respiratory infections (sinus infections), **headaches**, and **rash**. These are not all the possible side effects with adalimumab products, including Adalimumab-aaty. 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

Adalimumab-aaty is given by injection under the skin.

This is the most important information to know about Adalimumab-aaty. For more information, talk to your healthcare provider.

INDICATIONS

Adalimumab-aaty is a prescription medicine used:

- To reduce the signs and symptoms of:
  - Moderate to severe rheumatoid arthritis (RA) in adults. Adalimumab-aaty 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. Adalimumab-aaty can be used alone or with methotrexate.
  - Psoriatic arthritis (PsA) in adults. Adalimumab-aaty 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-aaty is effective in people who stopped responding to or could not tolerate anti-TNF medicines.
- To treat moderate to severe chronic plaque psoriasis (Ps) in adults who are candidates for systemic therapy or phototherapy, and when other systemic therapies are medically less appropriate.
- To treat non-infectious intermediate, posterior, and panuveitis in adults.

For more information about Adalimumab-aaty, see full Prescribing Information, including BOXED WARNING.

CELLTRION USA