Xeljanz | Rinvoq | Olumiant
(JAK inhibitors)

CRITERIA
Must have taken Xeljanz OR Rinvoq OR Olumiant
During use or after taking: Dx of Cancer; Major Cardiovascular Event (Stroke, heart attack, etc); Pulmonary Embolism, DVT, Blood Clot or Death due to any of these

Janus kinase (JAK) inhibitors are used for the treatment of rheumatoid arthritis, psoriatic arthritis, ulcerative colitis, and polyarticular course juvenile idiopathic arthritis.

Manufactures: Xeljanz - Pfizer Inc.
Rinvoq – AbbVie
Olumiant - Eli Lilly & Company

Injured name: _____ DOB: _____

Single, Widow, Divorced, Married (if married, spouse name): _____

Caller Name (if different): _____

Caller's relationship to injured person:_____

Why are you calling rather than the injured person? _____

Mailing Address (street/PO Box, city, state, zip): _____

Physical Address, if different: (street, city, state): _____

Cell phone: _____ May we text you? If yes, who is your provider: _____

Home phone: _____ Work phone: _____

Email Address: _____ Preferred method of contact: _____

(If Injured Person Is Deceased) Date of Death: _____

Cause(s) of Death: _____

Residency at time of Death (city & state): _____

Has an Estate been opened: _____ Appointed Personal Representative: _____

Have you taken Xeljanz, Rinvoq or Olumiant? Which: _____ (If none, decline)

When did you start taking: _____

When did you stop taking: _____

How many mg were you on? _____

How often did you take (once, twice, etc daily)? _____

Did your dosage amount ever change (increase/decrease & to what mg): _____

If yes, what date(s) did each change happen? _____

➢**Cancer**

Cancer Diagnosis: _____ (If skin cancer is only cancer dx, decline)

Date you were diagnosed: _____

If deceased, was death related to cancer? _____

➢**Cardiovascular (Heart)**

Did you have a Major Cardiovascular Event? (cardiac arrest, heart attack, ischemic stroke, heart failure, etc)

Diagnosis: _____

Date of Diagnosis: _____

Were you hospitalized? If so, where, when & how long:

_____

If deceased, was death related to this event? _____

➢**Pulmonary Embolisms, DVTS, Blood Clots**

Did you experience a Pulmonary Embolism, DVT &/or Blood Clots?

Diagnosis: _____

Date of Diagnosis: _____

Were you hospitalized? If so, where, when & how long:

_____

If deceased, was death related to this event? _____

What is your smoking history?

Current/former (dates)

Amount & how often _____

All pharmacies where you purchased your JAK Inhibitor (including city & state):

_____

How did you become aware you may have a claim? _____

When did you become aware you may have a claim? _____

**** Please be sure to save all evidence ** Includes any proof of purchase, receipts, packaging, boxes, etc.**