myAbbVie Assist | Patient Assistance

APPLICATION FOR MAVYRET™ (glecaprevir/pibrentasvir)

myAbbVie Assist provides free medicine to qualifying patients. We review all applications on a case-by-case basis. Participation in our program is free; we do not collect any fees from people seeking our assistance.

CHECKLIST FOR SUBMITTING AN APPLICATION

- ☐ **SECTION 1:** Patient Information and Shipping Preference
  - o **REQUIRED**: Please include proof of income for all in household. A copy of the patient's current federal tax return is preferred. If the patient does not file taxes, alternate documents are acceptable such as W-2 form, Social Security Statement or Pay Stubs.
- ☐ **SECTION 2:** Patient Insurance
  - o If the patient has insurance, include front and back copies of all prescription insurance cards.
- ☐ **SECTION 3:** Patient Consent and Signature
  - o Patient must read the HIPAA authorization, patient terms of participation and privacy notice in Section 8 on Page 3.
  - o Patient must confirm the understanding of our privacy policy by providing patient signature and date in Section 3.
- ☐ **SECTION 4:** Patient Medical History
- ☐ **SECTION 5:** Prescriber Information
- ☐ **SECTION 6:** Prescription
- ☐ **SECTION 7:** Prescriber Certification and Signature
  - o Section 6 and 7 must be completed by a licensed prescriber. The form must be faxed directly from the prescriber's office.
- ☐ **Please keep a copy for your records.**
- ☐ **Please do not staple documents together when mailing.**

FAX OR MAIL THE COMPLETED APPLICATION AND DOCUMENATION TO THE FOLLOWING:

myAbbVie Assist
D-617927, AP5 NE
1 N. Waukegan Rd.
North Chicago, IL 60064

Phone: 1-855-687-7503
Fax: 1-855-886-2481

Upon receipt of a completed application, we will notify the prescriber and patient about eligibility. If approved, we will ship the medication to the patient's home unless otherwise indicated on the application. Prior to each subsequent 28-day shipment, we will contact the shipping location to schedule the next delivery.

Please contact us at 1-855-687-7503 Monday through Friday for additional assistance.

myAbbVie Assist | Patient Assistance

Fax To: 1-855-886-2481
Phone: 1-855-687-7503
D-617927, AP5 NE, 1 N. Waukegan Rd.
North Chicago, IL 60064

APPLICATION FOR MAVYRET™ (glecaprevir/pibrentasvir)

1 PATIENT INFORMATION

☐ Check here if shipping to Prescriber's office (cannot ship to a PO Box)

Patient's Name: **DOB**: ☐ Male ☐ Female

SSN (Last 4 digits ONLY): ___ | ___ | ___ | ___ If you do not have an SSN, check here: ☐ Language: ☐ English ☐ Spanish ☐: _____

Mailing Address: Mailing City/State/Zip:

Shipping Address (No PO Box): Shipping City/State/Zip:

Preferred Phone: ☐ Cellphone ☐ Work ☐ Home Alternate Phone: ☐ Cellphone ☐ Work ☐ Home

Monthly Household Income: $ _____ **Number in Household (including self):** _____ **Number in household over 18 years old with income** _____

Please include financial documentation for everyone in the household. A copy of your current federal tax return is preferred.

2 PATIENT INSURANCE

☐ **No Insurance - go to Section 3**

INSURANCE TYPE: ☐ **Medicare** ☐ **Medicaid** ☐ **Private/Commercial** ☐ **Other:** _____

Please provide insurance details below and include a front and back copy of prescription and insurance cards.

MEDICAL INSURANCE		PRESCRIPTION INSURANCE	
Insurance Name:	Phone #:	Insurance Name:	Phone #:
Policy ID #:	Group #:	Policy ID #:	Group #:
Policyholder Name:	Relationship:	BIN #:	PCN #:

3 PATIENT CONSENT

PLEASE REVIEW HIPAA AUTHORIZATION, PATIENT TERMS OF PARTICIPATION AND PRIVACY NOTICE IN SECTION 8 TO UNDERSTAND HOW WE USE YOUR PERSONAL INFORMATION

I acknowledge that I have provided accurate and complete information and understand the Patient Terms of Participation in Section 8.

My signature below certifies that I have read, understood and agree to the release of my protected health information pursuant to the HIPAA Authorization in Section 8.

PLEASE SIGN AND DATE: ▶ _____ ▶ _____

PATIENT SIGNATURE / LEGAL REPRESENTATIVE (indicate relationship) **DATE**

4 PATIENT MEDICAL HISTORY

Fibrosis (F) Score: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 Check if patient has already started Mavyret therapy: ☐

Treatment History: ☐ Treatment – Naïve ☐ Treatment - Experienced **Medical History:** ☐ Compensated Cirrhosis (Child-Pugh A)

Medications (List): _____ **Allergies (List):** _____

5 PRESCRIBER INFORMATION

Prescriber Name: **NPI or SLN:** ☐ Hepatology ☐ Gastro ☐ ID ☐ Other:_____

Facility Name: Facility Phone:

Address: City/State/Zip:

Contact Name: Contact Phone: Contact Fax:

Collaborating/Supervising MD Name and NPI Name: NPI:

For additional information on how AbbVie processes your personal information, please visit www.abbvie.com/privacy.html.

6 PRESCRIPTION

PLEASE INDICATE THERAPY DURATION AND SIGN/DATE

MUST BE COMPLETED BY A LICENSED PRESCRIBER AND FAXED DIRECTLY FROM PRESCRIBER'S OFFICE

MEDICATION DOSE/STRENGTH		DIRECTIONS	QTY	THERAPY DURATION
MAVYRET	glecaprevir 100 mg; pibrentasvir 40 mg fixed-dose combination tablets	**Take 3 tablets at the same time orally once daily with food**	**84 tablets** (28-day supply)	☐ **8 weeks** ☐ **12 weeks** ☐ **16 weeks** **Other:** _____

PLEASE SUBMIT PRESCRIPTIONS ACCORDING TO YOUR SPECIFIC STATE LAWS, RULES AND REGULATIONS

7 PRESCRIBER SIGNATURE

▶ _____ ▶ _____ ▶ _____

Substitution Permitted **Dispense as Written** **Date**

PRESCIBER MUST MANUALLY SIGN. RUBBER STAMPS, SIGNATURE BY OTHER OFFICE PERSONNEL OR COMPUTER GENERATED IMAGES ARE NOT ALLOWED

I verify that the information provided is current, complete and accurate to the best of my knowledge. myAbbVie Assist reserves the right to request additional information if needed and to change or discontinue the program at any time, without notice. I shall not seek reimbursement for any medication dispensed hereunder from any government program or third party, including patient, nor will I sell, trade or distribute any such medication. I also understand that the applicant's acceptance into the program should not influence treatment decisions. By signing this form, I authorize the program and its representatives to transmit this prescription form electronically, by facsimile, or by mail to a pharmacy designated by the program for the dispensing of the medication called for herein. I understand that I may not delegate signature authority. I certify that treatment with this medication is medically necessary.

For full Prescribing Information please visit www.rxabbvie.com

HCV-APP1-20K-1 November 2020

myAbbVie Assist | Patient Assistance

Fax To: 1-855-886-2481
Phone: 1-855-687-7503
D-617927, AP5 NE, 1 N. Waukegan Rd.
North Chicago, IL 60064

APPLICATION FOR MAVYRET™ (glecaprevir/pibrentasvir)

8 HIPAA AUTHORIZATION, PATIENT TERMS OF PARTICIPATION AND PRIVACY NOTICE

HIPAA AUTHORIZATION Please provide signature in Section 3 of Enrollment Form

I authorize my healthcare providers, pharmacies, insurers, and laboratory testing facilities (my "Healthcare Companies") to disclose information about me, my medical condition, treatment, insurance coverage, and payment information in relation to my use of AbbVie products, to AbbVie to enroll me in and provide me with patient assistance and support for AbbVie products. I understand that information released under this Authorization will no longer be protected by HIPAA. I also understand that if my Healthcare Companies use or disclose my Personal Information for marketing purposes, they may receive financial remuneration.

I understand that I am not required to sign this Authorization and that my Healthcare Companies will not condition my treatment, payment, enrollment, or eligibility for benefits on whether I sign this Authorization. However, I understand that if I do not sign this Authorization, I cannot take part in myAbbVie Assist (should I qualify). This Authorization will expire in 10 years or a shorter period if required by state law, unless I cancel it sooner by calling 1-855-687-7503 or by writing myAbbVie Assist, D-617927, AP5 NE; 1 N. Waukegan Rd., North Chicago, IL 60064. I understand that cancelling my Authorization will not affect any use of my information that occurred before my request was processed.

PATIENT TERMS OF PARTICIPATION

myAbbVie Assist provides free medicine to qualifying patients. Participation in our program is free; we do not collect any fees myAbbVie Assist provides free medicine to qualifying patients. Participation in our program is free; we do not collect any fees from people seeking our assistance. Medication assistance is dependent on your ability to meet the eligibility criteria for program as determined by myAbbVie Assist. myAbbVie Assist does not have any obligation to provide the program services to you and is not liable in the provision of these services. The program may be changed or discontinued without notice. You will not seek reimbursement for any products dispensed under the program. You will notify the program if your insurance or financial situation changes. If this application has been completed by a personal representative, the personal representative will provide a copy of this completed application to you.

If you are a member of a Medicare plan including a Medicare Prescription Drug Plan and are qualified for program assistance, you will: (i) be eligible to obtain the medication from the program for a calendar year term (ii) not purchase this medication under your Medicare plan while enrolled in the program; (iii) not submit claims nor seek true out-of-pocket (TrOOP) credit for the medication provided during your enrollment; (iv) provide written notification to your Medicare Prescription Drug Plan, if applicable, that you are receiving your medication at no cost outside of the Medicare Part D benefit.

If you have questions, want to update your information, or terminate your enrollment, please call 1-800-222-6885 or write to us at D-617927, AP5 NE; 1 N. Waukegan Rd., North Chicago, IL 60064.

PATIENT PRIVACY NOTICE

myAbbVie Assist will use and disclose with authorized third parties your personal information including your financial and health information collected on this enrollment form and through participation in the program for the following purposes:

(1) To determine your eligibility for the program and to provide you with related services, including transfer to a separate private or public payer program, reimbursement services, services to ship your medication, and other support services.
(2) To perform research and data analytics to develop and evaluate products, services, materials, and treatments.
(3) To administer and maintain the quality of the program, including but not limited to case review, compliance checks, audit review and accounting purposes.

For additional information on how AbbVie processes your personal information, please visit www.abbvie.com/privacy.html.

For full Prescribing Information please visit www.rxabbvie.com