myAbbVie Assist | Patient Assistance

APPLICATION FOR ALLERGAN AESTHETICS, AN ABBVIE COMPANY

ALLODERM, NATRELLE, REVOLVE, STRATTICE, STRATTICE BPS, KELLER FUNNEL 2

myAbbVie Assist provides free products 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.

myAbbVie Assist approval is required prior to patient surgery. The surgeon must sign and date the application and certify that the requested product(s) are intended for a medically necessary non-cosmetic procedure.

CHECKLIST FOR SUBMITTING AN APPLICATION

☐ **IF YOU ARE THE PRESCRIBER, COMPLETE PAGE 2**

- **SECTION 1:** Licensed Surgeon and Surgery Location
- **SECTION 2:** Patient Medical Information
- **SECTION 3:** Allergan Product Request
- **SECTION 4:** Licensed Surgeon Certification and Signature

☐ **IF YOU ARE A PATIENT, COMPLETE PAGE 3. PLEASE READ PAGE 4**

- **SECTION 5:** Patient Information
- **SECTION 6:** Financial and Medical Information
  - **REQUIRED**: Please include proof of income for all in household. A copy of your current federal tax return is preferred. If you do not file taxes, alternate documents are acceptable such as W-2 form, Social Security Statement or Pay Stubs.
- **SECTION 7:** Insurance Information
  - If you do not have insurance, please go to Section 8
  - If you have Insurance, include front and back copies of all insurance cards.
  - A copy of insurance denial documents, specific to the requested Allergan product(s), are required.
  - People with Medicare are not eligible for the program
- **SECTION 8:** Additional Permission for Program Purposes (Optional)
- **SECTION 9:** Patient Consent and Signature
  - Carefully read the HIPAA authorization, patient terms of participation and privacy notice in Section 10 on Page 4.
  - Provide your consent for eligibility determination by checking the box in Section 9.
  - Confirm your understanding of our privacy policy by providing your signature and date in Section 9.

☐ **Please keep a copy for your records.**

FAX OR MAIL THE COMPLETED APPLICATION AND DOCUMENTATION TO THE FOLLOWING

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

Phone: 1-833-613-2419
Fax: 1-800-311-0260

Upon review of a completed application, we will notify the surgeon about eligibility. Upon approval, we will send the surgeon the Allergan Aesthetics PAP Credit Form to place the credit request. Credit will only be authorized for medical products used for the approved patient. **Serial numbers for implants and tissues are required for credit authorization. Credit requests must be received within 14 days following surgery.**

Please contact us at 1-833-613-2419 Monday through Friday for additional assistance.

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LICENSED SURGEON ORDER REQUEST AND CERTIFICATION
TO BE COMPLETED BY SURGEON

APPLICATION FOR ALLERGAN AESTHETICS

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NORTH CHICAGO, IL 60064
PHONE: 1-833-613-2419
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1 LICENSED SURGEON • SURGERY LOCATION

Surgeon Name: **NPI or SLN:** ☐ Physician's Office ☐ Hospital ☐ Other: _____

Office Name: Office Contact Name: Office Contact Email:

Address: City/State/Zip:

Phone: Fax: Surgeon Specialty: _____

Hospital / Surgery Center Name (if different from above)**:**

Shipping Address (if different from above): City/State/Zip:

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

2 PATIENT MEDICAL INFORMATION

Patient's Name: **DOB:** _____ **Patient Phone:** _____ ☐ Cellphone ☐ Work ☐ Home

Surgery Date – Date of Service (DOS): _____ **Procedure/Surgery Type:** _____

☐ ***By checking this box and signing this form, the surgeon certifies the requested medical product(s) are for a medically necessary non-cosmetic procedure***

3 ALLERGAN AESTHETIC PRODUCT REQUEST

Allergan Aesthetics Account information must be provided to issue credit for an approved patient

Allergan Aesthetics Account Number (required): _____

PRODUCTS AVAILABLE – CHECK ALL THAT APPLY.	PAP CREDIT REQUEST FORM WILL BE PROVIDED SEPARATELTY UPON APPROVAL
☐ **ALLODERM** Regenerative Tissue Matrix (Credit Limit: up to 2)	**DESCRIPTION** (contour, contour perforated, rectangle, rectangle perforated)
☐ **NATRELLE** Breast Implants (Credit Limit: up to 2)	**STYLE:** (smooth cohesive, smooth soft touch, smooth responsive)
☐ **NATRELLE*** Sizer (Credit Limit: up to 2)	***NATRELLE SIZERS USED BY A PAP PATIENT CANNOT BE RE-USED**
☐ **NATRELLE** Tissue Expanders (Credit Limit: up to 2)	
☐ **REVOLVE System** Advanced Adipose System (Credit Limit: 1)	
☐ **STRATTICE** Reconstructive Tissue Matrix (Credit Limit: up to 2)	**DESCRIPTION** (pliable, pliable pre-shaped, firm, extra thick, laparoscopic, perforated):
☐ **STRATTICE BPS** Reconstructive Tissue Matrix (Credit Limit: up to 2)	**DESCRIPTION** (pliable pre-shaped, slanted, rectangle):
☐ KELLER FUNNEL 2 (Sold in Case of 5 Units. Credit Limit: up to 2 Units)	**Note: Returns cannot be accepted on an open case**

4 LICENSED SURGEON CERTIFICATION • PLEASE SIGN AND DATE

RUBBER STAMPS, SIGNATURE BY OTHER OFFICE PERSONNEL OR COMPUTER-GENERATED IMAGES ARE NOT ALLOWED

LICENSED SURGEON

SIGNATURE: _____ **DATE:** _____

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, and I will instruct my facility to not, (a) seek reimbursement for any product provided hereunder from any government program or third party, including patient, (b) sell, trade or distribute any such product, or (c) return for credit any product provided under this program. I also understand that the applicant's acceptance into the program should not influence treatment decisions. I agree that any product that I receive for the patient named in the application will be used only for this patient. I also certify that my patient understands that he/she is responsible for any surgery, facility or treatment costs associated with this product(s), if I am unable to waive these associated fees. I certify that treatment with this medication is medically necessary and that I will be supervising the patient's treatment accordingly. I understand that I may not delegate signature authority. I certify that the requested product(s) are for a medically necessary non-cosmetic procedure.

AA-APP1-22I-1A September 2022

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PATIENT INFORMATION AND SIGNATURE
TO BE COMPLETED BY PATIENT

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5 PATIENT INFORMATION

Patient Name: | **DOB:** | Sex: ☐ M ☐ F

SSN (last four digits ONLY): ___|___|___|___ If you do not have an SSN, check here: ☐

Mailing Address: | City/State/Zip:

Shipping Address (No P.O. Box): | City/State/Zip:

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

Email address: _____

6 FINANCIAL AND MEDICAL INFORMATION

Please include financial documentation for everyone in the household. A copy of your current federal tax return is preferred. If you do not file taxes, alternate documents are acceptable such as W-2 forms, Social Security Statements and Pay Stubs.

Monthly Household Income $_____ | Number in Household (including yourself) : _____ | Number in household over 18 yrs old with income : _____

Surgeon Name: _____ **Phone:** _____ **Fax:** _____

If you have any changes to your medical information, please call us at 1-833-613-2419*

7 INSURANCE INFORMATION ☐ I have no insurance coverage – go to Section 8

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

Patients with Medicare are not eligible for the program.
Please provide insurance details below and attach a front and back copy of all insurance cards.
Please include copies of any insurance denial documents for the specific Allergan product(s)

MEDICAL INSURANCE		SECONDARY INSURANCE	
Insurance Company:		Insurance Company:	
Insurance Co. Phone:		Insurance Co. Phone:	
Policy ID #:	Group #:	Policy ID #:	Group #:
Policyholder Name:	Relationship:	Policyholder Name:	Relationship:

8 ADDITIONAL PERMISSION FOR PURPOSES OF THE PROGRAM (optional)

I permit myAbbVie Assist to speak with the following person about this application:

Name: _____ **Relationship:** _____ **Phone Number:** _____

9 PATIENT CONSENT

PLEASE REVIEW HIPAA AUTHORIZATION, PATIENT TERMS OF PARTICIPATION AND PRIVACY NOTICE IN SECTION 10 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 10.

CHECK THE BOX: ☐ ***I understand that I am providing written instructions to the Program under the Fair Credit Reporting Act authorizing the Program to obtain information about my credit profile from credit reporting agencies or other sources. I authorize the Program to obtain such information solely to determine PAP eligibility.***

PLEASE SIGN AND DATE: ***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 10.***

X_____ PATIENT SIGNATURE / LEGAL REPRESENTATIVE (indicate relationship)

X _____ DATE

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10 HIPAA AUTHORIZATION, PATIENT TERMS OF PARTICIPATION AND PRIVACY NOTICE

HIPAA AUTHORIZATION Please provide signature in Section 9 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 Allergan Aesthetics products, to AbbVie (including Allergan Aesthetics, an AbbVie Company), to enroll me in and provide me with patient assistance and support for Allergan Aesthetics 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 1-833-613-2419 or by writing to 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 product to qualifying patients. Participation in our program is free; we do not collect any fees from people seeking our assistance. 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 have questions, want to update your information, or terminate your enrollment, please call 1-833-613-2419 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 product, and other support services.
(2) To obtain information from your credit profile about your income for the sole purpose of determining eligibility for the program. This notice serves as written instruction under the Fair Credit Reporting Act authorizing myAbbVie Assist to obtain this information.
(3) To perform research and data analytics to develop and evaluate products, services, materials, and treatments.
(4) 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.