myAbbVie Assist | Patient Assistance

APPLICATION FOR MYABBVIE ASSIST

Refer to Page 5 for Medication List

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

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

- o **SECTION 1:** Prescriber Information
- o **SECTION 2:** Patient Information
- o **SECTION 3:** Product information – Please choose medication from list on Page 5.
  - If you are seeking assistance with another AbbVie medicine, please visit www.AbbVie.com/myAbbVieAssist to review our list of available medicines and their applications for assistance.
- o **SECTION 4:** Prescriber Certification and Signature

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

- o **SECTION 5:** Patient Information
- o **SECTION 6:** Financial Information
  - Include financial documentation for everyone in the household, preferably a copy of your current federal tax return. Please check the box in Section 8 so we can more quickly review your application.
- o **SECTION 7:** Insurance Information
  - If you have Insurance, include front and back copies of all insurance cards.
  - If you have insurance coverage, please attach a list of your medical or prescription drug out of pocket costs. If you are taking multiple prescriptions, a printout from your pharmacy will be helpful. This information will help us review your eligibility for our program.
- o **SECTION 8:** Patient Consent and Signature
  - Carefully read the HIPAA authorization, patient terms of participation and privacy notice in Section 10 on Page 4.
  - Please check the box in Section 8 to authorize us to verify your income electronically so we can more quickly review your application.
  - Confirm your understanding of our privacy policy by providing your signature and date in Section 8.
- o **SECTION 9:** Additional Permission for Program Purposes (Optional)

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

FAX OR MAIL THE COMPLETED APPLICATION AND DOCUMENTATION TO THE FOLLOWING

myAbbVie Assist
PO Box 270
Somerville, NJ 08876

Phone: 1-800-222-6885
Fax: 1-866-898-1473

Upon review of a completed application, we will notify the patient and the prescriber about eligibility. If approved, we will routinely ship medicine to the prescriber's office. Most products may be shipped to the patient's home on request. Please call 1-800-222-6885 to request refills.

Please contact us at 1-800-222-6885 Monday through Friday for additional assistance.

myAbbVie Assist is offered by AbbVie Inc. and the AbbVie Patient Assistance Foundation, a separate legal entity from AbbVie Inc.

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1 PRESCRIBER INFORMATION

Prescriber Name: ☐ MD ☐ DO ☐ Other:_____ Specialty: _____

Office Name: Office Contact Name:

Address: City/State/Zip:

NPI: Phone: Fax:

SLN: SLN Expiration Date:

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

2 PATIENT INFORMATION

☐ My patient's insurance denied coverage for the requested medication. Please include denial documentation.

Patient's Name: _____ **DOB:** _____

☐ No known allergies ☐ Allergies (Please list): _____

☐ No other medications ☐ Other Medications (Please list): _____

3 MEDICATION REQUESTED: MUST BE COMPLETED BY A LICENSED PRESCRIBER

Please choose medication from listing located on Page 5 and write in below.

MEDICATION	STRENGTH	QUANTITY	DIRECTIONS	REORDERS/ REFILLS
				☐ 1 year ☐ Other: _____
				☐ 1 year ☐ Other:_____

Please check to have medication shipped to patient's home: ☐ *New York Prescribers; prescription form must be included.*
Submit prescriptions according to your specific State Laws, Rules and Regulations.

4 PRESCRIBER PLEASE SIGN AND DATE • PRESCIBER MUST MANUALLY SIGN BELOW

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

PRESCRIBER SIGNATURE AND DATE: X _____ X _____ **DATE:** _____

Substitution Permitted **Dispense as Written**

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

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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

Check the Box for Text Messages* ☐ Mobile Phone: _____ Email Address: _____

* I consent to receive recurring text messages from myAbbVie Assist, including service updates and medication reminders to the above number. Message and data rates may apply. I am not required to consent or provide my consent as a condition of receiving any goods or services. I can reply HELP for help. I can text STOP to unsubscribe any time.

Treating Physician's Name: _____ Physician's Phone Number: _____

6 FINANCIAL INFORMATION

Monthly Total Income for everyone in the household: $ _____

Check the box in Section 8. Include financial documentation for everyone in the household, preferably a copy of your Federal Tax Return**.**

Total number of people in your household (including yourself): ____ Number in household over 18 years old with income: _____

If insured, enclose a detailed list of your prescription and medical costs.
Estimated total annual out of pocket cost for the household: $_____prescription cost $_____ medical cost

7 INSURANCE INFORMATION

☐ **I have no insurance coverage – go to Section 8**

Please attach a front and back copy of all insurance cards. Include a detailed list of prescription costs such as a Pharmacy print-out and medical expenses for the household to help us determine eligibility for our program

INSURANCE INFORMATION		Group or Policy Number	Insurance Name and Phone
Medicare			
Medicare Part B	❑ Yes ❑ No		
Medicare Supplement	❑ Yes ❑ No		
Medicare Advantage Plan	❑ Yes ❑ No		
Medicare Part D	❑ Yes ❑ No		
Medicaid	❑ Yes ❑ No		
Private/Commercial Insurance	❑ Yes ❑ No		

Has your insurance denied coverage for the requested medication? ❑ Yes ❑ No If yes, please include denial document.

PLEASE INCLUDE COPIES OF THE FRONT AND BACK OF ALL INSURANCE CARDS

8 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 on Page 4.

PLEASE CHECK 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 _____ X _____

PATIENT SIGNATURE / LEGAL REPRESENTATIVE (indicate relationship) DATE

9 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:** _____

For full Prescribing Information please visit www.rxabbvie.com

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10 HIPAA AUTHORIZATION, PATIENT TERMS OF PARTICIPATION AND PRIVACY NOTICE

HIPAA AUTHORIZATION Please provide signature in Section 8 on Page 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 the AbbVie Patient Assistance Foundation and AbbVie, to enroll me in and provide me with 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 1-800-222-6885 or by writing to myAbbVie Assist, PO BOX 270, Somerville, NJ 08876. 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 medicines 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 the 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) myAbbVie Assist will inform 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 PO BOX 270, Somerville, NJ 08876.

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 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.

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MEDICATION LIST FOR USE WITH THIS APPLICATION

Please use this application for the products listed below. If you are seeking assistance with another AbbVie medicine, please visit www.AbbVie.com/myAbbVieAssist to review our list of available medicines and their applications for assistance.

AeroChamber Plus® Flow-Vu®	Namenda® and Namenda XR® (memantine HCl) tablets
Armour Thyroid® (thyroid tablets, USP) tablets	Namzaric® (memantine HCl extended-release and donepezil HCl) capsules
Bystolic® (nebivolol) tablets	Norvir® (ritonavir)
Canasa® (mesalamine, USP) Suppositories	Pred Forte® (prednisolone acetate ophthalmic suspension, USP) 1%
Carafate® (sucralfate) suspension	Pylera® (bismuth subcitrate potassium, metronidazole, tetracycline HCl) capsules
Crinone® (progesterone) gel	Qulipta™ (atogepant)
Delzicol® (mesalamine) delayed-release capsules	Rapaflo® (silodosin) capsules
Estrace® (estradiol vaginal cream, USP, 0.01%)	Rectiv® (nitroglycerin) ointment 0.4%, for intra-anal use
Fetzima® (levomilnacipran) extended-release capsules and Titration Pack	Restasis® / Restasis Multidose (cyclosporine ophthalmic emulsion) 0.05%
Gelnique® (oxybutynin chloride) 10% topical gel	Saphris® (asenapine) sublingual tablets
Gengraf ® Capsules (cyclosporine capsules, USP)	Savella® (milnacipran HCl) tablets
Infed® (iron dextran injection USP)	Synthroid® (levothyroxine sodium tablets, USP)
Kaletra® (lopinavir/ritonavir)	Ubrelvy® (ubrogepant) tablets
Lexapro® (escitalopram oxalate) tablets	Viibryd® (vilazodone HCl) tablets, for oral use
Monurol® (fosfomycin tromethamine) granules for oral solution	Vraylar® (cariprazine) capsules for oral use