abbvie PATIENT ASSISTANCE FOUNDATION

Application for Lupron Depot® and Lupron Depot-PED® (leuprolide acetate for depot suspension) and Lupaneta Pack® (leuprolide acetate for depot suspension and norethindrone acetate tablets)

The AbbVie Patient Assistance Foundation provides AbbVie medicines at no cost to patients experiencing financial difficulties. Eligible patients typically have no healthcare coverage for the requested product and do not have access to alternative sources of coverage or funding. All applications are reviewed on a case-by-case basis to support the AbbVie Patient Assistance Foundation's purpose of providing products at no cost to individuals in need.

Checklist for submitting an application:

- ☐ Ensure all sections of the application are completed. Make a copy before sending as no documents will be returned.
- ☐ Attach current proof of income (tax return, W2, pay stub) for all in household.
- ☐ Patient's signature/date is required on the application in two separate sections
- ☐ Prescriber's signature/date is required on the application.
- ☐ Provide a copy of Medicare card or letter of Medicaid and/or Social Security denial, if applicable.

Fax or mail the completed application and documentation to:

AbbVie Patient Assistance Foundation
PO Box 270
Somerville, NJ 08876
Fax: (866) 483-1305
Phone: (800) 222-6885

Upon receipt of a completed application, the prescriber and patient will be notified of program eligibility. If patient is eligible for assistance, a supply of medication will be shipped to the prescriber's office. It is the responsibility of the prescriber or office staff to reorder at least 7 business days prior to the patient requiring further medication.

Please contact us at 1-800-222-6885 Mon-Fri 8am-5pm CST for additional assistance.

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PATIENT INFORMATION

Patient Name | Gender: Male ☐ Female ☐ | Telephone Number

Patient Address | City | State | Zip

Date of Birth: _____ SSN (Last four digits): only): XXX-XX- ☐☐☐☐

INSURANCE INFORMATION

I have no insurance coverage ☐

I have insurance coverage that does not adequately cover this medication ☐

(Please attach a copy of all insurance cards & include a detailed list of your prescription and medical expenses for the household)

Are you enrolled in Medicare? ☐Yes ☐No If YES, check all that apply: ☐Part A ☐Part B ☐Part D

Do you have private insurance for prescriptions? ☐Yes ☐No

Are you covered through a state Medicaid Program? ☐Yes ☐No Do you have private medical insurance? ☐Yes ☐No

Number of people in your household (including yourself) ☐ Number in household under 18 ☐

Total Monthly Income for your entire household $ ☐☐☐☐☐

Attach the most current copies of income documentation for you and all dependent persons
Acceptable documents: Federal Tax Return, SSA, 1099, W2, pay stubs or benefits award letter

MEDICATION REQUESTED

Lupron Depot 3.75 mg ☐	Lupron Depot 11.25 mg 3 month ☐	Lupron Depot PED 11.25mg 3month ☐	Lupaneta Pack 3.75mg 1month kit GYN ☐
Lupron Depot 7.5 mg ☐	Lupron Depot 22.5 mg 3 month ☐	Lupron Depot PED 30mg 3 month ☐	Lupaneta Pack 11.25mg 3 month kit GYN ☐
	Lupron Depot 30mg 4 month ☐	Lupron Depot PED 7.5 mg ☐	
	Lupron Depot 45mg 6 month ☐	Lupron Depot PED 11.25 mg ☐	
		Lupron Depot PED 15mg ☐	

PRESCRIBER INFORMATION

Name and Professional Designation of Prescriber | DEA # (if none available, State License Number) | NPI Number

Shipping Address (no PO boxes please) | City | State | Zip

Mailing Address | City | State | Zip

Office Contact Person | Telephone Number | Fax Number

PHYSICIAN CERTIFICATION

By signing this form, I represent to the AbbVie Patient Assistance Foundation (the "Foundation") that I have obtained all necessary Federal and state authorizations and consents from my patient to allow me to release health information to the Foundation and its contracted third parties.

I verify that the information provided is current, complete and accurate to the best of my knowledge and certify that I am authorized to receive medications at the shipping location identified in this application. I verify that my State License is currently in good standing. I further certify that I will notify the Foundation in writing immediately if the status of my State License Number registration changes. If this applicant is eligible for the Foundation's patient assistance program (the "PAP"), I understand that the Foundation will send the medication to my office for dispensing to the patient. The Foundation reserves the right to request additional information if needed and to change or discontinue the PAP at any time, without notice. By signing this form, I certify that I am prescribing the aforementioned medication for an individual participating in the PAP. I acknowledge that I shall not seek reimbursement for any medication dispensed hereunder from any government program or third party insurer. I also understand that the applicant's acceptance into the PAP is not made in exchange for any explicit or implicit agreement or understanding that AbbVie Product will be used, purchased, leased, ordered, prescribed, recommended, or arranged for or provided formulary or other preferential or qualifying status. I understand that I may not delegate signature authority. I certify that treatment with this medication is medically necessary.

Physician Signature: (no stamps) _____ **Date:** _____

Notice to Health Care Providers and Insurers: This form of authorization may not comply with all applicable Federal and state laws governing disclosure of the patient's information to the Foundation and its contracted third parties. The Foundation urges all entities disclosing information about the patient to consult with legal counsel prior to relying on this form.

TO BE COMPLETED BY THE PATIENT

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PATIENT CERTIFICATION FOR PATIENT ASSISTANCE (Required)

I understand that any assistance in the form of product at no cost is contingent upon my ability to meet the eligibility criteria for the AbbVie Patient Assistance Program ("PAP") as determined by the AbbVie Patient Assistance Foundation, AbbVie Inc. or third parties contracted by the AbbVie Patient Assistance Foundation (collectively, the "Foundation"). I agree that the Foundation does not have any obligation to provide the PAP services to me and I waive any and all liability of the Foundation in the provision of the PAP services. I understand that by completing this form I am not guaranteed eligibility to receive medication at no cost from the PAP. In the event that I am eligible for the PAP, I acknowledge that this assistance is temporary and that I may be asked to reapply at designated intervals as determined by the Foundation. I also understand that the PAP may be changed or discontinued at any time without any notice to me and at such time the PAP services will no longer be provided. I agree that I will not seek reimbursement for any products dispensed under the PAP from any government program or third party insurer. I certify that the information I have provided in this form is accurate and complete. I agree that I will notify the PAP if my insurance or financial situation changes.

Patient's Name: _____ **Signature:** _____ **Date:**_____

(If applicable)
Representative Name: _____ **Signature:**_____ **Date:**_____

Relationship: _____

PATIENT CERTIFICATION FOR PATIENTS WITH A MEDICARE PRESCRIPTION DRUG PLAN (Required only for these patients)

If I am a member of a Medicare Prescription Drug Plan that offers prescription drug coverage for the requested medication under my Medicare Prescription Drug Plan and I am eligible for assistance through the AbbVie Patient Assistance Foundation:

1. I understand that I will be eligible to obtain the requested medication through the Foundation for a calendar year term, assuming I continue to meet the Foundation's eligibility criteria.
2. I agree that I will not purchase this medication under my Medicare plan that provides prescription drug coverage while enrolled in this program and through the end of the calendar year of my Foundation enrollment.
3. I agree that I will not submit claims nor seek true out-of-pocket (TrOOP) credit for any of the requested medication provided under the Foundation while enrolled in this program and through the end of the calendar year of my Foundation enrollment.
4. I agree that I will provide written notification to my Medicare Prescription Drug Plan of my approval to receive a supply of the requested medication at no cost outside of the Medicare Part D benefit through the Foundation. The notification is to ensure that payment for the product is not made by my Medicare plan, that no part of the costs of the product is credited toward my TrOOP balance, and that my plan can undertake appropriate drug utilization review and medication therapy management program activities.
5. I will notify the Foundation immediately if my prescription drug coverage changes.

Patient's Name: _____ **Signature:** _____ **Date:**_____

(If applicable)
Representative Name: _____ **Signature:** _____ **Date:**_____

Relationship: _____

ADDITIONAL PERMISSION FOR PURPOSES OF THE PROGRAM (optional)

I permit the AbbVie Patient Assistance Foundation to speak with the following person about this application

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

Patient Signature: _____ **Date:**_____

PERSONAL REPRESENTATIVE REPRESENTATION (if applicable)

Personal Representative Representation (if applicable):

Note: A Patient's Personal Representative may sign this Form on behalf of the Patient. However, only certain individuals may qualify as the Patient's Personal Representative. A State law prescribes who can be a Personal Representative for purposes of this Authorization.

By signing below, I represent that I am an authorized Personal Representative of the Patient under applicable state law.

Representative Name_____ **Relationship:**_____ **Signature:** _____ **Date:**_____

PATIENT SIGNATURE REQUIRED

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AUTHORIZATION FOR DISCLOSURE OF INFORMATION

I understand that the purpose of this authorization ("Authorization") is to give my permission for the disclosure and use of my protected health information. I request and authorize my healthcare providers and healthcare insurers that have provided treatment, payment or services to me or for me to disclose any information regarding my health, treatment, and coverage that pertains to payment for medication to the AbbVie Patient Assistance Foundation, AbbVie Inc., its affiliates, or third parties contracted by the AbbVie Patient Assistance Foundation, (collectively, the "Foundation") for the following purposes: (i) to determine my eligibility for the Foundation's patient assistance program ("PAP"), (ii) if necessary, to account for and assist with my withdrawal from the PAP and/or transfer to a separate private or public payer program, and (iii) to administer and maintain the high quality of the PAP, including but not limited to case review, compliance checks, audit review and accounting purposes. I understand that once the Foundation receives my health information, it may communicate with my health care providers and insurers to determine my PAP eligibility. I understand that I am not required to sign this Authorization and that no health care provider or insurer will condition 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 the PAP (should I qualify). I understand that I may cancel this authorization at any time by writing to the AbbVie Patient Assistance Foundation at PO Box 270, Somerville, NJ, 08876 as well as by notifying my health care providers and insurers. If I cancel this Authorization, I can no longer participate in certain aspects of the PAP. Once the Foundation receives and processes my cancellation request, the Foundation will not use my health information going forward. I understand that cancelling my Authorization will not affect any use of my health information that occurred before my request was processed. This authorization shall be valid for 10 years from the date of the signature on this form (unless a shorter period is prescribed by state law). I understand that, unless otherwise restricted by state law, my health information released under this Authorization is subject to re-disclosure by the Foundation and will no longer be protected by HIPAA.

Patient's Name: _____ Signature: _____ Date:_____

(If applicable)
Representative Name : _____ Signature: _____ Date:_____
Relationship: _____