myAbbVie Assist | Patient Assistance

APPLICATION FOR BOTOX® (onabotulinumtoxinA)

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: Provider Sponsor Information and Shipping Preference**
- ☐ **SECTION 2: Treatment information and Provider Sponsor Signature**
- ☐ **SECTION 3: Patient 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 4: Insurance Information**
  - If you have Insurance, please include front and back copies of all insurance cards.
- ☐ **SECTION 5: Patient Consent and Signature**
  - Carefully read the HIPAA authorization, patient terms of participation and privacy notice in Section 6 on Page 3.
  - Confirm your understanding of our privacy policy by providing your signature and date in Section 5.
- ☐ **Please keep a copy for your records.**
- ☐ **Please do not staple documents together when mailing.**

FAX THE COMPLETED APPLICATION AND DOCUMENTATION TO THE FOLLOWING

myAbbVie Assist
Phone: 1-800-442--6869
Fax: 1-866-217-7178

Upon review of a completed application, we will notify the prescriber about eligibility. If approved, we will send the BOTOX Request Form to the Provider Sponsor to order the medication. Prior to each subsequent shipment, the Provider Sponsor must complete the BOTOX Request Form and schedule the next delivery.

Please contact us at 1-800-442-6869 Monday through Friday for additional assistance.

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1 PROVIDER SPONSOR INFORMATION • SHIPPING PREFERENCE

Provider Sponsor Name: ☐ Physician's Office ☐ Hospital ☐ Other_____

Facility Name: Contact Name and Title:

Address: City/State/Zip:

NPI or SLN: Contact Phone: Fax:

Please provide contact person and address for product shipment (if different from above):

Provider Sponsor Name: Contact Person and Title:

Address: City/State/Zip:

Contact Phone: Fax:

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

2 TREATMENT INFORMATION AND PROVIDER SPONSOR SIGNATURE

Diagnosis (ICD-10 Code): _____ **Estimated Dose (in 100 Unit vials):** _____

PROVIDER SPONSOR SIGNATURE AND DATE: X _____ **DATE:** _____

PROVIDER MUST MANUALLY SIGN. RUBBER STAMPS, SIGNATURE BY OTHER OFFICE PERSONS 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 or return for credit any medication provided under this program. I also understand that the applicant's acceptance into the program should not influence treatment decisions. I agree that any medication 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 the costs of administering this medication if I am unable to waive the administration fee. 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.

3 PATIENT INFORMATION

Patient Name: Date of Birth (DOB): Sex: ☐ M ☐ F

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

Mailing Address: City/State/Zip:

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

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

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

4 INSURANCE INFORMATION ☐ I have no insurance coverage – go to Section 5

INSURANCE TYPE: ☐ **HMO/EPO** ☐ **PPO** ☐ **POS** ☐ **Indemnity** ☐ **Medicare** ☐ **Medicaid** ☐ **Other:** _____

Please provide insurance details below and attach a front and back copy of all insurance cards.

MEDICAL INSURANCE			SECONDARY INSURANCE		
Insurance Company:			Insurance Company:		
Address, City, State, Zip:			Address, City, State, Zip:		
Insurance Co. Phone:			Insurance Co. Phone:		
Policy ID #:	Group #:		Policy ID #:	Group #:	
Policyholder Name and DOB:		Relationship:	Policyholder Name and DOB:		Relationship:

5 PATIENT CONSENT

PLEASE REVIEW HIPAA AUTHORIZATION, PATIENT TERMS OF PARTICIPATION AND PRIVACY NOTICE IN SECTION 6 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 6.

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 6.

X_____ PATIENT SIGNATURE / LEGAL REPRESENTATIVE (indicate relationship)

X_____ DATE

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6 HIPAA AUTHORIZATION, PATIENT TERMS OF PARTICIPATION AND PRIVACY NOTICE

HIPAA AUTHORIZATION Please provide signature in Section 5 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 1-800-442-6869. 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 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. I understand that this patient assistance program provides this medication at no charge and does not include the provider administration fee. I also understand that if the provider is not able to waive the fee for administering this medication, the administration costs will be my responsibility.

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 1-800-442-6869.

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.