myAbbVie Assist | Patient Assistance

APPLICATION FOR
CREON® (pancrelipase) Delayed Release Capsules

myAbbVie Assist provides free medicines 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**

- **SECTION 1:** Prescriber Information
- **SECTION 2:** Patient History
- **SECTION 3:** Prescription
- **SECTION 4:** Prescriber Certification and Signature

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

- **SECTION 5:** Patient Information
- **SECTION 6:** Financial Information
  - Please include proof of income for all in the household. Current federal tax return is preferred.
- **SECTION 7:** Insurance Information
  - If you have Insurance, include front and back copies of all prescription 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 print out from your pharmacy will be helpful. This information will help us review your eligibility for our program.
- **SECTION 8:** Patient Consent and Signature
  - Carefully read the HIPAA privacy notice, terms of participation and patient privacy notice in Section 10 on Page 4.
  - Confirm your understanding of our privacy policy by providing your signature and date in Section 8.
- **SECTION 9:** Additional Permission for Program Purposes (Optional)

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

FAX OR MAIL THE COMPLETED APPLICATION AND DOCUMENATION TO:

myAbbVie Assist
PO Box 270
Somerville, NJ 08876

Phone: 1-800-222-6885
Fax: 1-800-276-9901

Upon receipt of a completed application, we will notify the patient and the prescriber about eligibility. If approved, we will ship the medication to the patient's home. Patient or prescriber please call 1-800-222-6885 to request refill.

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

This program is part of the AbbVie Patient Assistance Foundation, a separate legal entity from AbbVie.

myAbbVie Assist | Patient Assistance

PRESCRIBER PRESCRIPTION AND CERTIFICATION
TO BE COMPLETED BY PRESCRIBER

APPLICATION FOR
CREON® (pancrelipase) Delayed Release Capsules

PO Box 270
Somerville, NJ 08876
PHONE: 1-800-222-6885
FAX: 1-800-276-9901

1 PRESCRIBER INFORMATION

Prescriber Name: ☐ MD ☐ DO ☐ Other:_____

Office Name: Office Contact Name:

Address: City/State/Zip:

NPI: Phone: Fax:

Tax ID: DEA/SLN: DEA/SLN Expiration Date:

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

2 PATIENT HISTORY

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

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

Other Medications_____

3 RX: MUST BE COMPLETED BY A LICENSED PRESCRIBER

Creon® (pancrelipase) Delayed-Release Capsules	Directions	Quantity	Refill
☐ **3,000 Lipase Units** ☐ **6,000 Lipase Units** ☐ **12,000 Lipase Units** ☐ **24,000 Lipase Units** ☐ **36,000 Lipase Units**			

Special Note: **New York Prescribers please submit prescription on an original NY State prescription blank. For all other States, if not faxed, must be on State specific blank if applicable for your State**

PLEASE 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 ALLOWED

PRESCRIBER SIGNATURE: **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.

myAbbVie Assist | Patient Assistance

PATIENT PLEASE COMPLETE, SIGN AND DATE

PO BOX 270
Somerville, NJ 08876
PHONE: 1-800-222-6885
FAX: 1-800-276-9901

APPLICATION FOR CREON® (pancrelipase) Delayed Release Capsules

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:

Email Address:

Preferred Phone: | ☐ Ok to leave a voicemail | Alternate Phone: | ☐ Ok to leave a voicemail

Treating Physician's name: _____ Physician's phone number: _____

6 FINANCIAL INFORMATION

Monthly Total Income for everyone in the household: $ _____ *Please include financial documentation for everyone in the household. A copy of your Federal Tax Return is preferred.*

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

7 INSURANCE INFORMATION

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

☐ **If you have insurance, please provide insurance details below and attach a front and back copy of the insurance card.**

Please include a detailed list of prescriptions such as a Pharmacy print-out and medical expenses for the household you would like us to consider.

INSURANCE INFORMATION		Group or Policy Number	Insurance Name and Phone
Medicare	❑ Yes ❑ No		
Medicare Part D	❑ Yes ❑ No		
Medicare Advantage Plan	❑ Yes ❑ No		
Private Insurance	❑ Yes ❑ No		
State Elderly Drug Assistance	❑ Yes ❑ No		
Medicaid or State Children Assistance Insurance	❑ Yes ❑ No		
Veterans Assistance	❑ Yes ❑ No		

MEDICARE INFORMATION:

Are you enrolled in a Medicare Prescription Drug Plan (Medicare Part D)? ☐ Yes ☐ No

If Yes, please provide your Medicare Part A Identification #: _____ Value of your assets: $ _____

Assets include checking and savings accounts, CD's, stocks and bonds, savings bonds, mutual funds, IRAs and other investments, cash at home or anywhere else, and the value of your life insurance policies if turned in for cash right now. Do not include your home, vehicles, burial plots, or personal possessions.

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.

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.

PLEASE SIGN → **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:** _____

myAbbVie Assist | Patient Assistance

PATIENT TERMS OF PARTICIPATION AND PRIVACY NOTICE
PATIENT: PLEASE READ AND SIGN IN SECTION 8

APPLICATION FOR
CREON® (pancrelipase) Delayed Release Capsules

PO Box 270
Somerville, NJ 08876
PHONE: 1-800-222-6885
FAX: 1-800-276-9901

10 HIPAA AUTHORIZATION, 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 the 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) 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 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 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.