APPLICATION FOR
Duopa® (carbidopa/levodopa enteral suspension)

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**
  - SECTION 1: Physician Information
  - SECTION 2: Physician Orders
  - SECTION 3: Physician Certification and Signature

- **IF YOU ARE THE PATIENT, COMPLETE PAGE 3. PLEASE READ PAGE 4**
  - SECTION 4: Patient Information
    - Please include proof of income for all in the household. Current federal tax return is preferred
  - SECTION 5: Insurance Information
  - SECTION 6: Patient Consent and Signature
    - Carefully read the HIPAA Authorization, terms of participation and patient privacy notice in Section 7 on page 4

**Fax or mail the completed application and documentation to:**

myAbbVie Assist
200 Pinecrest Plaza
Morgantown, WV 26505
Fax: 1-844-845-2323
Phone: 1-844-265-8027

Upon receipt of a completed application, we will notify the patient and the prescriber about eligibility. If approved, patient will be contacted to arrange shipment of product. Medication will be shipped to the destination indicated on the application.

Please contact us at 1-844-265-8027 Monday through Friday for additional assistance.
APPLICATION FOR
DUOPA® (carbidopa/levodopa enteral suspension)

1 PHYSICIAN INFORMATION

☐ MD  ☐ DO  ☐ Other:____

Physician Name:
Office Name:  Office Contact Name:
Address:  City/State/Zip:
Phone:  Fax:
State License #:  DEA #:  NPI/Insurance Provider #:

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

PATIENT HISTORY

Patient’s Name:  DOB:
Patient Diagnosis:  Date of Diagnosis:___________________  ☐ Parkinson’s disease (332)  ☐ Other (include code):___________________
☐ Other Medications:  ☐ No other medications
☐ Allergies (List):  ☐ No known allergies

2 PHYSICIAN’S ORDERS

DUOPA CASSETTES
Number of boxes (7 cassettes per box):___________  Days supply:___________  Refills:___________  SIG:_____________________

DUOPA PUMP (In states not permitting dual prescriptions, please fax a separate prescription)
☐ Non-programmed (default settings) CADD-Legacy 1400 portable infusion pump for Duopa and pump bag (Pump to be programmed by prescriber or agent)
☐ Programmed CADD-Legacy 1400 portable infusion pump for Duopa and pump bag

Flow Rates:  Morning Dose:_______________  Continuous Dose:______________  Lock Level:_____________________________
Extra dose enabled?  ☐ N  ☐ Y If Yes, extra dose amount:__________________  Extra dose lockout time:___________________
SIG:      Use to infuse Duopa cassettes__________________

SUPPLIES (In states not permitting dual prescriptions, please fax a separate prescription)
☐ Boston WW adapter  Qty:____________   Refills:________________     SIG: _____Use to infuse Duopa cassettes____
☐ Boston Luer lock cap  Qty:____________   Refills:________________     SIG: _____Use to infuse Duopa as directed____
☐ 10 mL Male Luer lock syringe  Qty:____________   Refills:________________     SIG: _____Use to infuse Duopa as directed____
☐ AA batteries                                   Qty:____________   Refills:________________     SIG: _____Use to infuse Duopa as directed____

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

3 PHYSICIAN CERTIFICATION

PRESCRIBER MUST MANUALLY SIGN. RUBBER STAMPS, SIGNATURE BY OTHER OFFICE PERSONNEL 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. 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.

Physician Signature:☐     (no stamps)     Date
(Dispense as Written)     Date

Physician Signature:☐     (Substitution Permitted)
### PATIENT INFORMATION

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>Sex:</th>
<th>M</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>DOB:</td>
<td>SSN (last four digits ONLY):</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Address (No P.O. Box):</td>
<td>City/State/Zip:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Daytime Phone:</td>
<td>Evening Phone:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician Name:</td>
<td>Physician Phone:</td>
<td>Physician Fax:</td>
<td></td>
</tr>
<tr>
<td>Current Monthly Household Income: $</td>
<td>Number in Household (circle):</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

Please include financial documentation for everyone in the household, preferably a copy of your most recent Federal Tax Return.

### INSURANCE INFORMATION

Please attach copies of the front and back of all of your insurance cards.

Do you have private insurance coverage? | Yes | No
---|---|---
Are you covered through a state Medicaid Program? | Yes | No

Are you enrolled in Medicare? | Yes | No
If YES, check all that apply: | Part A | Part B | Part D Prescription Drug Plan
Do you have a Medicare Advantage Plan? | Yes | No

Are you eligible for extra help (financial assistance from Social Security) with medication costs under Medicare Part D? | Yes | No | Unsure

Are you Disabled? | Yes | No
Are you a Veteran? | Yes | No

### PRIMARY INSURANCE

<table>
<thead>
<tr>
<th>Insurance Company:</th>
<th>Insurance Company:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insurance Co. Phone:</td>
<td>Insurance Co. Phone:</td>
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<tr>
<td>Policy #:</td>
<td>Group #:</td>
</tr>
<tr>
<td>Policyholder Name:</td>
<td>Relationship to Policyholder:</td>
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<tr>
<td>Policyholder DOB:</td>
<td>Policyholder DOB:</td>
</tr>
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<td>Policyholder DOB:</td>
<td>Relationship to Policyholder:</td>
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### SECONDARY INSURANCE

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<thead>
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<th>Insurance Company:</th>
<th>Insurance Company:</th>
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<tbody>
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<td>Relationship to Policyholder:</td>
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<tr>
<td>Policyholder DOB:</td>
<td>Policyholder DOB:</td>
</tr>
<tr>
<td>Policyholder DOB:</td>
<td>Relationship to Policyholder:</td>
</tr>
</tbody>
</table>

### PATIENT CONSENT

Please review HIPAA Authorization, Patient Terms of Participation and Privacy Notice in Section 7 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 7.

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 7.

Please sign: X

PATIENT SIGNATURE / LEGAL REPRESENTATIVE (indicate relationship) | DATE
HIPAA AUTHORIZATION

Please provide signature in Patient Consent section on Page 3 of the 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 Services. I understand that information released provided 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 1-844-386-4968 or by writing myAbbVie Assist, 200 Pinecrest Plaza Morgantown, WV 26505. 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 services to you and is not liable in the provision of these services. myAbbVie Assist may be changed or discontinued without notice. You will not seek reimbursement for any products dispensed under the program. You will notify myAbbVie Assist 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 PAP; (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 Plan regarding your program enrollment. If you have questions, want to update your information, or terminate your enrollment, please call 1-844-386-4968 or write to us at 200 Pinecrest Plaza, Morgantown, WV 26505.

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.