abbvie PATIENT ASSISTANCE FOUNDATION

Patient Assistance 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 eligible patients experiencing financial difficulties. We review all applications 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.

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 Information
- **SECTION 3:** Product information
- **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
  - Also include proof of income for all in household. A copy of your current federal tax return is preferred.
- **SECTION 7:** Insurance Information
  - If you have Insurance, include front and back copies of all prescription insurance card(s).
- **SECTION 8:** Patient Consent and Signature
  - Carefully read the privacy notice and terms of participation 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)
- **SECTION 10:** Patient Privacy Notice and Terms of Participation

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

FAX OR MAIL THE COMPLETED APPLICATION AND DOCUMENATION TO THE FOLLOWING

AbbVie Patient Assistance Foundation
PO Box 270
Somerville, NJ 08876

Phone: 1-800-222-6885
Fax: 1-866-483-1305

Upon review of a completed application, we will notify the prescriber and patient about eligibility. If approved, we will ship the medication to the prescriber's office. 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.

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PRESCRIBER PRESCRIPTION AND CERTIFICATION
TO BE COMPLETED BY PRESCRIBER

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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 EXIPRATION DATE:

2 PATIENT INFORMATION

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

3 Product: MUST BE COMPLETED BY A LICENSED PRESCRIBER

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

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 _____ **DATE:** _____

I verify that the information provided is current, complete and accurate to the best of my knowledge. The Foundation reserves the right to request additional information if needed and to change or discontinue the PAP 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 PAP should not influence treatment decisions. I understand that I may not delegate signature authority. I certify that treatment with this medication is medically necessary.

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

6 FINANCIAL INFORMATION

Monthly Total Income for everyone in the household: $ _____

Attach the most recent copies of proof of income for all in household. Your most recent tax return is preferred. Acceptable documents include: Federal Tax Return, SSA 1099, W2, pay stubs or benefits award letter.

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		
Medicaid	❑ Yes ❑ No		
Private Insurance	❑ Yes ❑ No		
State Elderly Drug Assistance	❑ Yes ❑ No		
State Children Health 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 PRIVACY NOTICE AND PROGRAM TERMS ON PAGE 4 TO UNDERSTAND HOW WE USE YOUR PERSONAL DATA

I acknowledge that I have provided accurate and complete information and understand the Patient Terms of Participation on Page 4.

PLEASE SIGN →

My signature below certifies that I have read, understood and agreed to the HIPAA Authorization on Page 4.

X_____

PATIENT SIGNATURE / LEGAL REPRESENTATIVE (indicate relationship) DATE

9 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:**_____

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10 PATIENT PRIVACY NOTICE AND TERMS OF PARTICIPATION

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, AbbVie, its affiliates, and agents/contractors (collectively the "Foundation"), to enroll me in and provide me with PAP Services. 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 AbbVie Patient Assistance Program ("PAP") (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 the AbbVie Patient Assistance Foundation, 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

The Foundation provides AbbVie medicines at no cost to eligible patients experiencing financial difficulties. 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 PAP as determined by the Foundation. The Foundation does not have any obligation to provide the PAP services to you and is not liable in the provision of these services. The PAP may be changed or discontinued without notice. You will not seek reimbursement for any products dispensed under the PAP. You will notify the PAP 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 Prescription Drug Plan and are qualified for PAP assistance, you will: (i) be eligible to obtain the medication from the PAP for a calendar year term (ii) not purchase this medication under your Medicare Prescription Drug 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) provide written notification to your Medicare Prescription Drug Plan that you are receiving your medication at no cost outside of the Medicare Part D benefit.

In order for you to participate, the PAP will use and disclose your personal information, including your health information, collected on this enrollment form and through participation in the PAP for the following purposes:

(1) To determine your eligibility for the PAP 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 ("PAP Services").
(2) To perform research and data analytics to develop and evaluate products, services, materials, and treatments.
(3) To administer and maintain the high quality of the PAP, including but not limited to case review, compliance checks, audit review and accounting purposes.

PAP may combine the information it receives about you with information from other sources. However, PAP will not sell or rent any information that can identify you to third parties for their own purposes or otherwise use or disclose any information that can identify you for any purpose not authorized above. If you have questions about this Privacy Notice, want to update your information, or terminate your PAP enrollment, please call 1-800-222-6885 or write to us at PO BOX 270, Somerville, NJ 08876.