APPLICATION FOR
MAVYRET™ (glecaprevir/pibrentasvir)

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

Ensure all sections of the application are completed. Failure to complete required information will delay the review process.

☐ SECTION 1: Patient Information and Shipping Preference
  o Please include proof of income for all in household. A copy of the patient’s current federal tax return is preferred.

☐ SECTION 2: Patient Insurance
  o If the patient has insurance, include front and back copies of all prescription insurance cards.

☐ SECTION 3: Patient Consent and Signature
  o Carefully read the privacy notice and terms of participation in Section 8 on Page 3.
  o Confirm your understanding of our privacy policy by providing your signature and date in Section 3.

☐ SECTION 4: Patient History and Diagnosis

☐ SECTION 5: Prescriber Information

☐ SECTION 6: Prescription

☐ SECTION 7: Prescriber Certification and Signature
  o Section 6 and 7 must be completed by a licensed prescriber. The form must be faxed directly from the prescriber’s office.

Please keep a copy for your records.

FAX OR MAIL THE COMPLETED APPLICATION AND DOCUMENTATION TO THE FOLLOWING:

myAbbVie Assist
PO Box 4280,
Gaithersburg, MD 20885

Phone: 1-855-687-7503
Fax: 1-855-886-2481

Upon receipt of a completed application, we will notify the prescriber and patient about eligibility. If approved, we will ship the medication to the patient’s home unless otherwise indicated on the application. Prior to each subsequent 28-day shipment, we will contact the shipping location to schedule the next delivery.

Please contact us at 1-855-687-7503 Monday through Friday for additional assistance.
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1 PATIENT INFORMATION

- Check if shipping to Prescriber’s office (cannot ship to a PO Box)
- Patient’s Name: ______________________
- DOB: ______________________
- Last 4 SSN: __________
- Male ☐ Female ☐
- Shipping Address (No PO Box): ______________________
- Shipping City/State/Zip: ______________________
- Mailing Address: ______________________
- Mailing City/State/Zip: ______________________
- Primary Phone: ______________________
- Alternate Phone: ______________________
- Language: ☐ English ☐ Spanish ☐
- Annual Household Income: $ ____________
- Number in Household (including self): __________

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

2 PATIENT INSURANCE

- No Insurance ☐ Medicaid ☐ Medicare ☐ Private/Commercial ☐ Other: ______________________
- Insurance Name: ______________________
- Phone #: ______________________
- PBM Name: ______________________
- PBM Phone #: ______________________
- Policy #: ______________________
- Group #: ______________________
- PBM BIN #: ______________________
- PBM Group #: ______________________
- Policyholder Name: ______________________
- Policyholder DOB: ______________________

Please also include a front and back copy of prescription and insurance cards.

3 PATIENT CONSENT

PLEASE REVIEW PRIVACY NOTICE AND PROGRAM TERMS IN SECTION 8 TO UNDERSTAND HOW WE USE YOUR PERSONAL DATA

I acknowledge that I have provided accurate and complete information and have read the Patient Terms of Participation in Section 8.

My signature below certifies that I have read, understood and agreed to the HIPAA Authorization in Section 8.

Please sign and date:

PATIENT SIGNATURE / LEGAL REPRESENTATIVE (indicate relationship) DATE ______________________

4 PATIENT HISTORY ● DIAGNOSIS

- HCV Genotype: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6
- Fibrosis (F) Score: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
- Diagnosis (ICD-10 Code): ☐ B18.2 Chronic Viral Hepatitis C ☐ B19.20 Unspecified Viral Hepatitis C without Hepatic Coma
- Treatment History: ☐ Treatment - Naive ☐ Treatment - Experienced ☐ Direct-Acting Antiviral ☐ Other HCV Medications
- Medical History: ☐ Renal Insufficiency ☐ CKD Stage: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ Compensated Cirrhosis (Child-Pugh A) ☐ Hep B Vaccine: Yes Year:_____ ☐ No ☐
- Medications (List): ______________________
- Allergies (List): ______________________

5 PRESCRIBER INFORMATION

- Prescriber Name: ______________________
- NPI or SLN: ______________________
- ☐ Hepatology ☐ Gastro ☐ ID ☐ Other: __________
- Facility Name: ______________________
- Facility Phone: ______________________
- Address: ______________________
- City/State/Zip: ______________________
- Contact Name: ______________________
- Contact Phone: ______________________
- Contact Fax: ______________________

6 PRESCRIPTION ● MUST FAX DIRECTLY FROM PRESCRIBER OFFICE

(PLEASE CHECK REFILL NUMBER AND SIGN/DATE)

<table>
<thead>
<tr>
<th>MEDICATION DOSE/STRENGTH</th>
<th>DIRECTIONS</th>
<th>QTY</th>
<th>REFILLS</th>
</tr>
</thead>
<tbody>
<tr>
<td>MAVYRET</td>
<td>1 daily dose pack (3 tablets) by mouth once daily with food</td>
<td>28-day supply</td>
<td>☐ 1 ☐ 2 ☐ 3</td>
</tr>
</tbody>
</table>

100 mg; pibrentasvir 40 mg fixed-dose combination tablets

NEW YORK PRESCRIBERS: PLEASE SUBMIT PRESCRIPTION PER NY STATE LAW RESTRICTIONS.
FOR ALL OTHER STATES, IF NOT FAXED, MUST BE ON STATE SPECIFIC BLANK IF APPLICABLE.

7 PRESCRIBER SIGNATURE

Substitution Permitted ☐ Dispense as Written ☐ Date ______________________

Prescriber must manually sign. Rubber stamps, signature by other office personnel or computer generated images are not allowed.

I certify that treatment with this medication is medically necessary.

For full Prescribing Information please visit www.rxabbvie.com

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8 PATIENT PRIVACY NOTICE AND TERMS OF PARTICIPATION

HIPAA AUTHORIZATION  Please provide signature in Section 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 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 1-855-687-7503 or by writing myAbbVie Assist, PO Box 4280, Gaithersburg, MD 20885. 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 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.

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

(1) To determine your eligibility 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 (“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.

We may combine the information we receive about you with information from other sources. However, we 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 enrollment, please call 1-855-687-7503 or write to myAbbVie Assist, PO Box 4280, Gaithersburg, MD 20885.