abbvie

AbbVie Patient Assistance Application
MAVYRET™ (glecaprevir/pibrentasvir)

The AbbVie Patient Assistance program provides MAVYRET at no cost to eligible uninsured and underinsured patients experiencing financial difficulties. Participation in our program is free; we do not collect any fees for submitting an application to our program.

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
  - 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
  - If the patient has insurance, include front and back copies of all prescription insurance card(s).
- **SECTION 3:** Patient Consent and Signature
  - Carefully read the privacy notice and terms of participation in Section 8 on Page 3.
  - 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 and Shipping Preference
- **SECTION 6:** Prescription
- **SECTION 7:** Prescriber Certification and Signature
  - Section 6 and 7 must be completed by a licensed prescriber. The form must be faxed directly from the prescriber's office.
- **SECTION 8:** Patient Terms of Participation and Privacy Notice

Please keep a copy for your records.

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

AbbVie Patient Assistance Program
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 regarding 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, the AbbVie Patient Assistance Program 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

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 income documentation for your household, such as a copy of your current federal tax return.***

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 ON PAGE 3 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 on Page 3.

My signature below certifies that I have read, understood and agreed to the HIPAA Authorization on Page 3.

✕ _____

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 - Naïve ☐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: ☐No ☐Yes Year:____

Medications (List): _____ **Allergies (List):** _____

5 PRESCRIBER INFORMATION ☐ Check if shipping to Prescriber's office (cannot ship to a PO Box)

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 (PLEASE CHECK REFILL NUMBER AND SIGN/DATE) ● MUST FAX DIRECTLY FROM PRESCRIBER OFFICE

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QTY	REFILLS
MAVYRET	glecaprevir 100 mg; pibrentasvir 40 mg fixed-dose combination tablets	**1 daily dose pack (3 tablets) by mouth once daily with food**	**28-day supply**	☐1 ☐2 ☐3 Other: _____

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**

PRESCIBER 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. The Patient Assistance Program ("PAP") 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. By signing this form, I authorize the PAP and its representatives to transmit this prescription form electronically, by facsimile, or by mail to a pharmacy designated by the PAP 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.

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 on Page 2 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 Program, AbbVie, its affiliates, and agents/contractors (collectively the "Program"), 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 1-855-687-7503 or by writing AbbVie Patient Assistance, 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

The Program 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 Program. The Program 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 1-855-687-7503 or write to AbbVie Patient Assistance, PO Box 4280, Gaithersburg, MD 20885.

For full Prescribing Information please visit www.rxabbvie.com