abbvie

# AbbVie Patient Assistance Program
# Application for ORILISSA™ (elagolix)

The AbbVie Patient Assistance Program provides ORILISSA™ (elagolix) at no cost to eligible uninsured and underinsured patients experiencing financial difficulties.

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 PATIENT:

- Section 1: Patient and financial Information. Please include proof of income for all in the household. Current federal tax return is preferred.
- Section 2: Insurance information. Please include copies of all insurance and prescription cards.
- Section 3: Patient Consent, please be sure to check the box and sign.
    - Section 6: Carefully read the privacy notice and terms of participation before signing Section 3.

IF YOU ARE THE PRESCRIBER:

- Section 4: Prescriber Information.
- Section 5: Prescription Information and Prescriber Signature needed.

ADDITIONAL REMINDERS BEFORE SUBMITTING:

- ❑ Ensure all sections of the application are completed.
- ❑ Make a copy before sending as no documents will be returned.
- ❑ Please include proof of income for all in household. A copy of the patient's current federal tax return is preferred.
- ❑ Include a copy of all insurance and pharmacy benefit cards.
- ❑ If applicable, include a copy of letter of Medicaid and/or Social Security Low Income Subsidy denial.

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

AbbVie Patient Assistance Program
PO Box 66570
St. Louis, MO 63166
Phone: (866) 244-9711
**FAX: (866) 750-6694**

## e-Prescriptions may be sent to:

Pharmacy Name: **ESSDS PAP Pharmacy**
NCPDP Number: **2641935**

Upon review 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. Patient may request refills by calling 1-866-244-9711.

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## 1 Patient Information *(*required field)*

*Patient Name: _____ Gender: ❑ Female ❑ Male

*Date of Birth: _____ *Patient Address: _____

Patient Email: _____ *City/State/Zip: _____

*Primary Phone #: ❑Home ❑Cell _____ Alternate Phone #: ❑Home ❑Cell _____

❑ Shipping Address Same as Patient Address ❑ Shipping Address: _____

Address City State Zip Code

Are you disabled? ❑ Yes ❑ No Are you a Veteran of the U.S. Armed Forces? ❑ Yes ❑ No

Number of people in your household (including yourself)? _____ Total Monthly Income for your entire household $ _____

*Attach the most current copies of income documentation for you and all dependent persons Federal Tax Return, SSA, 1099, W2, pay stubs, or benefits award letter*

## 2 Insurance Information *(*required field)*

**Must select one of the following:*

❑ I have no health insurance for prescriptions

❑ I have insurance coverage that does not adequately cover this medication (Please attach a copy of all insurance cards & include a detailed list of your prescription and medical expenses for the household)

→ Are you enrolled in Medicare? ❑ Yes ❑ No

→ If YES, check all that apply: ❑ Part A ❑ Part B ❑ Part C/Medicare Advantage ❑ Part D

→ Are you covered through a state Medicaid Program? ❑ Yes ❑ No

→ Do you have private insurance for prescriptions? ❑ Yes ❑ No

## 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 understand the Patient Terms of Participation on Page 3.

Please Check Box ☐ *I understand that I am providing written instructions to the Program under the Fair Credit Reporting Act authorizing the Program to obtain information about my credit profile from credit reporting agencies or other sources. I authorize the Program to obtain such information solely to determine PAP eligibility.*

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

→ X _____

PATIENT SIGNATURE / LEGAL REPRESENTATIVE (indicate relationship) DATE

## 4 Prescriber Information *(*required field)*

*Prescriber Name: _____ Specialty: _____

NPI Number: _____ Facility Name: _____

*DEA/State License #: _____ *Address: _____

Office Contact: _____

*Contact Phone #: _____ *City/State/Zip: _____

Contact E-Mail: _____ *Office Fax #: _____

## 5 Prescription & Healthcare Provider Information *(*required field)*

❑ ORILISSA (elagolix) tablets, 150mg Quantity: _____ Refill(s): _____ Directions for Use: _____

❑ ORILISSA (elagolix) tablets, 200 mg Quantity: _____ Refill(s): _____ Directions for Use: _____

Concurrent Medication(s): _____ Allergies: _____

**By signing this form, I represent to the AbbVie Patient Assistance Program (the "Program") that I have obtained all necessary Federal and state authorizations and consents from my patient to allow me to release health information to the Program and its contracted third parties.**

I verify that the information provided is current, complete and accurate to the best of my knowledge. The Program 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 is not made in exchange for any explicit or implicit agreement or understanding that AbbVie Product will be used, purchased, leased, ordered, prescribed, recommended, or arranged for or provided formulary or other preferential or qualifying status. I understand that I may not delegate signature authority. I certify that treatment with this medication is medically necessary.

→**The prescriber is to comply with his/her state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.**

Physician Signature: _____ Physician Signature: _____

(No Stamps) (Dispense as Written) Date (No Stamps) (Substitution Permitted) Date

**For states requiring handwritten expressions of Product Selection, use this area (e.g., medically necessary, may not substitute, dispense as written, etc.)**

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## 6 PATIENT PRIVACY NOTICE AND TERMS OF PARTICIPATION

**HIPAA AUTHORIZATION** **Please provide signature in Patient Consent Section on Page 2 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 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 1-866-244-9711 or by writing to the AbbVie Patient Assistance Program, PO Box 66570, St. Louis, MO 63166. 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 the 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 obtain information from your credit profile about your income for the sole purpose of determining eligibility for the PAP. This notice serves as written instruction under the Fair Credit Reporting Act authorizing the PAP to obtain this information.
(3) To perform research and data analytics to develop and evaluate products, services, materials, and treatments.
(4) 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 1-866-244-9711 or write to us at PO Box 66570, St. Louis, MO 63166.