myAbbVie Assist | Patient Assistance

Application for ORILISSA™ (elagolix)

myAbbVie Assist provides free medicines 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 SECTION 4 and 5 on PAGE 2**

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

☐ **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.
  - If you have insurance, include front and back copies of all prescription insurance cards
  - If you have insurance coverage, please attach a list of your medical or prescription drug out of pocket costs. If you are taking multiple prescriptions, a print out from your pharmacy will be helpful. This information will help us review your eligibility for our program
- **Section 3:** Patient Consent, please be sure to check the box, sign and date
- **Section 6:** Carefully read the privacy notice and terms of participation before signing Section 3

☐ Please keep a copy for your records

FAX OR MAIL THE COMPLETED APPLICATION AND DOCUMENTATION TO THE FOLLOWING

myAbbVie Assist
PO Box 66570
St. Louis, MO 63166

Phone: (866) 244-9711
FAX: (866) 750-6694

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 or prescriber please call 1-866-244-9711 to request a refill.

Please contact us at 1-866-244-9711 Monday through Friday for additional assistance.

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1 Patient Information

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:** _____
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** $ _____

Please include financial documentation for everyone in the household. A copy of your Federal Tax Return Is preferred.

2 Insurance Information

❑ **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 ❑ 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 HIPAA authorization, patient terms of participation and privacy notice 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 in section 6.

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 agree to the release of my protected health information pursuant to the HIPAA Authorization in section 6.

→ **X** _____ ***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: _____ ***City/State/Zip:** _____

***Contact Phone #:** _____ ***Office Fax #:** _____

Contact E-Mail: _____

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

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 myAbbVie Assist 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. 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 myAbbVie Assist 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**

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6 HIPAA AUTHORIZATION, PATIENT TERMS OF PARTICIPATION AND PRIVACY NOTICE

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 AbbVie, to enroll me in and provide me with 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 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 1-866-244-9711 or by writing to myAbbVie Assist, 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

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 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.

If you have questions, want to update your information, or terminate your enrollment, please call 1-866-244-9711 or write to us at PO Box 66570, St. Louis, MO 63166.

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 obtain information from your credit profile about your income for the sole purpose of determining eligibility for the program. This notice serves as written instruction under the Fair Credit Reporting Act authorizing myAbbVie Assist 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 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