Application for Kaletra® (lopinavir/ritonavir) and Norvir® (ritonavir)

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 PAGE 2
  o SECTION 1: Prescriber Information
  o SECTION 2: Patient Information
  o SECTION 3: Medication Request
  o SECTION 4: Prescriber Certification and Signature

☐ IF YOU ARE A PATIENT, COMPLETE PAGE 3. PLEASE READ PAGE 4
  o SECTION 5: Patient Information
  o SECTION 6: Financial Information
  o SECTION 7: 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.
  o 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.
  o SECTION 9: Additional Permission for Program Purposes (Optional)

☐ Please keep a copy for your records.

FAX OR MAIL THE COMPLETED APPLICATION AND DOCUMENTATION TO THE FOLLOWING

myAbbVie Assist
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. Please call 1-800-222-6885 to request refill.

Please contact us at 1-800-222-6885 Monday through Friday for additional assistance.

This program is part of the AbbVie Patient Assistance Foundation, a separate legal entity from AbbVie.
Application for
Kaletra® (lopinavir/ritonavir) and Norvir® (ritonavir)
myAbbVie Assist
PO Box 270
Somerville, NJ 08876
PHONE: 1-800-222-6885
FAX: 1-866-483-1305

1 PRESCRIBER INFORMATION

Prescriber Name: [Name]

Office Name: [Office Name]

Address: [Address]

NPI: [NPI]

Tax ID: [Tax ID]

2 PATIENT INFORMATION

Patient’s Name: [Patient’s Name]

DOB: [DOB]

3 MEDICATION REQUESTED: MUST BE COMPLETED BY A LICENSED PRESCRIBER

<table>
<thead>
<tr>
<th>PRODUCT:</th>
<th>STRENGTH:</th>
<th>DIRECTIONS</th>
<th>REFILLS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Reorders allowed up to 1 year</td>
</tr>
</tbody>
</table>

4 PRESCRIBER PLEASE SIGN AND DATE

PRESCRIBER SIGNATURE: [Signature]

DATE: [Date]

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 the program should not influence treatment decisions. I understand that I may not delegate signature authority. I certify that treatment with this medication is medically necessary.
Application for
Kaletra® (lopinavir/ritonavir) and Norvir® (ritonavir)

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: $ ___________ Number in household over 18 years old with income: ________

Total number of people in your household (including yourself): ________

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.

<table>
<thead>
<tr>
<th>INSURANCE INFORMATION</th>
<th>Group or Policy Number</th>
<th>Insurance Name and Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare</td>
<td>□ Yes □ No</td>
<td></td>
</tr>
<tr>
<td>Medicare Part D</td>
<td>□ Yes □ No</td>
<td></td>
</tr>
<tr>
<td>Medicaid</td>
<td>□ Yes □ No</td>
<td></td>
</tr>
<tr>
<td>Private Insurance</td>
<td>□ Yes □ No</td>
<td></td>
</tr>
<tr>
<td>ADAP</td>
<td>□ Yes □ No</td>
<td></td>
</tr>
<tr>
<td>ADAP Waitlisted or Pending</td>
<td>□ Yes □ No</td>
<td></td>
</tr>
<tr>
<td>State Elderly Drug Assistance</td>
<td>□ Yes □ No</td>
<td></td>
</tr>
<tr>
<td>State Children Health Insurance</td>
<td>□ Yes □ No</td>
<td></td>
</tr>
<tr>
<td>Veterans Assistance</td>
<td>□ Yes □ No</td>
<td></td>
</tr>
</tbody>
</table>

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.

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

PATIENT SIGNATURE / LEGAL REPRESENTATIVE (indicate relationship) ____________________________ DATE ____________________________

9 ADDITIONAL PERMISSION FOR PURPOSES OF THE PROGRAM (optional)

I permit myAbbVie Assist to speak with the following person about this application:

Name: ____________________________ Relationship: ____________________________ Phone Number: ____________________________

Patient Signature: ____________________________ Date: ____________________________
Application for
Kaletra® (lopinavir/ritonavir) and Norvir® (ritonavir)

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 and AbbVie, to enroll me in and provide me with 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 1-800-222-6885 or by writing to myAbbVie Assist, 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

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.

In order for you to participate, the program will use and disclose 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 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 (“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 it receives 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 1-800-222-6885 or write to us at PO BOX 270, Somerville, NJ 08876.