myAbbVie Assist | Patient Assistance

MyABBVIE ASSIST
PRESCRIPTION AND MEDICAL EXPENSE FORM

Patient Name: _____

Date of Birth: _____

Patient Address: _____

PRESCRIPTION MEDICATION - MEDICARE PART D INSURED PATIENTS ONLY

Please include all medications below or attach a printout from the pharmacy. Annual costs will be calculated.
Fill in prescription medications for **all household members with Medicare Part D**, including strength and frequency.

Patient or Household Member	Drug Name	Strength	Frequency
Example: Patient	*Medication Name*	*100 mg*	*2x daily*

PRESCRIPTION MEDICATION - COMMERCIAL / PRIVATE / NON-MEDICARE PART D PATIENTS

Please include household prescription medications below for **all household members who do not have Medicare Part D.**

Patient or Household Member	Drug Name	Strength	Copay
Example: Patient	*Medication Name*	*100 mg*	*$ 20.00* Monthly ☒ Annual ☐
			$_____ Monthly ☐ Annual ☐
			$_____ Monthly ☐ Annual ☐
			$_____ Monthly ☐ Annual ☐
			$_____ Monthly ☐ Annual ☐
			$_____ Monthly ☐ Annual ☐

OUT OF POCKET MEDICAL EXPENSE - PATIENT AND HOUSEHOLD MEMBERS

Please include medical expenses for **all household members**.

Health Insurance Premiums:	$_____	Monthly ☐ Annual ☐
Doctor Office Visit Copays:	$_____	Monthly ☐ Annual ☐
Vision (eye glasses, prescription contacts, etc.):	$_____	Monthly ☐ Annual ☐
Dental (copays, etc.):	$_____	Monthly ☐ Annual ☐
Lab Work/ Blood Tests:	$_____	Monthly ☐ Annual ☐
Hospital/ Surgery:	$_____	Monthly ☐ Annual ☐
Health-Related Travel Expenses:	$_____	Monthly ☐ Annual ☐
Over-the-Counter Medications:	$_____	Monthly ☐ Annual ☐

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