Patient Access Support

Allergan Aesthetics, an AbbVie Company (Alloderm, Natrelle, Revolve, Strattice, Strattice BPS, Keller Funnel 2)

AbbVie Patient Access Support includes programs that provide access and financial support and treatment-related resources to patients. We can help identify financial assistance options to support patients in accessing prescribed AbbVie medications. We understand that there's a lot more to you than just your condition. Think of us as your partner on your AbbVie medication treatment journey.

myAbbVie Assist approval is required prior to patient surgery. The surgeon must sign and date the application and certify that the requested product(s) are intended for a medically necessary non-cosmetic procedure.

Getting Started

If you are a patient:

1. Carefully read the terms of participation, privacy notice, financial information and HIPAA authorizations on pages 1–3.
2. Print and complete the enrollment form on page 4.
3. Provide your consent for eligibility determination by checking the boxes in Section 5 and confirm your understanding of the Terms of Participation by providing your signature and date. You must also provide a separate signature and date for HIPAA authorization.
4. If you have health insurance, please include front and back copies of all insurance cards. A copy of insurance denial documents, specific to the requested Allergan product(s), are required. Those with Medicare are not eligible for the program.
5. Keep a copy of this application for your records.

Questions?
Call 1-833-613-2419

If you are the Surgeon:

1. Complete the enrollment & product request information on page 5.
2. Confirm you will abide by the terms and conditions and that the product request is accurate by providing your signature and date in section 9.

Submitting an Application

AbbVie can start assessing you for eligibility of Patient Access Support programs when pages 4 and 5 of this form and required documentation are submitted by you and your surgeon's office in one of the following ways:

FAX

Fax to AbbVie:
1-800-311-0260

ONLINE

To learn more about our program, please visit:
www.AbbVie.com/patientaccesssupport

MAIL

myAbbVie Assist
D-617927, AP5 NE
1 N. Waukegan Rd.
North Chicago, IL 60064

Upon review of a completed application, we will notify the surgeon about eligibility for myAbbVie Assist Patient Assistance. Upon approval for myAbbVie Assist, we will send the surgeon the Allergan Aesthetics PAP Credit Form to place the credit request. Credit will only be authorized for medical products used for the approved patient. **Serial numbers for implants and tissues are required for credit authorization. Credit requests must be received within 14 days following surgery.**

Financial Information

AbbVie offers a financial assistance program that provides access and financial support to those meeting program guidelines. By signing this application form, you provide written instructions to the Program under the Fair Credit Reporting Act authorizing the Program to obtain information about your credit profile from credit reporting agencies or other sources. You authorize AbbVie to obtain such information solely to determine Patient Assistance Program (PAP) eligibility, and to perform an electronic income verification. You understand that you may be required to provide additional financial documentation for Patient Assistance consideration.

Patient Access Support

Terms of Participation

AbbVie Patient Access Support offers the following access programs:

PATIENT ASSISTANCE PROGRAM (PAP): myAbbVie Assist provides free medicine 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 our 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. Patients with insurance plans or employers participating in an alternate funding program (also sometimes referred to as patient advocacy programs, specialty networks, SHARx, Paydhealth, or Payer Matrix, among other names) requiring them to apply to a manufacturer's patient assistance program or otherwise pursue specialty drug prescription coverage through an alternate funding vendor as a condition of, requirement for, or prerequisite to coverage of relevant AbbVie products, or that otherwise denies, restricts, eliminates, delays, alters, or withholds any insurance benefits or coverage contingent upon application to, or denial of eligibility for, specialty drug prescription coverage through the alternate funding program are not eligible for the myAbbVie Assist program. You agree to inform myAbbVie Assist if you are a member of such an insurance plan or if you are applying to myAbbVie Assist on behalf of a patient who is a member of such an insurance plan. 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) myAbbVie Assist will inform 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 1-833-613-2419 or write to us at D-617927, AP5 NE 1 N. Waukegan Rd. North Chicago, IL 60064.

Patient Access Support

Privacy Notice

AbbVie may collect your personal data through your online and offline interactions with us, including your contact, transaction, financial, demographic, insurance, geolocation, and health-related data. We may also collect your online usage data automatically through cookies and similar technologies. We may use this information for several purposes, such as to provide and administer the Program, including eligibility, administration, income verification, internal and external compliance obligations, and to customize your experiences, as well as for research and data analytics to improve our services and products. We retain your personal data for as long as necessary to fulfill these purposes or to comply with our record retention obligations. We do not sell your personal data, but may use and disclose your personal data with marketing and advertising partners to deliver you ads based on your interests inferred from your activity across other unaffiliated sites and services ("online targeted advertising") and for website analytics. To opt out of the use or disclosure of your personal data for online targeted advertising or for website analytics, go to Your Privacy Choices, https://abbviemetadata.my.site.com/AbbvieDSRM on our website. For more information on the personal data categories we collect, the purposes for their collection, disclosures to third parties, and data retention, visit our Privacy Policy at https://privacy.abbvie/privacy-policies/us-privacy-policy.html.

HIPAA Authorization

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION: I authorize my health care providers and staff, health plan, and pharmacies (collectively, my "Healthcare Providers") to disclose individually identifiable information about me, my health or condition(s), treatment and care that I have received, my insurance coverage, my payment information, and my medication history and prescriptions (collectively, "Protected Health Information") to AbbVie Inc. and/or its designated affiliates, agents, representatives, and service providers (collectively, "AbbVie") in order for AbbVie to (i) enroll me in, provide, operate and administer the AbbVie Financial Support Program ("Program"); (ii) provide me with information concerning the Program; and (iii) develop, evaluate, and improve products, services, materials, and programs related to my condition or treatment. I understand that Protected Health Information disclosed to AbbVie under this Authorization will no longer be protected by HIPAA and may be subject to redisclosure by AbbVie. I understand that I am not required to sign this Authorization and that my Healthcare Providers will not otherwise condition my treatment, payment, health insurance enrollment, or eligibility for health care benefits to which I am otherwise entitled on whether I sign this Authorization. However, I understand that if I do not sign this Authorization, I cannot take part in the Program. I understand that this Authorization will expire once I am no longer participating in the Program, unless I cancel it sooner.

I understand that I may cancel this Authorization at any time by making a data subject rights request at https://abbv.force.com/AbbvieDSRM/s/?language=en_US or by or by writing to privacydsr@abbvie.com. However, I understand that if I cancel this Authorization, it will end my enrollment in the Program. I understand that cancelling this Authorization will not affect any use or disclosure of my Protected Health Information that has already taken place in reliance on this Authorization.

Allergan Aesthetics (Alloderm, Natrelle, Revolve, Strattice, Strattice BPS, Keller Funnel 2) Patient Access Support: Enrollment Form

PLEASE SUBMIT THIS PAGE.
Fax to AbbVie: 1-800-311-0260

Please print clearly.

⇩ **TO BE COMPLETED BY PATIENT** ⇩

1 PATIENT INFORMATION: See Privacy Notice on page 3 for information about how your personal data will be collected, used, and disclosed.

FIRST NAME: **LAST NAME:**

DATE OF BIRTH: / / **SEX:** ☐ MALE ☐ FEMALE **SSN (last four digits ONLY):**

MAILING ADDRESS: **CITY:** **STATE:** **ZIP:**

SHIPPING ADDRESS (no P.O. box): **CITY:** **STATE:** **ZIP:**

PHONE: ☐ HOME ☐ MOBILE* **EMAIL:**

**OPTIONAL: To consent to text messaging, see the consent language on page 3 of the Patient Privacy Notice and Consent Terms section of this form.*

2 INSURANCE INFORMATION: A copy of front and back sides of **ALL** Insurance Cards is **REQUIRED.**

INSURANCE TYPE: ☐ No insurance ☐ Medicaid ☐ Private/Commercial (*Is insurance through an employer?:* ☐ YES ☐ NO) ☐ Other: _____

Patients with Medicare are not eligible for the program.
Please provide insurance details below. Please include copies of any insurance denial documents for the specific Allergan product(s).

EMPLOYER NAME:

MEDICAL INSURANCE COMPANY: **MEDICAL INSURANCE CO. PHONE:**

POLICY ID #: **GROUP #:** **POLICYHOLDER NAME:** **RELATIONSHIP:**

SECONDARY INSURANCE COMPANY: **SECONDARY INSURANCE CO. PHONE:**

POLICY ID #: **GROUP #:** **POLICYHOLDER NAME:** **RELATIONSHIP:**

*****If you have any changes to your medical information, please call us at 1-833-613-2419*****

3 LICENSED SURGEON INFORMATION:

SURGEON NAME: **OFFICE PHONE:** **OFFICE FAX:**

4 ADDITIONAL PERMISSION FOR PURPOSES OF THE PROGRAM (optional):

☐ I permit AbbVie to speak with the following person about this application: (AbbVie reserves the right to limit some program-related communications to the patient and/or their legal representative only.)

NAME: **RELATIONSHIP:** **PHONE NUMBER:**

5 PATIENT CONSENT: Please review Terms of Participation, Privacy Notice, Financial Information and HIPAA Authorization on pages 1–3.

☐ **REQUIRED—PRIVACY NOTICE:** I consent to the collection, use, and disclosure of my personal health data by AbbVie as described in the Privacy Notice above and in AbbVie's Privacy Notice in the "How We May Disclose Personal Data" section https://abbv.ie/PrivacyDiscloseData. My consent is required to process sensitive personal data under certain privacy laws, and I have the right to withdraw my consent by visiting "Your Privacy Choices", https://abbviemetadata.my.site.com/AbbvieDSRM on AbbVie's website.

☐ **REQUIRED—FAIR CREDIT REPORTING ACT CONSENT:** 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.

☐ **SMS TEXT CONSENT:** I consent to receive automated and recurring text messages from "AbbVie", including services updates, marketing messages, refill reminders, and Rx notifications to the above mobile number. Message and data rates may apply. I am not required to consent as a condition of receiving goods or services. I can reply HELP for help. I can reply STOP to opt out at any time. View Privacy Notice, https://abbv.ie/PrivacyRights. l and Mobile T&C, https://privacy.abbvie/us-mobile-terms-and-conditions.html.

☐ **MARKETING CONSENT:** I consent to the collection, use, and disclosure of my health-related personal data to receive communications from AbbVie regarding its products, programs, services, scientific research and other research opportunities, and for online targeted advertising, as further described in the "How we may use Personal Data", https://abbv.ie/PrivacyUseData, "How we may disclose Personal Data", https://abbv.ie/PrivacyDiscloseData and "Cookies and similar tracking and data collection technologies" sections, https://abbv.ie/PrivacyTrackingCollection of our Privacy Notice, https://privacy.abbvie/privacy-policies/us-privacy-policy.html. My consent is required to process sensitive personal data under certain privacy laws, and I have the right to withdraw my consent by visiting "Your Privacy Choices" https://abbviemetadata.my.site.com/AbbvieDSRM on AbbVie's website.

My signature below certifies that I have provided accurate and complete information and that I have read, understood, and agree to the Patient Terms of Participation on page 2.

REQUIRED—PATIENT SIGNATURE or LEGAL REPRESENTATIVE*: **DATE:** / /

My signature certifies that I have read, understood, and agree to the release of my protected health information pursuant to the HIPAA Authorization.
Note: You have a right to receive a copy of this Authorization. You may print a copy of or save this Authorization and retain a copy for your records.

REQUIRED—PATIENT SIGNATURE or LEGAL REPRESENTATIVE*: **DATE:** / /

Only representatives with legal authority for healthcare decisions may apply on a patient's behalf.* ***Indicate relationship* *next to signature if signing on behalf of the patient.*

Allergan Aesthetics (Alloderm, Natrelle, Revolve, Strattice, Strattice BPS, Keller Funnel 2) Patient Access Support: Enrollment & Prescription Form

PLEASE SUBMIT THIS PAGE.
Fax to AbbVie: 1-800-311-0260

Please print clearly. ⇩ **FOR HEALTH CARE PROVIDER USE ONLY** ⇩

Must be completed by a licensed prescriber and faxed directly from a healthcare office.

6 LICENSED SURGEON - SURGERY LOCATION:

SURGEON NAME: **SURGEON SPECIALTY:** ☐ **PHYSICIAN'S OFFICE** ☐ **HOSPITAL** ☐ **OTHER:**

NPI OR SLN: **OFFICE NAME:** **OFFICE CONTACT NAME:**

OFFICE EMAIL: **OFFICE PHONE:** **OFFICE FAX:**

ADDRESS: **CITY:** **STATE:** **ZIP:**

HOSPITAL / SURGERY CENTER NAME *(if different from above):*

SHIPPING ADDRESS *(if different from above):* **CITY:** **STATE:** **ZIP:**

7 PATIENT INFORMATION:

PATIENT NAME: **DOB:** / /

PATIENT PHONE: ☐ **CELLPHONE** ☐ **WORK** ☐ **HOME**

SURGERY DATE – DATE OF SERVICE (DOS): / / **PROCEDURE/SURGERY TYPE:**

☐ ***By checking this box and signing this form, the surgeon certifies the requested medical product(s) are for a medically necessary non-cosmetic procedure***

8 ALLERGAN AESTHETIC PRODUCT REQUEST: ALLERGAN AESTHETICS ACCOUNT INFORMATION MUST BE PROVIDED TO ISSUE CREDIT FOR AN APPROVED PATIENT

ALLERGAN AESTHETICS ACCOUNT NUMBER (REQUIRED): _____

PRODUCTS AVAILABLE – CHECK ALL THAT APPLY. PAP CREDIT REQUEST FORM WILL BE PROVIDED SEPARATELTY UPON APPROVAL

☐ **ALLODERM** REGENERATIVE TISSUE MATRIX (CREDIT LIMIT: UP TO 2)	**DESCRIPTION** (CONTOUR, CONTOUR PERFORATED, RECTANGLE, RECTANGLE PERFORATED)
☐ **NATRELLE** BREAST IMPLANTS (CREDIT LIMIT: UP TO 2)	**STYLE** (SMOOTH COHESIVE, SMOOTH SOFT TOUCH, SMOOTH RESPONSIVE)
☐ **NATRELLE*** SIZER (CREDIT LIMIT: UP TO 2)	***NATRELLE SIZERS USED BY A PAP PATIENT CANNOT BE RE-USED**
☐ **NATRELLE** TISSUE EXPANDERS (CREDIT LIMIT: UP TO 2)	
☐ **REVOLVE SYSTEM** ADVANCED ADIPOSE SYSTEM (CREDIT LIMIT: 1)	
☐ **STRATTICE** RECONSTRUCTIVE TISSUE MATRIX (CREDIT LIMIT: UP TO 2)	**DESCRIPTION** (PLIABLE, PLIABLE PRE-SHAPED, FIRM, EXTRA THICK, LAPAROSCOPIC, PERFORATED):
☐ **STRATTICE BPS** RECONSTRUCTIVE TISSUE MATRIX (CREDIT LIMIT: UP TO 2)	**DESCRIPTION** (PLIABLE PRE-SHAPED, SLANTED, RECTANGLE):
☐ **KELLER FUNNEL 2** (SOLD IN CASE OF 5 UNITS. CREDIT LIMIT: UP TO 2 UNITS)	**NOTE: RETURNS CANNOT BE ACCEPTED ON AN OPEN CASE**

9 LICENSED SURGEON CERTIFICATION: See Program Terms of Participation on page 2.

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, and I will instruct my facility to not, (a) seek reimbursement for any product provided hereunder from any government program or third party, including patient, (b) sell, trade or distribute any such product, or (c) return for credit any product provided under this program. I also understand that the applicant's acceptance into the program should not influence treatment decisions. I agree that any product that I receive for the patient named in the application will be used only for this patient. I also certify that my patient understands that he/she is responsible for any surgery, facility or treatment costs associated with this product(s), if I am unable to waive these associated fees. I certify that treatment with this medication is medically necessary and that I will be supervising the patient's treatment accordingly. I understand that I may not delegate signature authority. I certify that the requested product(s) are for a medically necessary non-cosmetic procedure.

LICENSED SURGEON (REQUIRED): **DATE:** / /

RUBBER STAMPS, SIGNATURE BY OTHER OFFICE PERSONNEL OR COMPUTER-GENERATED IMAGES ARE NOT ALLOWED

IMPORTANT INFORMATION: *AbbVie may collect your personal data about you through your online and offline interactions with us, including your contact, transaction, financial account, demographic, geolocation, payment, and professional data. We may also collect your online usage data automatically through cookies and similar technologies. We use this data for several purposes, such as to comply with our legal obligations, to perform a contract with you, and to provide and improve our services and products and to customize your experiences. We retain your personal data only for as long as necessary to fulfill these purposes or to comply with our record retention obligations. We do not sell your personal data, but we may use and disclose it to marketing and advertising third party partners to deliver you ads based on your interests inferred from your activity across other unaffiliated sites and services ("online targeted advertising") and for website analytics. To opt out of the use or disclosure of your personal data for online targeted advertising or for website analytics, go to your Privacy Choices https://abbviemetadata.my.site.com/AbbvieDSRM on our website. For more information on the data categories we collect, the purposes for their collection, our disclosures to third parties, your data subject rights, and our data retention criteria, visit our Privacy Policy https://privacy.abbvie/.*