abbvie PATIENT ASSISTANCE FOUNDATION

Patient Assistance Application for HUMIRA® (adalimumab)

The AbbVie Patient Assistance Foundation provides AbbVie medicines at no cost to patients experiencing financial difficulties. Eligible patients typically have no healthcare coverage for the requested product and do not have access to alternative sources of coverage or funding. We review all applications on a case-by-case basis to support the AbbVie Patient Assistance Foundation's purpose of providing products at no cost to individuals in need.

Checklist for submitting an application:

☐ Ensure all sections of the application are completed. Failure to complete required information will delay the review process.

☐ To complete the enrollment process, information and signatures from both the Prescriber and the Patient are required.

☐ IF YOU ARE A PATIENT

- o Complete the Patient Information Page
- o Provide front and back copies of all prescription insurance card(s).
- o Provide proof of income (such as a federal tax return, W2 or pay stubs) for all in household. A copy of your current federal tax return is preferred.
  - ▪ If there is no household income ($0), you do not need to provide income documents. We may contact you for further information.
- o Sign and date the Patient Certification Page and the Patient Authorization for Disclosure Page
- o If you have Medicare Prescription Drug coverage, sign and date the *Patient Certification for Patients with a Medicare Prescription Drug Plan* section of the Patient Certification Page.
- o Please keep a copy for your records.

☐ IF YOU ARE A PRESCRIBER

- o Complete the Prescriber Prescription and Certification Page
- o Your signature and date are required.

Fax or mail the completed application and documentation to:

AbbVie Patient Assistance Foundation
D-617927, AP5 NE
1 N. Waukegan Rd.
North Chicago, IL 60064
Phone: 1-800-222-6885
Fax: 1-866-250-2803

Upon receipt 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 on the application. Prior to each subsequent 90-day shipment, the AbbVie Patient Assistance Foundation will contact the shipping location to schedule the next delivery.

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

PRESCRIBER PRESCRIPTION AND CERTIFICATION
TO BE COMPLETED BY PRESCRIBER

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ABBVIE PATIENT ASSISTANCE FOUNDATION ● D-617927, AP5 NE ● 1 N. WAUKEGAN RD ● NORTH CHICAGO, IL 60064

PRESCRIBER INFORMATION

Prescriber Name: ☐ MD ☐ DO ☐ Other:____ ☐ Rheum ☐ Derm ☐ Gastro ☐ Other:____

Office Name: Office Contact Name:

Address: City/State/Zip:

NPI or SLN: Phone: Fax:

PATIENT HISTORY ● DIAGNOSIS ● SHIPPING PREFERENCE

Patient's Name: _____ **DOB:** _____

☐ No known allergies ☐ Allergies (Please list): _____

☐ **RHEUMATOID ARTHRITIS** ☐ **PSORIATIC ARTHRITIS** ☐ **PLAQUE PSORIASIS** ☐ **ANKYLOSING SPONDYLITIS**

☐ **CROHN'S DISEASE** ☐ **ULCERATIVE COLITIS** ☐ **HIDRADENITIS SUPPURATIVA** ☐ **UVEITIS**

☐ **POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS [JIA]** - Patient weight :_____kg ☐ **OTHER**: _____

☐ **PEDIATRIC CROHN'S DISEASE** - Patient weight :_____kg ***Check ONLY if you prefer shipping to the Prescriber's office*:** ☐

PRESCRIBER PRESCRIPTION AND CERTIFICATION

HUMIRA STARTER PACKS

		Quantity	
☐ CD/UC/HS Starter Package (Humira 40 mg/0.8 mL PEN) ☐ Humira 40 mg/0.8 mL prefilled SYRINGE	***Weight: > 40kg (88lbs)*** ☐ Four 40 mg sc injections day 1, two 40 mg sc injections day 15 ☐ Two 40 mg sc injections day 1, 2 and 15	# 6	No refills
☐ Psoriasis/Uveitis Starter Package (Humira 40mg/0.8 mL PEN) ☐ Humira 40 mg/0.8 mL prefilled SYRINGE	Two 40 mg sc injections day 1, one 40 mg sc injection day 8 and 22	# 4	No refills
☐ Pediatric Crohn's Disease Starter Package (Humira 40 mg/0.8 mL prefilled SYRINGE)	***Weight: 17kg (37lbs) to < 40kg (88lbs)*** Two 40 mg sc injections day 1, one 40 mg sc injection day 15	# 3	No refills

HUMIRA *(Choose 1 from each column)*

		Quantity *(Choose one)*	Refills *(Choose one)*
☐ Humira 40 mg/0.8 mL AUTO INJECTOR PEN ☐ Humira 40 mg/0.8 mL prefilled SYRINGE ☐ Humira 20 mg/0.4 mL prefilled SYRINGE ☐ Other: _____	☐ 40 mg sc injection EVERY OTHER week ☐ 40 mg sc injection EVERY week ☐ 20 mg sc injection EVERY OTHER week ☐ Other: _____	☐ 3 months standard program supply ☐ Other: _____	☐ 1 year ☐ Other: ___

NEW YORK PRESCRIBERS PLEASE SUBMIT PRESCRIPTION PER NY STATE LAW RESTRICTIONS.
FOR ALL OTHER STATES, IF NOT FAXED, MUST BE ON STATE SPECIFIC BLANK IF APPLICABLE.

PRESCRIBER PLEASE SIGN AND DATE BELOW

PRESCRIBER SIGNATURE _____ **Substitution Permitted** **Date**
(STAMPED SIGNATURES ARE INVALID)

PRESCRIBER SIGNATURE _____ **Dispense as Written** **Date**
(STAMPED SIGNATURES ARE INVALID)

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

I verify that the information provided is current, complete and accurate to the best of my knowledge and certify that I am authorized to receive medications at the shipping location identified in this application. If this applicant is eligible for the Foundation's patient assistance program (the "PAP"), I understand that the Foundation will send the medication to the designated shipping location, which could include my office or the patient's home. The Foundation reserves the right to request additional information if needed and to change or discontinue the PAP at any time, without notice. By signing this form, I certify that I am prescribing the aforementioned medication for an individual participating in the PAP. I acknowledge that I shall not seek reimbursement for any medication dispensed hereunder from any government program or third party insurer. 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. By signing this form, I authorize the Foundation and its representatives to transmit this prescription form electronically, by facsimile, or by mail to a pharmacy designated by the Foundation for the dispensing of the medication called for herein. I understand that I may not delegate signature authority. I certify that treatment with this medication is medically necessary.

Notice to Health Care Providers and Insurers: This form of authorization may not comply with all applicable Federal and state laws governing disclosure of the patient's information to the Foundation and its contracted third parties. The Foundation urges all entities disclosing information about the patient to consult with legal counsel prior to relying on this form.

PATIENT INFORMATION
TO BE COMPLETED BY PATIENT

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ABBVIE PATIENT ASSISTANCE FOUNDATION ● D-617927, AP5 NE ● 1 N. WAUKEGAN RD ● NORTH CHICAGO, IL 60064

The AbbVie Patient Assistance Foundation provides HUMIRA at no cost to individuals who meet specific program eligibility criteria

PATIENT INFORMATION

Patient Name: Sex: ☐ M ☐ F

DOB: SSN (last four digits ONLY): ___ ___ ___ If you do not have an SSN, check here: ☐

Address (No P.O. Box):

City/State/Zip:

Daytime Phone: Evening Phone:

Treating Physician Name:

Treating Physician Phone: Treating Physician Fax:

Other Medications (Please list):

FINANCIAL INFORMATION (Income documentation is also required)

Current Monthly Household Income: for everyone in the household $ _____

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

Number in household under 18 years old: ____

Source of Income: ☐ Wages ☐ SSDI ☐ SSI ☐ Unemployment ☐ Pension ☐ Other: _____

Please include income documentation for <u>everyone in the household.</u> A copy of your current federal tax return is preferred.

If there is no household income ($0), you do not need to provide income documents.

INSURANCE INFORMATION

☐ **I have no insurance coverage**

☐ **I have insurance coverage that does not adequately cover HUMIRA**

- Please provide insurance details below or attach a front and back copy of the insurance card.
- Include detailed list of medical expenses for household, including medications, office visits, insurance premiums, medical bills, etc.

PRIMARY INSURANCE		**SECONDARY INSURANCE**	
Insurance Company:		Insurance Company:	
Insurance Co. Phone:		Insurance Co. Phone:	
Policy #:	Group #:	Policy #:	Group #:
Policyholder Name:		Policyholder Name:	
Relationship to Policyholder:		Relationship to Policyholder:	
Policyholder DOB:		Policyholder DOB:	

Medicare Questions:

- Are you eligible for Medicare? ☐ Yes ☐ No
  - o If Yes, please provide your Medicare Part A Identification #: _____
  - o If No, please provide the anticipated date of Medicare eligibility (if within the year) _____
- Are you enrolled in a Medicare Prescription Drug Plan (Medicare Part D)? ☐ Yes ☐ No ☐ Unsure
- Are you eligible for extra help (financial assistance from Social Security) with medication costs under Medicare Part D?
  ☐ Yes ☐ No ☐ Unsure
- If Medicare eligible, please provide the 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.

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PATIENT CERTIFICATION
TO BE COMPLETED BY PATIENT

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PATIENT CERTIFICATION FOR PATIENT ASSISTANCE (Required)

I understand that any assistance in the form of product at no cost is contingent upon my ability to meet the eligibility criteria for the AbbVie Patient Assistance Program ("PAP") as determined by the AbbVie Patient Assistance Foundation, AbbVie Inc. or third parties contracted by the AbbVie Patient Assistance Foundation (collectively, the "Foundation"). I agree that the Foundation does not have any obligation to provide the PAP services to me and I waive any and all liability of the Foundation in the provision of the PAP services. I understand that by completing this form I am not guaranteed eligibility to receive medication at no cost from the PAP. In the event that I am eligible for the PAP, I acknowledge that this assistance is temporary and that I may be asked to reapply at designated intervals as determined by the Foundation. I also understand that the PAP may be changed or discontinued at any time without any notice to me and at such time the PAP services will no longer be provided. I agree that I will not seek reimbursement for any products dispensed under the PAP from any government program or third party insurer. I certify that the information I have provided in this form is accurate and complete. I agree that I will notify the PAP if my insurance or financial situation changes. If this application has been completed by an personal representative, the personal representative warrants that it has provided a copy of this completed application to the patient.

Patient's Name: _____ **Signature:** _____ **Date:**_____

(If applicable)
Representative Name: _____ **Signature:**_____ **Date:**_____

Relationship: _____

PATIENT CERTIFICATION FOR PATIENTS WITH A MEDICARE PRESCRIPTION DRUG PLAN (Required only for these patients)

If I am a member of a Medicare Prescription Drug Plan that offers prescription drug coverage for the requested medication under my Medicare Prescription Drug Plan and I am eligible for assistance through the AbbVie Patient Assistance Foundation:

1. I understand that I will be eligible to obtain the requested medication through the Foundation for a calendar year term, assuming I continue to meet the Foundation's eligibility criteria.
2. I agree that I will not purchase this medication under my Medicare plan that provides prescription drug coverage while enrolled in this program and through the end of the calendar year of my Foundation enrollment.
3. I agree that I will not submit claims nor seek true out-of-pocket (TrOOP) credit for any of the requested medication provided under the Foundation while enrolled in this program and through the end of the calendar year of my Foundation enrollment.
4. I agree that I will provide written notification to my Medicare Prescription Drug Plan of my approval to receive a supply of the requested medication at no cost outside of the Medicare Part D benefit through the Foundation. The notification is to ensure that payment for the product is not made by my Medicare plan, that no part of the costs of the product is credited toward my TrOOP balance, and that my plan can undertake appropriate drug utilization review and medication therapy management program activities.
5. I will notify the Foundation immediately if my prescription drug coverage changes.

Patient's Name: _____ **Signature:** _____ **Date:**_____

(If applicable)
Representative Name: _____ **Signature:** _____ **Date:**_____

Relationship: _____

PERSONAL REPRESENTATIVE REPRESENTATION (if applicable)

A Patient's Personal Representative may sign this form on behalf of the Patient. However, only certain individuals may qualify as the Patient's Personal Representative. A State law prescribes who can be a Personal Representative for purposes of this Authorization. The Personal Representative warrants that it has provided a copy of this completed application to the patient.

By signing below, I represent that I am an authorized Personal Representative of the Patient under applicable state law.

Representative Name_____ **Relationship:**_____ **Signature:** _____ **Date:**_____

ADDITIONAL PERMISSION FOR PURPOSES OF THE PROGRAM (optional)

I permit the AbbVie Patient Assistance Foundation to speak with the following person about this application:

Name: _____ **Relationship:**_____ **Phone Number:** _____

Patient Signature: _____ **Date:**_____

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AUTHORIZATION FOR DISCLOSURE OF INFORMATION

I understand that the purpose of this authorization ("Authorization") is to give my permission for the disclosure and use of my protected health information. I request and authorize my health care providers and health care insurers that have provided treatment, payment or services to me or for me to disclose any information regarding my health, treatment, and coverage that pertains to payment for medication to the AbbVie Patient Assistance Foundation, AbbVie Inc., its affiliates, or third parties contracted by the AbbVie Patient Assistance Foundation, (collectively, the "Foundation") for the following purposes: (i) to determine my eligibility for the Foundation's patient assistance program ("PAP"), (ii) if necessary, to account for and assist with my withdrawal from the PAP and/or transfer to a separate private or public payer program, and (iii) to administer and maintain the high quality of the PAP, including but not limited to case review, compliance checks, audit review and accounting purposes. I understand that once the Foundation receives my health information, it may communicate with my health care providers and insurers to determine my PAP eligibility. I understand that I am not required to sign this Authorization and that no health care provider or insurer will condition 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 PAP (should I qualify). I understand that I may cancel this authorization at any time by writing to the AbbVie Patient Assistance Foundation at D-617927, AP5 NE, 1 N. Waukegan Rd. North Chicago, IL, 60064 as well as by notifying my health care providers and insurers. If I cancel this Authorization, I can no longer participate in certain aspects of the PAP. Once the Foundation receives and processes my cancellation request, the Foundation will not use my health information going forward. I understand that cancelling my Authorization will not affect any use of my health information that occurred before my request was processed. This authorization shall be valid for 10 years from the date of the signature on this form (unless a shorter period is prescribed by state law). I understand that, unless otherwise restricted by state law, my health information released under this Authorization is subject to re-disclosure by the Foundation and will no longer be protected by HIPAA.

Patient's Name: _____ Signature: _____ Date_____

(If applicable)
Representative Name : _____ Signature: _____ Date:_____

Relationship: _____