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. All applications are reviewed 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.
- ☐ Provide front and back copies of all prescription insurance card(s).
- ☐ Provide proof of income (tax return, W2, pay stub) for all in household.
    - If there is no household income ($0) due to job loss or other circumstance, you do not need to provide income documents.
- ☐ Physician's signature is required at the bottom of the 1st page.
- ☐ Patient's signature is required at the bottom of the 3rd page.

Fax or mail the completed application and documentation to:

Note: If application is faxed, Prescriber MUST sign and fax it with MD office cover sheet.

AbbVie Patient Assistance Foundation
P.O. Box 789
San Bruno, CA 94066
Fax: 1-866-250-2803
Phone: 1-800-222-6885

Upon receipt of a completed application, the physician and patient will be notified of eligibility. If approved, medication will be shipped to the destination indicated on the application. It is the responsibility of the physician or patient to reorder 3 weeks prior to the patient requiring further medication.

Please note, if approved, medication will be scheduled for shipment to the specified location on the application.

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

THIS PAGE TO BE COMPLETED BY PHYSICIAN

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PLEASE COMPLETE ALL SECTIONS, SIGN, AND FAX THIS FORM TO 1-866-250-2803 OR MAIL TO:
ABBVIE PATIENT ASSISTANCE FOUNDATION ● P.O. BOX 789 ● SAN BRUNO, CA 94066. FOR QUESTIONS PLEASE CALL 1-800-222-6885.

PHYSICIAN INFORMATION

Physician Name: ☐MD ☐ DO ☐ Other:_____ ☐ Rheum ☐ Derm ☐ Gastro ☐ Other:_____

Office Name: Office Contact Name:

Address: City/State/Zip:

Phone: Fax:

State License #: Tax ID#: NPI/Insurance Provider #:

PATIENT HISTORY AND SHIPPING PREFERENCE *(Please circle specific diagnosis code(s))*

Patient's Name: DOB:

☐ Allergies (List): ☐ No known allergies

☐ Rheumatoid Arthritis (714.0)
☐ Psoriatic Arthritis (696.0)
☐ Ankylosing Spondylitis (720.0)
☐ Ulcerative Colitis (556.3, 556.5, 556.6, 556.8, 556.9)
☐ Crohn's Disease (555.0, 555.1, 555.2, 555.9)
☐ Polyarticular Juvenile Idiopathic Arthritis [JIA] (714.30)
☐ Plaque Psoriasis (696.1)
Date of Diagnosis: _____
☐ Other

If this patient is eligible to receive medication through the AbbVie Patient Assistance Foundation, ship to: ☐ Physician Office ☐ Patient
Shipping Address (if different from physician/patient address):

PHYSICIAN'S ORDERS

Rheumatoid Arthritis, Ankylosing Spondylitis, Psoriatic Arthritis, and Polyarticular JIA if ≥30kg(66 lbs)

☐ HUMIRA Pen 40 mg/0.8mL	40 mg SC inj. every other week	84 day supply	Refills:
☐ HUMIRA Pre-Filled Syringe 40 mg/0.8mL	40 mg SC inj. every other week	84 day supply	Refills:

Polyarticular JIA 15kg(33 lbs) to <30kg(66 lbs) only

☐ HUMIRA Pre-Filled Syringe 20 mg/0.4mL	20 mg SC inj. every other week	84 day supply	Refills:

Crohn's Disease or Ulcerative Colitis

STARTING THERAPY

☐ Crohn's Disease/Ulcerative Colitis Starter Package (HUMIRA Pen 40 mg/0.8mL)	☐ Four 40 mg SC inj. Day 1, Two 40 mg SC inj. Day 15, #6 pens	No Refills
	☐ Two 40 mg SC inj. Day 1, Two 40 mg SC inj. Day 2, Two 40 mg SC inj. Day 15, #6 pens	No Refills
☐ HUMIRA Pre-Filled Syringe 40 mg/0.8mL	☐ Four 40 mg SC inj. Day 1, Two 40 mg SC inj. Day 15, #6 syringes	No Refills
	☐ Two 40 mg SC inj. Day 1, Two 40 mg SC inj. Day 2, Two 40 mg SC inj. Day 15, #6 syringes	No Refills

ONGOING THERAPY

☐ HUMIRA Pen 40 mg/0.8mL	40 mg SC inj. every other week	84 day supply	Refills:
☐ HUMIRA Pre-Filled Syringe 40 mg/0.8mL	40 mg SC inj. every other week	84 day supply	Refills:

Plaque Psoriasis

STARTING THERAPY

☐ Psoriasis Starter Package (HUMIRA Pen 40 mg/0.8mL)	Two 40 mg SC inj. for first dose (Day 1), then one 40 mg SC inj. one week after first dose (Day 8), then one 40 mg SC inj. three weeks after first dose (Day 22), #4 pens	No Refills
☐ HUMIRA Pre-Filled Syringe 40 mg/0.8mL	Two 40 mg SC inj. for first dose (Day 1), then one 40 mg SC inj. one week after first dose (Day 8), then one 40 mg SC inj. three weeks after first dose (Day 22), #4 syringes	No Refills

ONGOING THERAPY

☐ HUMIRA Pen 40 mg/0.8mL	40 mg SC inj. every other week	84 day supply	Refills:
☐ HUMIRA Pre-Filled Syringe 40 mg/0.8mL	40 mg SC inj. every other week	84 day supply	Refills:
Other ☐ HUMIRA	SIG:	Qty:	Refills:

Special Note: New York Prescribers please submit prescription on an original NY State prescription blank, for all other States, if not faxed, must be on State specific blank if applicable for your State

PHYSICIAN CERTIFICATION

Physician Signature: ☐ _____
(no stamps) (Substitution Permitted) Date

Physician Signature: ☐ _____
(no stamps) (Dispense as Written) Date

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. I verify that my State License is currently in good standing. I further certify that I will notify the Foundation in writing immediately if the status of my State License Number registration changes. If this applicant is eligible for the Foundation's patient assistance program (the "PAP") for HUMIRA, 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.

THIS PAGE TO BE COMPLETED BY PATIENT

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PATIENT INFORMATION

Patient Name:	Sex: ☐ M ☐ F
DOB:	SSN (last four digits ONLY): ___|___|___|___
Address (No P.O. Box):	
City/State/Zip:	
Daytime Phone:	Evening Phone:
Treating Physician Name:	
Treating Physician Phone:	Treating Physician Fax:
Primary Care Physician Name:	Primary Care Physician Phone:
Other Medications (List):	

INSURANCE INFORMATION

☐ I have no insurance coverage

☐ I have insurance coverage that does not adequately cover HUMIRA (Please provide details below or attach a 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 #:	Policy #:
Group #:	Group #:
Policyholder Name:	Policyholder Name:
Relationship to Policyholder:	Relationship to Policyholder:
Policyholder DOB:	Policyholder DOB:

Medicare Questions:

- Are you eligible for Medicare? ☐ Yes ☐ No If No, anticipated date of Medicare eligibility (if within the year)? _____
- Are you enrolled into a Medicare Prescription Drug Plan? ☐ 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.)

FINANCIAL INFORMATION (Proof of income required)

Current Monthly Household Income: $_____ # in Household (circle): 1 2 3 4 5 6 _____

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

Please provide current income documentation (tax return, pay stub, etc) to avoid processing time delay.

- ***If there is no household income ($0) due to job loss or other circumstance, you do not need to provide income documents.***
- ***If income documents do not match current income, please explain:*** _____

REPRESENTATIVE INFORMATION

I permit the AbbVie Patient Assistance Foundation to speak with the following person about this application and permit such person(s) to sign any related documents on my behalf for purposes of this Program:

Name:	Relationship:	Phone Number:
Name:	Relationship:	Phone Number:

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Patient Certification and Authorization for Disclosure of Information

I request and authorize the sharing of any information regarding my health, treatment, and coverage that pertains to payment for HUMIRA among my insurance companies, my physicians, AbbVie Inc. or third parties contracted by AbbVie, and the AbbVie Patient Assistance Foundation (the "Foundation") or third parties contracted by the Foundation. The Foundation will use my information for purposes of determining patient assistance eligibility. I understand that I need to give my authorization to take part in the Foundation's patient assistance program (the "PAP") (should I qualify). However, if I do not provide this authorization, my decision will not affect my ability to obtain treatment from my health care providers or decisions about payment, enrollment, or eligibility for benefits made by my insurance companies. I know I may cancel this authorization at any time by writing to the AbbVie Patient Assistance Foundation at P.O. Box 789 San Bruno, CA 94066. If I cancel this Authorization, I can no longer participate in certain aspects of the PAP. This authorization shall be valid for 10 years from the date of the signature on this form. I authorize the Foundation to use my information: (i) to determine eligibility for the PAP, (ii) to account for my withdrawal if I decide to stop participating in the PAP, (iii) to administer and maintain the high quality of the PAP, and (iv) as otherwise required or permitted by law. I agree that the Foundation does not have any liability in providing the PAP services to me.

For Eligible Patient Assistance Patients Only:

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 PAP as determined by the Foundation. 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 by the Foundation. I also understand that the PAP may be changed or discontinued at any time without any notice to me. I agree that I will not seek reimbursement for any products dispensed under the Foundation from any government program or third party insurer. I certify that the information I have provided in this form is accurate and complete. I understand that by completing this form I am not guaranteed eligibility to receive medication at no cost from the Foundation. I agree that I will notify the Foundation if my insurance or financial situation changes.

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

Personal Representative Authorization (if Applicable):

Note: If the Patient is unable to sign, is under the age of 18, or has designated signature authority, the Patient's Personal Representative may sign this Form. However, only certain individuals may qualify as the Patient's Personal Representative for purposes of this Authorization. A Patient's Representative must have the requisite knowledge and information regarding the Patient's financial and health care status to verify that all responses provided are accurate. State law may prescribe who can be a Personal Representative for purposes of this Authorization. A person or entity in the supply chain of the product to be received through the Program, including a health care provider or pharmacy receiving the medicines at no cost, may not be named a Personal Representative. If Patient's Personal Representative is a consumer assistance or charitable organization, please list name of entity and purpose of entity under Relationship to Patient.

Patient's Personal Representative's Name:_____ **Signature:**_____

Relationship to Patient:_____ **Date:**_____

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.