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Return of Private Foundation
or Section 4947(a)(1) Nonexempt Charitable Trust
Treated as a Private Foundation

Note. The foundation may be able to use a copy of this return to satisfy state reporting requirements.

2010

For calendar year 2010, or tax year beginning

, and ending

G Check all that apply: Initial return Initial return of a former public charity Final return
 Amended return Address change Name change

Name of foundation ABBOTT PATIENT ASSISTANCE FOUNDATION		A Employer identification number 26-1215559																																																																																																																																																																																										
Number and street (or P O box number if mail is not delivered to street address) D-031C AP31-3NW, 200 ABBOTT PARK ROAD		B Telephone number 847-938-2906																																																																																																																																																																																										
C If exemption application is pending, check here ► <input type="checkbox"/> D 1. Foreign organizations, check here ► <input type="checkbox"/> 2. Foreign organizations meeting the 85% test, check here and attach computation ► <input type="checkbox"/>																																																																																																																																																																																												
H Check type of organization: <input checked="" type="checkbox"/> Section 501(c)(3) exempt private foundation <input type="checkbox"/> Section 4947(a)(1) nonexempt charitable trust <input type="checkbox"/> Other taxable private foundation																																																																																																																																																																																												
I Fair market value of all assets at end of year (from Part II, col (c), line 16) ► \$ 21,717,130.	J Accounting method: <input checked="" type="checkbox"/> Cash <input type="checkbox"/> Accrual <input type="checkbox"/> Other (specify) _____																																																																																																																																																																																											
E If private foundation status was terminated under section 507(b)(1)(A), check here ► <input type="checkbox"/> F If the foundation is in a 60-month termination under section 507(b)(1)(B), check here ► <input type="checkbox"/>																																																																																																																																																																																												
Part I Analysis of Revenue and Expenses <small>(The total of amounts in columns (b), (c), and (d) may not necessarily equal the amounts in column (a))</small> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 30%;"></th> <th style="width: 25%; text-align: center;">(a) Revenue and expenses per books</th> <th style="width: 25%; text-align: center;">(b) Net investment income</th> <th style="width: 20%; text-align: center;">(c) Adjusted net income</th> <th style="width: 20%; text-align: center;">(d) Disbursements for charitable purposes (cash basis only)</th> </tr> </thead> <tbody> <tr> <td>1 Contributions, gifts, grants, etc., received</td> <td style="text-align: right;">492,857,634.</td> <td></td> <td style="text-align: center;">N/A</td> <td></td> </tr> <tr> <td>2 Check ► <input type="checkbox"/> if the foundation is not required to attach Sch B</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>3 Interest on savings and temporary cash investments</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>4 Dividends and interest from securities</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>5a Gross rents</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>b Net rental income or (loss)</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>6a Net gain or (loss) from sale of assets not on line 10</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>b Gross sales price for all assets on line 6a</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>7 Capital gain net income (from Part IV, line 2)</td> <td></td> <td style="text-align: right;">0.</td> <td></td> <td></td> </tr> <tr> <td>8 Net short-term capital gain</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>9 Income modifications</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>10a Gross sales less returns and allowances</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>b Less Cost of goods sold</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>c Gross profit or (loss)</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>11 Other income</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>12 Total. 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12-07-10 LHA For Paperwork Reduction Act Notice, see the instructions.

Form 990-PF (2010)

TOP

Part II	Balance Sheets	Attached schedules and amounts in the description column should be for end-of-year amounts only	Beginning of year	End of year	
			(a) Book Value	(b) Book Value	(c) Fair Market Value
	1 Cash - non-interest-bearing		641,242.	1,137,006.	1,137,006.
	2 Savings and temporary cash investments				
	3 Accounts receivable ►				
	Less: allowance for doubtful accounts ►				
	4 Pledges receivable ►				
	Less: allowance for doubtful accounts ►				
	5 Grants receivable				
	6 Receivables due from officers, directors, trustees, and other disqualified persons				
	7 Other notes and loans receivable ►				
	Less: allowance for doubtful accounts ►				
	8 Inventories for sale or use		14,833,094.	20,580,124.	20,580,124.
	9 Prepaid expenses and deferred charges				
	10a Investments - U.S. and state government obligations				
	b Investments - corporate stock				
	c Investments - corporate bonds				
	11 Investments - land, buildings, and equipment basis ►				
	Less accumulated depreciation ►				
	12 Investments - mortgage loans				
	13 Investments - other				
	14 Land, buildings, and equipment basis ►				
	Less accumulated depreciation ►				
	15 Other assets (describe ►)				
	16 Total assets (to be completed by all filers)		15,474,336.	21,717,130.	21,717,130.
	17 Accounts payable and accrued expenses		537,045.	1,109,579.	
	18 Grants payable				
	19 Deferred revenue				
	20 Loans from officers, directors, trustees, and other disqualified persons				
	21 Mortgages and other notes payable				
	22 Other liabilities (describe ►)				
	23 Total liabilities (add lines 17 through 22)		537,045.	1,109,579.	
	Foundations that follow SFAS 117, check here ► <input type="checkbox"/> and complete lines 24 through 26 and lines 30 and 31.				
	24 Unrestricted				
	25 Temporarily restricted				
	26 Permanently restricted				
	Foundations that do not follow SFAS 117, check here ► <input checked="" type="checkbox"/> and complete lines 27 through 31.				
	27 Capital stock, trust principal, or current funds		0.	0.	
	28 Paid-in or capital surplus, or land, bldg., and equipment fund		0.	0.	
	29 Retained earnings, accumulated income, endowment, or other funds		14,937,291.	20,607,551.	
	30 Total net assets or fund balances		14,937,291.	20,607,551.	
	31 Total liabilities and net assets/fund balances		15,474,336.	21,717,130.	

Part III Analysis of Changes in Net Assets or Fund Balances

1 Total net assets or fund balances at beginning of year - Part II, column (a), line 30 (must agree with end-of-year figure reported on prior year's return)	1	14,937,291.
2 Enter amount from Part I, line 27a	2	5,670,260.
3 Other increases not included in line 2 (itemize) ►	3	0.
4 Add lines 1, 2, and 3	4	20,607,551.
5 Decreases not included in line 2 (itemize) ►	5	0.
6 Total net assets or fund balances at end of year (line 4 minus line 5) - Part II, column (b), line 30	6	20,607,551.

Part IV Capital Gains and Losses for Tax on Investment Income

(a) List and describe the kind(s) of property sold (e.g., real estate, 2-story brick warehouse; or common stock, 200 shs. MLC Co.)			(b) How acquired P - Purchase D - Donation	(c) Date acquired (mo., day, yr.)	(d) Date sold (mo., day, yr.)
1a					
b	NONE				
c					
d					
e					
	(e) Gross sales price	(f) Depreciation allowed (or allowable)	(g) Cost or other basis plus expense of sale	(h) Gain or (loss) (e) plus (f) minus (g)	
a					
b					
c					
d					
e					
Complete only for assets showing gain in column (h) and owned by the foundation on 12/31/69				(I) Gains (Col. (h) gain minus col. (k), but not less than -0-) or Losses (from col. (h))	
(i) F.M.V. as of 12/31/69	(j) Adjusted basis as of 12/31/69	(k) Excess of col. (i) over col. (j), if any			
a					
b					
c					
d					
e					
2 Capital gain net income or (net capital loss)	{ If gain, also enter in Part I, line 7 If (loss), enter -0- in Part I, line 7 }		2		
3 Net short-term capital gain or (loss) as defined in sections 1222(5) and (6): If gain, also enter in Part I, line 8, column (c). If (loss), enter -0- in Part I, line 8			3		

Part V Qualification Under Section 4940(e) for Reduced Tax on Net Investment Income

(For optional use by domestic private foundations subject to the section 4940(a) tax on net investment income.)

If section 4940(d)(2) applies, leave this part blank.

Was the foundation liable for the section 4942 tax on the distributable amount of any year in the base period?

 Yes No

If "Yes," the foundation does not qualify under section 4940(e). Do not complete this part.

1 Enter the appropriate amount in each column for each year; see instructions before making any entries.

(a) Base period years Calendar year (or tax year beginning in)	(b) Adjusted qualifying distributions	(c) Net value of noncharitable-use assets	(d) Distribution ratio (col. (b) divided by col. (c))
2009	338,809,732.	759,255.	446.239711
2008	161,089,088.	340,773.	472.716700
2007	15,784,069.	0.	.000000
2006			
2005			

2 Total of line 1, column (d)	2	918,956411
3 Average distribution ratio for the 5-year base period - divide the total on line 2 by 5, or by the number of years the foundation has been in existence if less than 5 years	3	306,318804
4 Enter the net value of noncharitable-use assets for 2010 from Part X, line 5	4	626,704.
5 Multiply line 4 by line 3	5	191,971,220.
6 Enter 1% of net investment income (1% of Part I, line 27b)	6	0.
7 Add lines 5 and 6	7	191,971,220.
8 Enter qualifying distributions from Part XII, line 4	8	487,187,374.

If line 8 is equal to or greater than line 7, check the box in Part VI, line 1b, and complete that part using a 1% tax rate.
See the Part VI instructions.

Part VI Excise Tax Based on Investment Income (Section 4940(a), 4940(b), 4940(e), or 4948 - see instructions)1a Exempt operating foundations described in section 4940(d)(2), check here ► and enter "N/A" on line 1.

Date of ruling or determination letter: _____ (attach copy of letter if necessary-see instructions)

b Domestic foundations that meet the section 4940(e) requirements in Part V, check here ► and enter 1% of Part I, line 27b

c All other domestic foundations enter 2% of line 27b. Exempt foreign organizations enter 4% of Part I, line 12, col. (b).

2 Tax under section 511 (domestic section 4947(a)(1) trusts and taxable foundations only. Others enter -0-)

3 Add lines 1 and 2

4 Subtitle A (income) tax (domestic section 4947(a)(1) trusts and taxable foundations only. Others enter -0-)

5 Tax based on investment income. Subtract line 4 from line 3. If zero or less, enter -0-

6 Credits/Payments:

a 2010 estimated tax payments and 2009 overpayment credited to 2010

b Exempt foreign organizations - tax withheld at source

c Tax paid with application for extension of time to file (Form 8868)

d Backup withholding erroneously withheld

6a

6b

6c

6d

7 Total credits and payments. Add lines 6a through 6d

8 Enter any penalty for underpayment of estimated tax. Check here if Form 2220 is attached

9 Tax due. If the total of lines 5 and 8 is more than line 7, enter amount owed

10 Overpayment. If line 7 is more than the total of lines 5 and 8, enter the amount overpaid

11 Enter the amount of line 10 to be: Credited to 2011 estimated tax ►

Refunded ►

7 0.

8 0.

9 0.

10 0.

11 0.

Part VII-A Statements Regarding Activities

1a During the tax year, did the foundation attempt to influence any national, state, or local legislation or did it participate or intervene in any political campaign?

Yes

No

1a X

b Did it spend more than \$100 during the year (either directly or indirectly) for political purposes (see instructions for definition)?

1b X

If the answer is "Yes" to 1a or 1b, attach a detailed description of the activities and copies of any materials published or distributed by the foundation in connection with the activities.

1c X

c Did the foundation file Form 1120-POL for this year?

d Enter the amount (if any) of tax on political expenditures (section 4955) imposed during the year:

0.

(1) On the foundation. ► \$ _____ 0. (2) On foundation managers. ► \$ _____ 0.

e Enter the reimbursement (if any) paid by the foundation during the year for political expenditure tax imposed on foundation managers. ► \$ _____ 0.

2 Has the foundation engaged in any activities that have not previously been reported to the IRS?

2 X

*If "Yes," attach a detailed description of the activities.*3 Has the foundation made any changes, not previously reported to the IRS, in its governing instrument, articles of incorporation, or bylaws, or other similar instruments? *If "Yes," attach a conformed copy of the changes*

3 X

4a Did the foundation have unrelated business gross income of \$1,000 or more during the year?

4a X

b If "Yes," has it filed a tax return on Form 990-T for this year?

4b

5 Was there a liquidation, termination, dissolution, or substantial contraction during the year?

5 X

If "Yes," attach the statement required by General Instruction T.

6 Are the requirements of section 508(e) (relating to sections 4941 through 4945) satisfied either:

6 X

• By language in the governing instrument, or

7 X

• By state legislation that effectively amends the governing instrument so that no mandatory directions that conflict with the state law remain in the governing instrument?

7 Did the foundation have at least \$5,000 in assets at any time during the year?

8b X

If "Yes," complete Part II, col. (c), and Part XV.

8a Enter the states to which the foundation reports or with which it is registered (see instructions) ►

9 X

b If the answer is "Yes" to line 7, has the foundation furnished a copy of Form 990-PF to the Attorney General (or designate) of each state as required by General Instruction G? *If "No," attach explanation*

10 X

9 Is the foundation claiming status as a private operating foundation within the meaning of section 4942(j)(3) or 4942(j)(5) for calendar year 2010 or the taxable year beginning in 2010 (see instructions for Part XIV)? *If "Yes," complete Part XIV*10 Did any persons become substantial contributors during the tax year? *If "Yes," attach a schedule listing their names and addresses*

Part VIII **Information About Officers, Directors, Trustees, Foundation Managers, Highly Paid Employees, and Contractors (continued)**
3 Five highest-paid independent contractors for professional services. If none, enter "NONE."

(a) Name and address of each person paid more than \$50,000	(b) Type of service	(c) Compensation
NONE		

Total number of others receiving over \$50,000 for professional services ► 0

Part IX-A **Summary of Direct Charitable Activities**

List the foundation's four largest direct charitable activities during the tax year. Include relevant statistical information such as the number of organizations and other beneficiaries served, conferences convened, research papers produced, etc.

	Expenses
1 N/A	
2	
3	
4	

Part IX-B **Summary of Program-Related Investments**

Describe the two largest program-related investments made by the foundation during the tax year on lines 1 and 2.

	Amount
1 N/A	
2	
All other program-related investments. See instructions.	
3	
Total. Add lines 1 through 3	► 0.

Form 990-PF (2010)

Part X Minimum Investment Return (All domestic foundations must complete this part. Foreign foundations, see instructions.)

1	Fair market value of assets not used (or held for use) directly in carrying out charitable, etc., purposes:		
a	Average monthly fair market value of securities	1a	0.
b	Average of monthly cash balances	1b	636,248.
c	Fair market value of all other assets	1c	
d	Total (add lines 1a, b, and c)	1d	636,248.
e	Reduction claimed for blockage or other factors reported on lines 1a and 1c (attach detailed explanation)	1e	0.
2	Acquisition indebtedness applicable to line 1 assets	2	0.
3	Subtract line 2 from line 1d	3	636,248.
4	Cash deemed held for charitable activities. Enter 1 1/2% of line 3 (for greater amount, see instructions)	4	9,544.
5	Net value of noncharitable-use assets. Subtract line 4 from line 3. Enter here and on Part V, line 4	5	626,704.
6	Minimum investment return. Enter 5% of line 5	6	31,335.

Part XI Distributable Amount (see instructions) (Section 4942(j)(3) and (j)(5) private operating foundations and certain foreign organizations check here ► and do not complete this part.)

1	Minimum investment return from Part X, line 6	1	
2a	Tax on investment income for 2010 from Part VI, line 5	2a	
b	Income tax for 2010. (This does not include the tax from Part VI.)	2b	
c	Add lines 2a and 2b	2c	
3	Distributable amount before adjustments. Subtract line 2c from line 1	3	
4	Recoveries of amounts treated as qualifying distributions	4	
5	Add lines 3 and 4	5	
6	Deduction from distributable amount (see instructions)	6	
7	Distributable amount as adjusted. Subtract line 6 from line 5. Enter here and on Part XIII, line 1	7	

Part XII Qualifying Distributions (see instructions)

1	Amounts paid (including administrative expenses) to accomplish charitable, etc., purposes:		
a	Expenses, contributions, gifts, etc. - total from Part I, column (d), line 26	1a	487,187,374.
b	Program-related investments - total from Part IX-B	1b	0.
2	Amounts paid to acquire assets used (or held for use) directly in carrying out charitable, etc., purposes	2	
3	Amounts set aside for specific charitable projects that satisfy the:		
a	Suitability test (prior IRS approval required)	3a	
b	Cash distribution test (attach the required schedule)	3b	
4	Qualifying distributions. Add lines 1a through 3b. Enter here and on Part V, line 8, and Part XIII, line 4	4	487,187,374.
5	Foundations that qualify under section 4940(e) for the reduced rate of tax on net investment income. Enter 1% of Part I, line 27b	5	0.
6	Adjusted qualifying distributions. Subtract line 5 from line 4	6	487,187,374.

Note. The amount on line 6 will be used in Part V, column (b), in subsequent years when calculating whether the foundation qualifies for the section 4940(e) reduction of tax in those years.

Part XIII Undistributed Income (see instructions)

N/A

	(a) Corpus	(b) Years prior to 2009	(c) 2009	(d) 2010
1 Distributable amount for 2010 from Part XI, line 7				
2 Undistributed income, if any, as of the end of 2010				
a Enter amount for 2009 only				
b Total for prior years:				
3 Excess distributions carryover, if any, to 2010:				
a From 2005				
b From 2006				
c From 2007				
d From 2008				
e From 2009				
f Total of lines 3a through e				
4 Qualifying distributions for 2010 from Part XII, line 4: ► \$				
a Applied to 2009, but not more than line 2a				
b Applied to undistributed income of prior years (Election required - see instructions)				
c Treated as distributions out of corpus (Election required - see instructions)				
d Applied to 2010 distributable amount				
e Remaining amount distributed out of corpus				
5 Excess distributions carryover applied to 2010 (If an amount appears in column (d), the same amount must be shown in column (a))				
6 Enter the net total of each column as indicated below:				
a Corpus Add lines 3f, 4c, and 4e Subtract line 5				
b Prior years' undistributed income. Subtract line 4b from line 2b				
c Enter the amount of prior years' undistributed income for which a notice of deficiency has been issued, or on which the section 4942(a) tax has been previously assessed				
d Subtract line 6c from line 6b. Taxable amount - see instructions				
e Undistributed income for 2009. Subtract line 4a from line 2a. Taxable amount - see instr.				
f Undistributed income for 2010. Subtract lines 4d and 5 from line 1. This amount must be distributed in 2011				
7 Amounts treated as distributions out of corpus to satisfy requirements imposed by section 170(b)(1)(F) or 4942(g)(3)				
8 Excess distributions carryover from 2005 not applied on line 5 or line 7				
9 Excess distributions carryover to 2011. Subtract lines 7 and 8 from line 6a				
10 Analysis of line 9:				
a Excess from 2006				
b Excess from 2007				
c Excess from 2008				
d Excess from 2009				
e Excess from 2010				

Part XIV | Private Operating Foundations (see instructions and Part VII-A, question 9)

1 a If the foundation has received a ruling or determination letter that it is a private operating foundation, and the ruling is effective for 2010, enter the date of the ruling ► **10/10/07**

b Check box to indicate whether the foundation is a private operating foundation described in section 4942(j)(3) or 4942(j)(5)

2 a Enter the lesser of the adjusted net income from Part I or the minimum investment return from Part X for each year listed	Prior 3 years				(e) Total
	(a) 2010	(b) 2009	(c) 2008	(d) 2007	
0.	0.	0.	0.	0.	0.
0.	0.	0.	0.	0.	0.
487,187,374.	338,809,732.	161,089,088.	15,784,069.	1,002,870,263.	
0.	0.	0.	0.	0.	0.
487,187,374.	338,809,732.	161,089,088.	15,784,069.	1,002,870,263.	
21,717,131.	15,474,336.	12,005,575.	9,028,288.	58,225,330.	
21,717,131.	15,474,336.	12,005,575.	9,028,288.	58,225,330.	
					0.
492,857,634.	342,099,778.	163,709,394.	24,812,357.	1,023,479,163.	
0.	0.	0.	0.	0.	0.
0.	0.	0.	0.	0.	0.
0.	0.	0.	0.	0.	0.

Part XV | Supplementary Information (Complete this part only if the foundation had \$5,000 or more in assets at any time during the year-see the instructions.)**1 Information Regarding Foundation Managers:**

a List any managers of the foundation who have contributed more than 2% of the total contributions received by the foundation before the close of any tax year (but only if they have contributed more than \$5,000). (See section 507(d)(2).)

NONE

b List any managers of the foundation who own 10% or more of the stock of a corporation (or an equally large portion of the ownership of a partnership or other entity) of which the foundation has a 10% or greater interest.

NONE

2 Information Regarding Contribution, Grant, Gift, Loan, Scholarship, etc., Programs:

Check here ► if the foundation only makes contributions to preselected charitable organizations and does not accept unsolicited requests for funds. If the foundation makes gifts, grants, etc. (see instructions) to individuals or organizations under other conditions, complete items 2a, b, c, and d.

a The name, address, and telephone number of the person to whom applications should be addressed:

SEE ATTACHED

b The form in which applications should be submitted and information and materials they should include:

SEE ATTACHED

c Any submission deadlines:

N/A

d Any restrictions or limitations on awards, such as by geographical areas, charitable fields, kinds of institutions, or other factors:

SEE ATTACHED

Part XV **Supplementary Information** (continued)**3 Grants and Contributions Paid During the Year or Approved for Future Payment**

Recipient Name and address (home or business)	If recipient is an individual, show any relationship to any foundation manager or substantial contributor	Foundation status of recipient	Purpose of grant or contribution	Amount
a Paid during the year OVER 200,000 ELIGIBLE INDIVIDUALS (LIST AVAILABLE UPON REQUEST), N/A, N/A	NONE	N/A	PROVIDE VARIOUS PHARMACEUTICAL, MEDICAL NUTRITIONAL, AND DIABETES CARE PRODUCTS AT NO CHARGE TO ELIGIBLE INDIVIDUALS	482,610,604.
Total			► 3a	482,610,604.
b Approved for future payment				
NONE				
Total			► 3b	0.

023611 12-07-10

Form 990-PF (2010)

Part XVI-A Analysis of Income-Producing Activities

Enter gross amounts unless otherwise indicated.

Part XVI, B Relationship of Activities

Relationship of Activities to the Accomplishment of Exempt Purposes

023621
12-07-10

Schedule B(Form 990, 990-EZ,
or 990-PF)Department of the Treasury
Internal Revenue Service**Schedule of Contributors**

► Attach to Form 990, 990-EZ, or 990-PF.

OMB No. 1545-0047

2010

Name of the organization

ABBOTT PATIENT ASSISTANCE FOUNDATION

Employer identification number

26-1215559

Organization type (check one)

Filers of:

Section:

Form 990 or 990-EZ

 501(c)() (enter number) organization 4947(a)(1) nonexempt charitable trust **not** treated as a private foundation 527 political organization

Form 990-PF

 501(c)(3) exempt private foundation 4947(a)(1) nonexempt charitable trust treated as a private foundation 501(c)(3) taxable private foundationCheck if your organization is covered by the **General Rule** or a **Special Rule**.**Note.** Only a section 501(c)(7), (8), or (10) organization can check boxes for both the General Rule and a Special Rule. See instructions**General Rule**

For an organization filing Form 990, 990-EZ, or 990-PF that received, during the year, \$5,000 or more (in money or property) from any one contributor. Complete Parts I and II.

Special Rules

For a section 501(c)(3) organization filing Form 990 or 990-EZ that met the 33 1/3% support test of the regulations under sections 509(a)(1) and 170(b)(1)(A)(vi), and received from any one contributor, during the year, a contribution of (1) \$5,000 or (2) 2% of the amount on (i) Form 990, Part VIII, line 1h or (ii) Form 990-EZ, line 1. Complete Parts I and II.

For a section 501(c)(7), (8), or (10) organization filing Form 990 or 990-EZ that received from any one contributor, during the year, aggregate contributions of more than \$1,000 for use *exclusively* for religious, charitable, scientific, literary, or educational purposes, or the prevention of cruelty to children or animals. Complete Parts I, II, and III.

For a section 501(c)(7), (8), or (10) organization filing Form 990 or 990-EZ that received from any one contributor, during the year, contributions for use *exclusively* for religious, charitable, etc., purposes, but these contributions did not aggregate to more than \$1,000. If this box is checked, enter here the total contributions that were received during the year for an *exclusively* religious, charitable, etc., purpose. Do not complete any of the parts unless the **General Rule** applies to this organization because it received nonexclusively religious, charitable, etc., contributions of \$5,000 or more during the year

► \$ _____

Caution. An organization that is not covered by the General Rule and/or the Special Rules does not file Schedule B (Form 990, 990-EZ, or 990-PF), but it **must** answer "No" on Part IV, line 2 of its Form 990, or check the box on line H of its Form 990-EZ, or on line 2 of its Form 990-PF, to certify that it does not meet the filing requirements of Schedule B (Form 990, 990-EZ, or 990-PF)

LHA For Paperwork Reduction Act Notice, see the Instructions for Form 990, 990-EZ, or 990-PF. Schedule B (Form 990, 990-EZ, or 990-PF) (2010)

Name of organization.

ABBOTT PATIENT ASSISTANCE FOUNDATION

Employer identification number

26-1215559

Part I **Contributors** (see instructions)

(a) No.	(b) Name, address, and ZIP + 4	(c) Aggregate contributions	(d) Type of contribution
1	ABBOTT LABORATORIES 100 ABBOTT PARK ROAD ABBOTT PARK, IL 60064-3500	\$ 488,357,634.	<input checked="" type="checkbox"/> Person <input type="checkbox"/> Payroll <input checked="" type="checkbox"/> Noncash <small>(Complete Part II if there is a noncash contribution.)</small>
2	ABBOTT LABORATORIES 100 ABBOTT PARK ROAD ABBOTT PARK, IL 60064-3500	\$ 4,500,000.	<input checked="" type="checkbox"/> Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <small>(Complete Part II if there is a noncash contribution.)</small>
		\$	<input type="checkbox"/> Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <small>(Complete Part II if there is a noncash contribution.)</small>
		\$	<input type="checkbox"/> Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <small>(Complete Part II if there is a noncash contribution.)</small>
		\$	<input type="checkbox"/> Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <small>(Complete Part II if there is a noncash contribution.)</small>
		\$	<input type="checkbox"/> Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <small>(Complete Part II if there is a noncash contribution.)</small>
		\$	<input type="checkbox"/> Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <small>(Complete Part II if there is a noncash contribution.)</small>
		\$	<input type="checkbox"/> Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <small>(Complete Part II if there is a noncash contribution.)</small>

Name of organization

Employer identification number

ABBOTT PATIENT ASSISTANCE FOUNDATION

26-1215559

Part II Noncash Property (see instructions)

(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
1	VARIOUS MEDICATIONS	\$ 488,357,634.	VARIOUS
(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
		\$	
(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
		\$	
(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
		\$	
(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
		\$	
(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
		\$	

023453 12-23-10

Schedule B (Form 990, 990-EZ, or 990-PF) (2010)

Name of organization

Employer identification number

ABBOTT PATIENT ASSISTANCE FOUNDATION

26-1215559

Part III

Exclusively religious, charitable, etc., individual contributions to section 501(c)(7), (8), or (10) organizations aggregating more than \$1,000 for the year. Complete columns (a) through (e) and the following line entry. For organizations completing Part III, enter the total of exclusively religious, charitable, etc., contributions of \$1,000 or less for the year. (Enter this information once. See instructions) ► \$

FORM 990-PF	OTHER EXPENSES	STATEMENT	1
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DESCRIPTION	(A) EXPENSES PER BOOKS	(B) NET INVEST- MENT INCOME	(C) ADJUSTED NET INCOME	(D) CHARITABLE PURPOSES
SHIPPING AND DISTRIBUTION	1,863,705.	0.		1,863,705.
ADMINISTRATIVE	23,398.	0.		23,398.
OUTSIDE SERVICES	2,689,667.	0.		2,689,667.
TO FORM 990-PF, PG 1, LN 23	4,576,770.	0.		4,576,770.

FORM 990-PF	PART VIII - LIST OF OFFICERS, DIRECTORS TRUSTEES AND FOUNDATION MANAGERS	STATEMENT	2
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NAME AND ADDRESS	TITLE AND AVRG HRS/WK	COMPEN- SATION	EMPLOYEE BEN PLAN EXPENSE CONTRIB ACCOUNT
THAD SMITH D-031C AP31-3NW, 200 ABBOTT PARK ROAD ABBOTT PARK, IL 600646197	VICE PRESIDENT 0.00	0.	0.
WAYNE BROWN D-031C AP31-3NW, 200 ABBOTT PARK ROAD ABBOTT PARK, IL 600646197	TREASURER 0.00	0.	0.
DALE JOHNSON D-031C AP31-3NW, 200 ABBOTT PARK ROAD ABBOTT PARK, IL 600646197	DIRECTOR 0.00	0.	0.
JOHN PILOTTE D-031C AP31-3NW, 200 ABBOTT PARK ROAD ABBOTT PARK, IL 600646197	PRESIDENT 0.00	0.	0.
SCOTT ROE D-031C AP31-3NW, 200 ABBOTT PARK ROAD ABBOTT PARK, IL 600646197	DIRECTOR 0.00	0.	0.
KELLY INGOLD D-031C AP31-3NW, 200 ABBOTT PARK ROAD ABBOTT PARK, IL 600646197	DIRECTOR 0.00	0.	0.

ABBOTT PATIENT ASSISTANCE FOUNDATION

26-1215559

KEVIN DOLAN
D-031C AP31-3NW, 200 ABBOTT PARK
ROAD
ABBOTT PARK, IL 600646197

DIRECTOR

0.00

0.

0.

0.

TOTALS INCLUDED ON 990-PF, PAGE 6, PART VIII

0.

0.

0.

Abbott Patient Assistance Foundation's Application for Medical Nutrition Products

The Abbott Patient Assistance Foundation provides Abbott Medical Nutrition Products 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 Abbott Patient Assistance Foundation's purpose of providing products at no cost to individuals in need. **The Abbott Patient Assistance Foundation's Medical Nutrition Products Patient Assistance Program is designed to supplement medical nutrition product needs.**

Checklist for submitting an application:

- Ensure all sections of the application are completed. Incomplete applications will be returned for further information.
- Attach current proof of income (tax return, W2, pay stub, or benefit awards letter) for all in household.
- Patient's signature/date is required on the application.
- Prescriber's signature/date is required on the application.
- Provide copy of Medicaid and/or Social Security denial, if applicable.
- Provide copy of private insurance denial letter OR the published policy that states nutritional products are not a covered benefit, if applicable.

Fax or mail the completed application and documentation to:

Abbott Patient Assistance Foundation
PO Box 270
Somerville, NJ 08876
Fax: 866-483-1305
Phone: 800-222-6885

Upon receipt of a completed application, the prescriber will be notified of program eligibility. The approved supply of product will be shipped to the patient's home. It is the responsibility of the prescriber's office or the patient to reorder 3 weeks prior to the patient requiring further supply.

Please contact us at 1-800-222-6885 Mon-Fri 8am-5pm CST for additional assistance.



Abbott
Patient Assistance
Foundation

Medical Nutrition Products Patient Assistance Program Application

Abbott Patient Assistance Foundation • PO Box 270 • Somerville NJ 08876
Phone (800) 222-6885 • Fax: (866) 483-1305

Applications are available by calling 1-800-222-6885 or visiting www.abbottpatientassistancefoundation.org

Patient Name	Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>	Telephone Number	
Shipping address	City	State	Zip
Date of birth	____/____/____	Social Security Number	____-____-____
Are you enrolled in Medicare <input type="checkbox"/> Yes <input type="checkbox"/> No (if YES, check all that apply) <input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Part D(name)			
Do you have prescription coverage for Nutrition supplies? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Are you covered thru a state Medicaid Program? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Total Monthly Income for your entire household	\$ _____	(Attach the most current copies of income documentation for you and all dependent persons)	

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 Abbott Patient Assistance Foundation. In the event that I am eligible for Foundation assistance, 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 Foundation assistance may change at anytime or be discontinued at the end of the calendar year 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 from the Foundation. I agree that I will notify the Foundation if my insurance or financial situation changes. 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 ("PAP") (should I qualify). I know I may cancel this authorization at any time by writing to the Abbott Patient Assistance Foundation at P O Box 270 Somerville, NJ 08876. If I cancel this Authorization, I can no longer participate in 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 PAP services to me.

Patient's Signature _____ Date. _____

Number of people in your household (including yourself) _____ Number in household under 18 _____

Representative For Purposes of Program:

I permit the Abbott Patient Assistance Foundation to speak with the following person(s) about my application and/or care and sign any documents related to the Program on my behalf:

Name: _____	Relationship: _____	Phone #: _____
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Personal Representative Authorization (if Applicable):

Note: If the Applicant is unable to sign, is under the age of 18, or has designated signature authority, the Applicant's Personal Representative may sign this Form. However, only certain individuals may qualify as the Applicant's Personal Representative for purposes of this Authorization. An Applicant's Representative must have the requisite knowledge and information regarding the Applicant'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 Foundation, including a health care provider or pharmacy receiving the medicines at no cost, may not be named a Personal Representative. If Applicant's Personal Representative is a consumer assistance or charitable organization, please list name of entity and purpose of entity under Relationship to Applicant.

Patient's Representative Signature _____ Relationship _____ Date _____

Prescriber name and professional designation	DEA# (if none available, State license #)	Expiration Date
--	---	-----------------

Shipping address	City	State	Zip
------------------	------	-------	-----

Mailing address	City	State	Zip
-----------------	------	-------	-----

Office contact person	Telephone number	Fax number
-----------------------	------------------	------------

Product: _____ Flavor(s): _____ Administration Oral Tube

% Caloric Need to be met with Product _____ Estimated Total Caloric Need of Patient (Daily) _____ Number per day _____ (Cans)

Product: _____ Flavor(s): _____ Administration Oral Tube

% Caloric Need to be met with Product _____ Estimated Total Caloric Need of Patient (Daily) _____ Number per day _____ (Cans)

Primary Diagnosis: _____ **Indications for Use:** _____

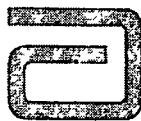
Please provide both a primary diagnosis (i.e. HIV/Aids, diabetes, etc.) and the indications for use (i.e. involuntary weight loss, cachexia, malnutrition, etc.) that requires the need for nutrition therapy. Applications for Metabolic products and Elecare require a primary diagnosis only.

Note: Prescriber may not delegate signature authority. (STAMPS NOT ACCEPTED)

- 1 Authorization for Release of Health Information: By signing this form, I represent to the Abbott Patient Assistance 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 Abbott Patient Assistance Foundation and its contracted third parties.
- 2 Physician/Care Coordinator Verification: 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 Abbott Patient Assistance Foundation (the "Foundation") in writing immediately if the status of my State License Number registration changes. If this applicant is eligible for the Abbott Patient Assistance Foundation assistance, I understand that the Foundation will send the medication to my office for dispensing to the patient. The Foundation reserves the right to request additional information if needed and to change or discontinue the assistance at any time, without notice. By signing this form, I certify that I am prescribing the aforementioned medication for an individual participating in the Foundation. 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 by the Abbott Patient Assistance Foundation is not made in exchange for any explicit or implicit agreement or understanding that Abbott Product will be used, purchased, leased, ordered, prescribed, recommended, or arranged for or provided formulary or other preferential or qualifying status. I understand that I may not delegate signature authority. I certify that treatment with this medication is medically necessary.

Prescriber's Signature: _____ **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 applicant's information to the Foundation and its contracted third parties. The Foundation urges all entities disclosing information about the applicant to consult with legal counsel prior to relying on this form.



Abbott Patient Assistance Foundation's Application for Lupron Depot® and Lupron Depot-PED® (leuprolide acetate for depot suspension)

The Abbott Patient Assistance Foundation provides Abbott 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 Abbott 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. Incomplete applications will be returned for further information.
- Attach current proof of income (tax return, W2, pay stub) for all in household.
- Patient's signature/date is required on the application.
- Prescriber's signature/date is required on the application.
- Provide a copy of Medicare card or letter of Medicaid and/or Social Security denial, if applicable.

Fax or mail the completed application and documentation to:

Abbott Patient Assistance Foundation
PO Box 270
Somerville, NJ 08876
Fax: (866) 483-1305
Phone: (800) 222-6885

Upon receipt of a completed application, the prescriber and patient will be notified of program eligibility. If patient is eligible for assistance, a supply of medication will be shipped to the prescriber's office. It is the responsibility of the prescriber or office staff to reorder 3 weeks prior to the patient requiring further medication.

Please contact us at 1-800-222-6885 Mon-Fri 8 am-5 pm CST for additional assistance.

**Patient Assistance Application for
 Lupron Depot® and Lupron Depot-PED®
 (leuprolide acetate for depot suspension)**

 Abbott Patient Assistance Foundation • PO Box 270 • Somerville NJ 08876
 Phone (800) 222-6885 • Fax: (866) 483-1305

 Applications are available by calling 1-800-222-6885 or visiting www.abbottpatientassistancefoundation.org

Patient Name	Gender: Male <input type="checkbox"/> Female <input type="checkbox"/> Telephone Number		
Patient address	City	State	Zip
Date of birth	____/____/____	Social Security Number	____-____-____
Are you enrolled in Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No (if YES, check all that apply) <input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Part D(name)			
Do you have private insurance coverage for prescriptions <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, are injectables covered by pharmacy benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Are you covered thru a state Medicaid Program? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, are injectables covered? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Total Monthly Income for your entire household	\$ <input type="text"/>	(Attach the most current copies of income documentation for you and all dependent persons.)	

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 Abbott Patient Assistance Foundation. In the event that I am eligible for Foundation assistance, 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 Foundation assistance may change or be 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 from the Foundation. I agree that I will notify the Foundation if my insurance or financial situation changes. 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 ("PAP") (should I qualify). I know I may cancel this authorization at any time by writing to the Abbott Patient Assistance Foundation at P.O. Box 270 Somerville, NJ 08876. If I cancel this Authorization, I can no longer participate in 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 PAP services to me.

Patient's Signature: _____ Date: _____

 Number of people in your household (including yourself) Number in household under 18
Representative For Purposes of Program:

I permit the Abbott Patient Assistance Foundation to speak with the following person(s) about my application and/or care and sign any documents related to the Program on my behalf:

Name: _____ Relationship: _____ Phone #: _____

Personal Representative Authorization (if Applicable):

Note: If the Applicant is unable to sign, is under the age of 18, or has designated signature authority, the Applicant's Personal Representative may sign this Form. However, only certain individuals may qualify as the Applicant's Personal Representative for purposes of this Authorization. An Applicant's Representative must have the requisite knowledge and information regarding the Applicant'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 Foundation, including a health care provider or pharmacy receiving the medicines at no cost, may not be named a Personal Representative. If Applicant's Personal Representative is a consumer assistance or charitable organization, please list name of entity and purpose of entity under Relationship to Applicant.

Patient's Representative Signature _____ Relationship: _____ Date: _____

Prescriber Name and professional designation _____ DEA# (if none available, State license #) _____ Expiration Date _____

Shipping address _____ City _____ State _____ Zip _____

Mailing address _____ City _____ State _____ Zip _____

Office contact person _____ Telephone number _____ Fax number _____

Lupron Depot 3.75mg _____ Lupron Depot 3 month 11.25mg _____ Lupron Depot 4 month 30mg _____ Lupron Depot PED 11.25mg _____

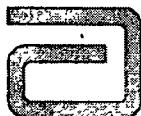
Lupron Depot 7.5mg _____ Lupron Depot 3 month 22.5mg _____ Lupron Depot PED 7.5mg _____ Lupron Depot PED 15mg _____

Note: Prescriber may not delegate signature authority. (STAMPS NOT ACCEPTED)

- 1 Authorization for Release of Health Information: By signing this form, I represent to the Abbott Patient Assistance 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 Abbott Patient Assistance Foundation and its contracted third parties.
- 2 Physician/Care Coordinator Verification: 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 Abbott Patient Assistance Foundation (the "Foundation") in writing immediately if the status of my State License Number registration changes. If this applicant is eligible for the Abbott Patient Assistance Foundation assistance, I understand that the Foundation will send the medication to my office for dispensing to the patient. The Foundation reserves the right to request additional information if needed and to change or discontinue the assistance at any time, without notice. By signing this form, I certify that I am prescribing the aforementioned medication for an individual participating in the Foundation. 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 by the Abbott Patient Assistance Foundation is not made in exchange for any explicit or implicit agreement or understanding that Abbott Product will be used, purchased, leased, ordered, prescribed, recommended, or arranged for or provided formulary or other preferential or qualifying status. I understand that I may not delegate signature authority. I certify that treatment with this medication is medically necessary.

Prescriber's Signature: _____ 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 applicant's information to the Foundation and its contracted third parties. The Foundation urges all entities disclosing information about the applicant to consult with legal counsel prior to relying on this form.



Abbott
Patient Assistance
Foundation

Abbott Patient Assistance Foundation's Application for Kaletra® (lopinavir/ritonavir) & Norvir® (ritonavir)

The Abbott Patient Assistance Foundation provides Abbott 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 Abbott 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. Incomplete applications will be returned for further information.
- Patient's signature/date is required on the application.
- Prescriber's signature/date is required on the application.
- For Norvir Assistance: Financial information section is not required.

Fax or mail the completed application and documentation to:

Abbott Patient Assistance Foundation
<<Variable: Address>>
<<Variable: Address>>
<<Variable: Fax Number>>
<<Variable: Phone Number>>

Upon receipt of a completed application, the Prescriber will be notified of program eligibility. A supply of medication will be shipped to the prescriber's office. It is the responsibility of the prescriber or office staff to reorder 3 weeks prior to the patient requiring further medication.

Please contact us at <<Variable: Phone Number>> 8am-5pm CST for additional assistance.

For alternative shipping options, please contact the Abbott Patient Assistance Foundation at <<Variable: Phone number>>

Kaletra® (lopinavir/ritonavir) & Norvir® (ritonavir)
Patient Assistance Application

 Abbott Patient Assistance Foundation •<<Variable Address>>
 <<Vanalbe Phone Number>> • <<Variable Fax Number>>

 Applications are available by calling <<Variable: Phone Number>> or visiting www.abbottpatientassistancefoundation.org

Patient Name	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Telephone Number
Patient address	City	State
Date of birth	Social Security Number	Zip
<u>Are you enrolled in Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No (if YES, check all that apply) <input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Part D(name)</u> <u>Do you have private insurance coverage for prescriptions? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you covered by Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No</u> <u>Are you enrolled in ADAP? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you been <input type="checkbox"/> Denied <input type="checkbox"/> Waitlisted <input type="checkbox"/> Pending <input type="checkbox"/> Not Applied</u>		

List of other antiretroviral medications:
Total Monthly Income for your entire household \$ _____ (Financial Information – For Kaletra Assistance only)

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 ("PAP") (should I qualify). I know I may cancel this authorization at any time by writing to the Abbott Patient Assistance Foundation at P O Box 270 Somerville, NJ 08876. If I cancel this Authorization, I can no longer participate in 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 PAP services to me.

Patient's Signature: _____ Date: _____

Number of people in your household (including yourself) _____ Number in household under 18 _____

Representative For Purposes of Program:

I permit the Abbott Patient Assistance Foundation to speak with the following person(s) about my application and/or care and sign any documents related to the Program on my behalf:

Name: _____ Relationship: _____ Phone #: _____

Personal Representative Authorization (if Applicable):

Note: If the Applicant is unable to sign, is under the age of 18, or has designated signature authority, the Applicant's Personal Representative may sign this Form. However, only certain individuals may qualify as the Applicant's Personal Representative for purposes of this Authorization. An Applicant's Representative must have the requisite knowledge and information regarding the Applicant'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 Foundation, including a health care provider or pharmacy receiving the medicines at no cost, may not be named a Personal Representative. If Applicant's Personal Representative is a consumer assistance or charitable organization, please list name of entity and purpose of entity under Relationship to Applicant.

Patient's Representative Signature: _____ Relationship: _____ Date: _____

Prescriber name and professional designation _____ DEA# (if none available, State license #) _____ Expiration Date _____

Shipping address _____ City _____ State _____ Zip _____

Mailing address _____ City _____ State _____ Zip _____

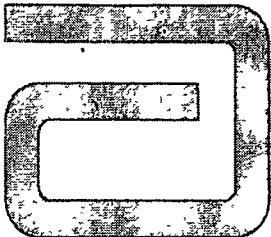
Office contact person _____ Telephone number _____ Fax number _____

 Product: _____ Strength: _____ Sig: _____ Reorders allowed: up to 1 year
Note: Prescriber may not delegate signature authority. (STAMPS NOT ACCEPTED)

- 1 Authorization for Release of Health Information: By signing this form, I represent to the Abbott Patient Assistance 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 Abbott Patient Assistance Foundation and its contracted third parties.
- 2 Physician/Care Coordinator Verification: 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 Abbott Patient Assistance Foundation (the "Foundation") in writing immediately if the status of my State License Number registration changes. If this applicant is eligible for the Abbott Patient Assistance Foundation assistance, I understand that the Foundation will send the medication to my office for dispensing to the patient. The Foundation reserves the right to request additional information if needed and to change or discontinue the assistance at any time, without notice. By signing this form, I certify that I am prescribing the aforementioned medication for an individual participating in the Foundation. 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 by the Abbott Patient Assistance Foundation is not made in exchange for any explicit or implicit agreement or understanding that Abbott Product will be used, purchased, leased, ordered, prescribed, recommended, or arranged for or provided formulary or other preferential or qualifying status. I understand that I may not delegate signature authority. I certify that treatment with this medication is medically necessary.

Prescriber's Signature: _____ 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 applicant's information to the Foundation and its contracted third parties. The Foundation urges all entities disclosing information about the applicant to consult with legal counsel prior to relying on this form.



Abbott Patient Assistance Foundation Application for AndroGel® (testosterone gel) 1%, Creon®, (pancrelipase delayed release capsules) and Prometrium® (progesterone, USP)

The Abbott Patient Assistance Foundation provides Abbott 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 Abbott 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. Incomplete applications will be returned for further information.
- Attach current proof of income (tax return, W2, pay stub) for all in household.
- Patient's signature/date is required on the application.
- Prescriber's signature/date is required on the application.
- Provide a copy of Medicare card or letter of Medicaid and/or Social Security denial, if applicable.

Fax or mail the completed application and documentation to:

Abbott Patient Assistance Foundation
P.O. Box 66550
St. Louis, MO 63166-6550
Phone: 1-800-256-8918
FAX: 1-800-276-9901

Please contact us at 1-800-256-8918, Monday thru Friday 8:00 am to 5:00 pm Central Time for additional assistance.



Abbott Patient Assistance Foundation Application

Abbott Patient Assistance Foundation

P.O. Box 65500 St. Louis, MO 63166-6550

Phone: 1-800-256-8918 FAX: 1-800-276-9901

AndroGel®, Creon® and Prometrium®

Applications are available by calling 1-800-256-8918 or visiting www.abbottpatientassistancefoundation.org

HEALTHCARE PROVIDER INFORMATION						
DEA Number.	Physician Name (First)			(Last)		
Address:	City	State:	Zip			
Email Address	Office Contact.	Phone: ()	Fax: ()			
MEDICATION INFORMATION – Please complete Prescription/Order Form on second page						
Requested product	<input type="checkbox"/> AndroGel®		<input type="checkbox"/> CREON®		<input type="checkbox"/> PROMETRIUM®	
<i>The product listed above must be shipped to the patient's address</i>			<i>The products listed above may be shipped to either:</i> Licensed Prescriber's Office <input type="checkbox"/> Patient's Address <input type="checkbox"/>			
Patient diagnosis (ICD-9 code):						
<p>1 Authorization for Release of Health Information By signing this form, I represent to the Abbott Patient Assistance 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 Abbott Patient Assistance Foundation and its contracted third parties</p> <p>2 Physician/Care Coordinator Verification 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 Abbott Patient Assistance Foundation (the "Foundation") in writing immediately if the status of my State License Number registration changes. If this applicant is eligible for the Abbott Patient Assistance Foundation assistance, I understand that the Foundation will send the medication to my office for dispensing to the patient or the patient's home. The Foundation reserves the right to request additional information if needed and to change or discontinue the assistance at any time, without notice. By signing this form, I certify that I am prescribing the aforementioned medication for an individual participating in the Foundation. 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 by the Abbott Patient Assistance Foundation is not made in exchange for any explicit or implicit agreement or understanding that Abbott Product will be used, purchased, leased, ordered, prescribed, recommended, or arranged for or provided formulary or other preferential or qualifying status. I understand that I may not delegate signature authority. I certify that treatment with this medication is medically necessary</p>						
Signature of Physician			Date			
PATIENT INFORMATION – Please complete to fullest extent possible. If an item does not apply, please mark N/A on that line						
Social Security / ID No.	Patient Name. (First)			(Last)		
Address:	Home Phone: ()			Work Phone: ()		
City:	State:			Zip:		
US Resident <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Birth: _____			Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		
Veteran: <input type="checkbox"/> Yes <input type="checkbox"/> No	Disabled: <input type="checkbox"/> Yes <input type="checkbox"/> No					
FINANCIAL INFORMATION – Please attach a copy of household's most recent year tax return (1040, 1040EZ, 1099, etc.)						
Total # of people in household (include self): _____	Total Assets per Household Includes bank account, IRA, annuity, stocks, bonds, etc.					
<u>LIST ALL SOURCES OF GROSS MONTHLY AMOUNTS PER HOUSEHOLD</u>						
Salary/Wages (All Sources)	\$	ATTACH	Disability	\$	ATTACH	
Pension/Retirement	\$	PROOF	Alimony/Child Support	\$	PROOF	
Social Secuity	\$	OF INCOME	Unemployment Compensation	\$	OF INCOME	
Total Gross Monthly Household Income: _____						
INSURANCE INFORMATION – Please include a copy of patient's Insurance Card and Prescription Card (front and back)						
	Medical Coverage(circle one)	Prescription Drug Coverage for Requested Product (circle one)	Eligibility Status E=Eligible P=Pending I=Ineligible (reason)	Policy Number	Phone Number	Contact Person
Medicare	Y N	Y N			()	
Medicare Part D	Y N	Y N			()	
Medicaid	Y N	Y N			()	
Private Insurance	Y N	Y N			()	
State Elderly Drug Assistance	Y N	Y N			()	
State Children Health Insurance	Y N	Y N			()	
Veterans Assistance	Y N	Y N			()	
Other	Y N	Y N			()	
APPLICANT DECLARATION						
<p>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 Abbott Patient Assistance Foundation. In the event that I am eligible for Foundation assistance, 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 Foundation assistance may change or be 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 from the Foundation. I agree that I will notify the Foundation if my insurance or financial situation changes. 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 ("PAP") (should I qualify). I know I may cancel this authorization at any time by writing to the Abbott Patient Assistance Foundation at P.O. Box 65500 St. Louis, MO 63166-6550. If I cancel this Authorization, I can no longer participate in 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 PAP services to me.</p>						
Signature of Patient or Legal Guardian					Date.	



Abbott Patient Assistance Foundation Application

Abbott Patient Assistance Foundation
P.O. Box 65500 St. Louis, MO 63166-6550
Phone: 1-800-256-8918 FAX: 1-800-276-9901
AndroGel®, Creon® and Prometrium®

Prescription and Order Form

Section 1 - Physician and Prescription Information

Physician Name:	DEA/State License #:	Phone ()	Fax ()	
Address. (no P.O. Box)		City:	State Zip.	
Prescription	Instructions	Quantity	Day Supply	Refills
AndroGel® 1% Topical (maximum daily dose 10 gms)	<input type="checkbox"/> 30 packets per box <input type="checkbox"/> 2x75gm pump (1 metered dose is 1 25gm)		<input type="checkbox"/> 30 <input type="checkbox"/> 60 <input type="checkbox"/> 90	
Strength: <input type="checkbox"/> 2.5gm <input type="checkbox"/> 5 gm				

Enclose a copy of a government issued ID of the patient when ordering the product listed above:

Driver License, State ID, Military ID, etc.,

The products listed above must be shipped to the patient's address

Physician Signature.

(must be MD / DO no PAC / NP) _____ / _____ / _____
(substitution allowed) (date) (dispense as written)

*The products listed below may be shipped to patient's address or healthcare provider's office;
if not indicated medications will be shipped to patient's address.*

Medication should be sent to: Licensed Prescriber's Office Patient's Address

Product Requested	Instructions	Quantity	Bottles Req.	Refills
CREON® (pancrelipase) Delayed-Release Capsules <input type="checkbox"/> 6,000 Lipase Units <input type="checkbox"/> 12,000 Lipase Units <input type="checkbox"/> 24,000 Lipase Units			<input type="checkbox"/> 100	
PROMETRIUM® (progesterone, USP) <input type="checkbox"/> 100MG <input type="checkbox"/> 200MG			<input type="checkbox"/> 100	

Physician Signature.

_____ / _____ / _____
(substitution allowed) (date) (dispense as written)

Section 2 - Patient Information

Patient Name:	SS #, Green Card, VISA:		
Street Address	Date of Birth		
City.	State:	Zip:	Phone. ()

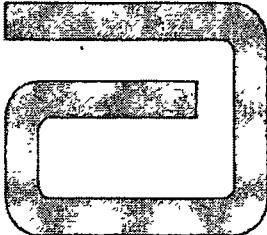
Medication Information

Patient allergies. No Known _____

Please list the names of other medications the patient is currently taking. None _____

Please fax this form to 1-800-276-9901 or mail to address above

**If you are a New York or New Jersey Prescriber, please use an original New York State or
New Jersey State Prescription Form.**



Abbott Patient Assistance Foundation Application

The Abbott Patient Assistance Foundation provides Abbott 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 Abbott 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. Incomplete applications will be returned for further information.
- Attach current proof of income (tax return, W2, pay stub) for all in household.
- Patient's signature/date is required on the application.
- Prescriber's signature/date is required on the application.
- Provide a copy of Medicare card or letter of Medicaid and/or Social Security denial, if applicable.

Fax or mail the completed application and documentation to:

Abbott Patient Assistance Foundation
PO Box 270
Somerville, NJ 08876
Fax: (866) 898-1473
Phone: (800) 222-6885

Upon receipt of a completed application, the prescriber will be notified of program eligibility. If patient is eligible for assistance, a supply of medication will be shipped to the prescriber's office. It is the responsibility of the prescriber or office staff to reorder 3 weeks prior to the patient requiring further medication.

Please contact us at 1-800-222-6885 Mon-Fri 8am-5pm CST for additional assistance.



Abbott Patient Assistance Foundation Application

Abbott Patient Assistance Foundation • PO Box 270 • Somerville NJ 08876
(800) 222-6885 • (866) 898-1473

Applications are available by calling <Variable Phone Number> or visiting www.abbottpatientassistancefoundation.org

Patient Name

Gender: Male Female Telephone Number

Patient address

City

State

Zip

Date of birth / / /

Social Security Number - -

Are you enrolled in Medicare? Yes No (if YES, check all that apply) Part A Part B Part D(name)

Do you have private insurance coverage for prescriptions? Yes No

Are you covered thru a state Medicaid Program? Yes No

Total Monthly Income for your entire household

\$

(Attach the most current copies of income documentation for you and all dependent persons. Acceptable documents include Federal Tax Return, SSA 1099, W2, pay stubs or benefits award letter)

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 ("PAP") (should I qualify). I know I may cancel this authorization at any time by writing to the Abbott Patient Assistance Foundation at P O Box 270 Somerville, NJ 08876. If I cancel this Authorization, I can no longer participate in 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 PAP services to me.

Patient's Signature: _____

Date: _____

Number of people in your household (including yourself)

Number in household under 18

Representative For Purposes of Program:

I permit the Abbott Patient Assistance Foundation to speak with the following person(s) about my application and/or care and sign any documents related to the Program on my behalf:

Name: _____

Relationship: _____

Phone #: _____

Personal Representative Authorization (if Applicable):

Note: If the Applicant is unable to sign, is under the age of 18, or has designated signature authority, the Applicant's Personal Representative may sign this Form. However, only certain individuals may qualify as the Applicant's Personal Representative for purposes of this Authorization. An Applicant's Representative must have the requisite knowledge and information regarding the Applicant'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 Foundation, including a health care provider or pharmacy receiving the medicines at no cost, may not be named a Personal Representative. If Applicant's Personal Representative is a consumer assistance or charitable organization, please list name of entity and purpose of entity under Relationship to Applicant.

Patient's Representative Signature: _____ Relationship: _____ Date: _____

Name and professional designation of Prescriber

DEA# (if none available, State license #)

Expiration Date

Shipping address

City

State

Zip

Mailing address

City

State

Zip

Office contact person

Telephone number

Fax number

Product: _____

Strength: _____

Sig: _____

Reorders allowed: up to 1 year

Product: _____

Strength: _____

Sig: _____

Reorders allowed: up to 1 year

Note: Prescriber may not delegate signature authority. (STAMPS NOT ACCEPTED)

- 1 Authorization for Release of Health Information: By signing this form, I represent to the Abbott Patient Assistance 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 Abbott Patient Assistance Foundation and its contracted third parties.
- 2 Physician/Care Coordinator Verification: 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 Abbott Patient Assistance Foundation (the "Foundation") in writing immediately if the status of my State License Number registration changes. If this applicant is eligible for the Abbott Patient Assistance Foundation assistance, I understand that the Foundation will send the medication to my office for dispensing to the patient. The Foundation reserves the right to request additional information if needed and to change or discontinue the assistance at any time, without notice. By signing this form, I certify that I am prescribing the aforementioned medication for an individual participating in the Foundation. 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 by the Abbott Patient Assistance Foundation is not made in exchange for any explicit or implicit agreement or understanding that Abbott Product will be used, purchased, leased, ordered, prescribed, recommended, or arranged for or provided formulary or other preferential or qualifying status. I understand that I may not delegate signature authority. I certify that treatment with this medication is medically necessary.

Prescriber's Signature: _____ 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 applicant's information to the Foundation and its contracted third parties. The Foundation urges all entities disclosing information about the applicant to consult with legal counsel prior to relying on this form.



Abbott Patient Assistance Foundation's Diabetes Care Patient Assistance Application

The Abbott Patient Assistance Foundation provides Abbott diabetes care products 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 Abbott Patient Assistance Foundation's purpose of providing products at no cost to individuals in need. **The Abbott Patient Assistance Foundation's Diabetes Care Patient Assistance Program is designed to supplement test strip supplies.**

Checklist for submitting an application:

- Ensure all sections of the application are completed. Incomplete applications will be returned for proper completion and resubmission.
- Documentation of monthly income (e.g., Federal tax return, W2, full month of pay stubs). If no income, please submit a signed and dated letter, indicating there is no income.
- Copy of Medicaid Denial Letter dated within 2 years.
- Copy of Prescriber's order indicating your daily testing frequency required if not included on the application.
- Patient's signature/date is required at the bottom of the application.
- Physician's signature/date is required on the application.

Fax or mail the completed application and documentation to:

Abbott Patient Assistance Foundation-Diabetes Care
PO Box 270
Somerville, NJ 08876
Fax: 1-866-488-6576
Phone: 1-800-222-6885

Upon receipt of a completed application, the patient will be notified of program eligibility. If eligible, a supply of product will be shipped to the patient's home. It is the responsibility of the prescriber or patient to reorder 3 weeks prior to the patient requiring further medication.

Please contact us at 1-800-222-6885 Mon-Fri 8am-5pm CST for additional assistance.



Abbott
Patient Assistance
Foundation

Diabetes Care Patient Assistance Program Application

Abbott Patient Assistance Foundation • PO Box 270 • Somerville NJ 08876
Phone 1-800-222-6885 • Fax: 1-866-488-6576

Applications are available by calling 1-800-222-6885 or visiting www.abbottpatientassistancefoundation.org

Patient Name	Gender: Male <input type="checkbox"/> Female <input type="checkbox"/> Telephone Number		
Shipping address	City	State	Zip
Date of birth <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Social Security Number <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		
<p><u>Are you enrolled in Medicare</u> <input type="checkbox"/> Yes <input type="checkbox"/> No (if YES, check all that apply) <input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Part D(name)</p> <p><u>Do you have prescription coverage for Diabetic supplies?</u> <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><u>Are you covered thru a state Medicaid Program?</u> <input type="checkbox"/> Yes <input type="checkbox"/> No</p>			
<u>Total Monthly Income for your entire household</u>	\$ <input type="text"/>	(Attach the most current copies of income documentation for you and all dependent persons.)	

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 Abbott Patient Assistance Foundation. In the event that I am eligible for Foundation assistance, 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 Foundation assistance may change or be 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 from the Foundation. I agree that I will notify the Foundation if my insurance or financial situation changes. 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 ("PAP") (should I qualify). I know I may cancel this authorization at any time by writing to the Abbott Patient Assistance Foundation at P.O. Box 270 Somerville, NJ 08876. If I cancel this Authorization, I can no longer participate in 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 PAP services to me.

Patient's Signature: _____ Date _____

Number of people in your household (including yourself) _____ **Number in household under 18** _____

Representative For Purposes of Program:

I permit the Abbott Patient Assistance Foundation to speak with the following person(s) about my application and/or care and sign any documents related to the Program on my behalf:

Name: _____ **Relationship:** _____ **Phone #** _____

Personal Representative Authorization (if Applicable):

Note If the Applicant is unable to sign, is under the age of 18, or has designated signature authority, the Applicant's Personal Representative may sign this Form. However, only certain individuals may

quality as the Applicant's Personal Representative for purposes of this Authorization. An Applicant's Representative must have the requisite knowledge and information regarding the Applicant'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 may be a Personal Representative for purposes of this Authorization.

chain of the product to be received through the Foundation, including a health care provider or pharmacy receiving the medicines at no cost, may not be named a Personal Representative. If Applicant's Personal Representative is a consumer assistance or charitable organization, please list name of entity and purpose of entity under Relationship to Applicant.

Patient's Representative Signature _____ Relationship _____ Date _____

Prescriber's name and professional designation **DEA# (if none available, State license #)** **Expiration Date**

Shipping address	City	State	Zip
Mailing address	City	State	Zip
Office contact person	Telephone number	Fax number	

Glucose Meter Does Patient need a glucometer? Yes No If yes, a meter will be provided **Is your patient Insulin Dependent? Yes No**
Program is supplemental
Currently which brand is patient using: Optium Freestyle Lite Freestyle Precision <Variable: brand> Other **Testing Frequency**

Note: Prescriber may not delegate signature authority. (STAMPS NOT ACCEPTED)

1 Authorization for Release of Health Information By signing this form, I represent to the Abbott Patient Assistance 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 Abbott Patient Assistance Foundation and its contracted third parties

2 Physician/Care Coordinator Verification 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 Abbott Patient Assistance Foundation (the "Foundation") in writing immediately if the status of my State License Number registration changes If this applicant is eligible for the Abbott Patient Assistance Foundation assistance, I understand that the Foundation will send the medication to my office for dispensing to the patient The Foundation reserves the right to request additional information if needed and to change or discontinue the assistance at any time, without notice By signing this form, I certify that I am prescribing the aforementioned medication for an individual participating in the Foundation 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 by the Abbott Patient Assistance Foundation is not made in exchange for any explicit or implicit agreement or understanding that Abbott Product will be used, purchased, leased, ordered, prescribed, recommended, or arranged for or provided formulary or other preferential or qualifying status I understand that I may not delegate signature authority I certify that treatment with this medication is medically necessary

Prescriber's Signature: _____ **Date:** _____
Not to be Used for Prescribing Schedule II Substances. The form of authorization may not comply with all applicable Federal and state laws concerning disclosure of the health information to the Foundation.



Abbott Patient Assistance Foundation's Application for HUMIRA® (adalimumab)

The Abbott Patient Assistance Foundation provides Abbott 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 Abbott 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:

Abbott 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 contact us at 1-800-222-6885 Mon-Fri 8am-8pm EST for additional assistance.

**Abbott**Patient Assistance
Foundation**THIS PAGE TO BE COMPLETED BY PHYSICIAN****Patient Assistance Application for HUMIRA® (adalimumab)**

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

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

Physician Name	<input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> Other _____	<input type="checkbox"/> Rheum <input type="checkbox"/> Derm <input type="checkbox"/> Gastro <input type="checkbox"/> Other _____
Office Name	Office Contact Name _____	
Address	City/State/Zip _____	
Phone	Fax _____	
State License #	Tax ID#	NPI/Insurance Provider #

PATIENT HISTORY AND SHIPPING PREFERENCE

Patient's Name	DOB _____	
<input type="checkbox"/> Allergies (List)	<input type="checkbox"/> No known allergies	
<input type="checkbox"/> Rheumatoid Arthritis (714 0)	<input type="checkbox"/> Crohn's Disease (555 0, 555 1, 555 2, 555 9)	<input type="checkbox"/> Polyarticular Juvenile Idiopathic Arthritis (JIA) (714 30)
<input type="checkbox"/> Psoriatic Arthritis (696 0)	Please circle specific diagnosis code(s) _____	
<input type="checkbox"/> Ankylosing Spondylitis (720 0)	<input type="checkbox"/> Plaque Psoriasis (696 1)	<input type="checkbox"/> Other _____
Date of Diagnosis _____		
If this patient is eligible to receive medication through the Abbott Patient Assistance Foundation, ship to		<input type="checkbox"/> Physician Office <input type="checkbox"/> Patient
Shipping Address (if different from physician/patient address)		

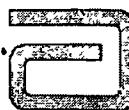
PHYSICIAN'S ORDERS

Rheumatoid Arthritis, Ankylosing Spondylitis, Psoriatic Arthritis, and Polyarticular JIA if >30kg(66 lbs)			
<input type="checkbox"/> HUMIRA Pen 40mg/0 8mL	40mg SC inj every other week	84 day supply	Refills
<input type="checkbox"/> HUMIRA Pre-Filled Syringe 40mg/0 8mL	40mg SC inj every other week	84 day supply	Refills
Polyarticular JIA 15kg(33 lbs) to <30kg(66 lbs) only			
<input type="checkbox"/> HUMIRA Pre-Filled Syringe 20mg/0 4mL	20mg SC inj every other week	84 day supply	Refills
Crohn's Disease			
STARTING THERAPY			
<input type="checkbox"/> Crohn's Disease Starter Package (HUMIRA Pen 40mg/0 8mL)	<input type="checkbox"/> Four 40mg SC inj Day 1, Two 40mg SC inj Day 15, #6 pens <input type="checkbox"/> Two 40mg SC inj Day 1, Two 40mg SC inj Day 2, Two 40mg SC inj Day 15, #6 pens	No Refills	No Refills
<input type="checkbox"/> HUMIRA Pre-Filled Syringe 40mg/0 8mL	<input type="checkbox"/> Four 40mg SC inj Day 1, Two 40mg SC inj Day 15, #6 syringes <input type="checkbox"/> Two 40mg SC inj Day 1, Two 40mg SC inj Day 2, Two 40mg SC inj Day 15, #6 syringes	No Refills	No Refills
ONGOING THERAPY			
<input type="checkbox"/> HUMIRA Pen 40mg/0 8mL	40mg SC inj every other week	84 day supply	Refills
<input type="checkbox"/> HUMIRA Pre-Filled Syringe 40mg/0 8mL	40mg SC inj every other week	84 day supply	Refills
Plaque Psoriasis			
STARTING THERAPY			
<input type="checkbox"/> Psoriasis Starter Package (HUMIRA Pen 40mg/0 8mL)	Two 40mg SC inj for first dose (Day 1), then one 40mg SC inj one week after first dose (Day 8), then one 40mg SC inj three weeks after first dose (Day 22), #4 pens	No Refills	No Refills
<input type="checkbox"/> HUMIRA Pre-Filled Syringe 40mg/0 8mL	Two 40mg SC inj for first dose (Day 1), then one 40mg SC inj one week after first dose (Day 8), then one 40mg SC inj three weeks after first dose (Day 22), #4 syringes	No Refills	No Refills
ONGOING THERAPY			
<input type="checkbox"/> HUMIRA Pen 40mg/0 8mL	40mg SC inj every other week	84 day supply	Refills
<input type="checkbox"/> HUMIRA Pre-Filled Syringe 40mg/0 8mL	40mg SC inj every other week	84 day supply	Refills
Other			
<input type="checkbox"/> HUMIRA	SIG	Qty	Refills

In New Jersey and New York, please fax your original state prescription to 1-866-250-2803 or call 1-866-548-6472.**PHYSICIAN CERTIFICATION****Physician Signature (no stamps): _____ Date: _____ Dispense as Written Generic Substitution Permitted**

By signing this form, I represent to the Abbott 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 Abbott 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.

**Abbott**Patient Assistance
Foundation**THIS PAGE TO BE COMPLETED BY PATIENT****Patient Assistance Application for HUMIRA® (adalimumab)**

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

PLEASE COMPLETE ALL SECTIONS, SIGN, AND FAX THIS FORM TO 1-866-250-2803 OR MAIL TO:

ABBOTT PATIENT ASSISTANCE FOUNDATION • P.O. BOX 789 • SAN BRUNO, CA 94066. FOR QUESTIONS PLEASE CALL 1-800-222-6885.

PATIENT INFORMATION

Patient Name:	Sex <input type="checkbox"/> M <input type="checkbox"/> F
DOB:	SSN (last four digits ONLY): <u> </u> <u> </u> <u> </u> <u> </u>
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)

PRIMARY INSURANCE

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

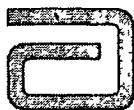
Please provide current income documentation (tax return, pay stub, etc) to avoid processing time.

- 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 Abbott 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.

**Abbott**Patient Assistance
Foundation**THIS PAGE TO BE COMPLETED BY PATIENT****Patient Assistance Application for HUMIRA® (adalimumab)***The Abbott Patient Assistance Foundation provides HUMIRA at no cost to individuals who meet specific program eligibility criteria***PLEASE COMPLETE ALL SECTIONS, SIGN, AND FAX THIS FORM TO 1-866-250-2803 OR MAIL TO:****ABBOTT PATIENT ASSISTANCE FOUNDATION • P.O. BOX 789 • SAN BRUNO, CA 94066. FOR QUESTIONS PLEASE CALL 1-800-222-6885.****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, Abbott Laboratories or third parties contracted by Abbott, and the Abbott 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 Abbott 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: _____

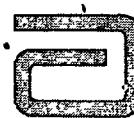
Personal Representative Authorization (if Applicable):

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



Abbott Patient Assistance Foundation's Application for Zemplar® (paricalcitol)

The Abbott Patient Assistance Foundation provides Abbott 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 Abbott Patient Assistance Foundation's purpose of providing products at no cost to individuals in need.

Checklist for submitting an application

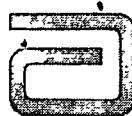
- Ensure all sections of the application are completed. Failure to complete required information will delay the review process.
- Provide front and back copies of all prescription insurance card(s).
- Provide proof of income (tax return, W2, pay stub) for all in household.
 - If there is no household 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:

Abbott Patient Assistance Foundation
P.O. Box 399
San Bruno, CA 94066
Fax: 1-800-361-9942
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 contact us at 1-800-222-6885 Mon-Fri 8am-8pm EST for additional assistance.

**Abbott**Patient Assistance
Foundation**THIS PAGE TO BE COMPLETED BY PHYSICIAN****Patient Assistance Application for Zemplar® (paricalcitol)***The Abbott Patient Assistance Foundation provides Zemplar at no cost to individuals who meet specific program eligibility criteria***PLEASE COMPLETE ALL SECTIONS, SIGN, AND FAX THIS FORM TO 1-800-361-9942 OR MAIL TO:****ABBOTT PATIENT ASSISTANCE FOUNDATION • P.O. BOX 399 • SAN BRUNO, CA 94066. FOR QUESTIONS PLEASE CALL 1-800-222-6885.****PHYSICIAN INFORMATION**

Physician Name	<input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> Other _____	<input type="checkbox"/> Nephrology <input type="checkbox"/> Other _____
Office Name:	Office Contact Name:	
Address	City/State/Zip	
Phone	Fax	
State License Number	Tax ID#	NPI/Insurance Provider #.

PATIENT HISTORY AND SHIPPING PREFERENCE

Patient's Name:	DOB
Allergies (List)	<input type="checkbox"/> No known allergies
PTH Level:	Date of PTH Level.
If patient is eligible to receive medication through the Abbott Patient Assistance Foundation, ship to (No P.O. Boxes)	
<input type="checkbox"/> Patient <input type="checkbox"/> Physician Office NOTE: Injectable products must be shipped to Physician's office	
Shipping Address (if different from patient address):	

PRESCRIPTION INFORMATION

ZEMPLAR CAPSULES	ZEMPLAR INJECTION
<input type="checkbox"/> Secondary Hyperparathyroidism (588.81) and CKD Stage 3 (585.3)	<input type="checkbox"/> Secondary Hyperparathyroidism (588.81) and CKD Stage 5 (585.5)
<input type="checkbox"/> Secondary Hyperparathyroidism (588.81) and CKD Stage 4 (585.4)	<input type="checkbox"/> Other _____
<input type="checkbox"/> Secondary Hyperparathyroidism (588.81) and CKD Stage 5 (585.5)	
<input type="checkbox"/> Other (include code(s)) _____	
<input type="checkbox"/> Zemplar Capsules 1mcg NDC 00074-4317-30	<input type="checkbox"/> Zemplar Injection 2 mcg/mL, 2mcg/vial NDC 00074-4637-01
<input type="checkbox"/> Zemplar Capsules 2mcg NDC 00074-4314-30	<input type="checkbox"/> Zemplar Injection 5 mcg/mL, 5mcg/vial NDC 00074-1658-01
<input type="checkbox"/> Zemplar Capsules 4mcg NDC 00074-4315-30	<input type="checkbox"/> Zemplar Injection 5 mcg/mL, 10mcg/vial NDC 00074-1658-02
Route of Administration Oral	Route of Administration IV
Directions for Use:	Directions for Use _____
Quantity to be Dispensed	Quantity to be Dispensed
<input type="checkbox"/> 90 day supply	<input type="checkbox"/> 90 day supply
<input type="checkbox"/> Other _____	<input type="checkbox"/> 1 year
	<input type="checkbox"/> Other _____
	<input type="checkbox"/> Other

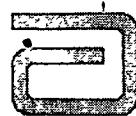
*In New Jersey and New York, please fax your original state prescription to 1-800-361-9942.***PHYSICIAN CERTIFICATION**

Physician Signature (no stamps): _____ **Date:** _____ Dispense as Written Generic Substitution Permitted

Authorization for Release of Health Information: By signing this form, I represent to the Abbott Patient Assistance 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 Abbott Patient Assistance Foundation.

Physician/Care Coordinator Verification:

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 Abbott Patient Assistance Foundation (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 Zemplar, 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 Abbott 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 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.

**Abbott**Patient Assistance
Foundation**THIS PAGE TO BE COMPLETED BY PATIENT****Patient Assistance Application for Zemplar® (paricalcitol)***The Abbott Patient Assistance Foundation provides Zemplar at no cost to individuals who meet specific program eligibility criteria***PLEASE COMPLETE ALL SECTIONS, SIGN, AND FAX THIS FORM TO 1-800-361-9942 OR MAIL TO:****ABBOTT PATIENT ASSISTANCE FOUNDATION • P.O. BOX 399 • SAN BRUNO, CA 94066. FOR QUESTIONS PLEASE CALL 1-800-222-6885.****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 cover Zemplar (please provide details below or attach a copy of the insurance card)

PRIMARY INSURANCE

Insurance Company:

Insurance Co. Phone:

Policy #:

Group #:

Policyholder Name

Relationship to Policyholder:

Policyholder DOB

SECONDARY INSURANCE

Insurance Company:

Insurance Co. Phone

Policy #:

Group #:

Policyholder Name

Relationship to Policyholder

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)

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

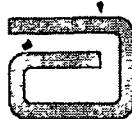
Source of Income. Wages SSDI SSI Unemployment Pension Other: _____**Please provide current income documentation (tax return, pay stub, etc.) to avoid delays in processing time.**

- 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 Abbott 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:



Patient Assistance Application for Zemplar® (paricalcitol)

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

PLEASE COMPLETE ALL SECTIONS, SIGN, AND FAX THIS FORM TO 1-800-361-9942 OR MAIL TO:

ABBOTT PATIENT ASSISTANCE FOUNDATION • P.O. BOX 399 • SAN BRUNO, CA 94066. FOR QUESTIONS PLEASE CALL 1-800-222-6885.

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 Zemplar among my insurance companies, my physicians, Abbott Laboratories or third parties contracted by Abbott, and the Abbott 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 Abbott Patient Assistance Foundation at P.O. Box 399, 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 PAP services to me.

For Eligible Patient Assistance Patients Only:

I understand that any assistance in the form of free product 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 free medication 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 Applicant is unable to sign, or has designated signature authority, the Applicant's Personal Representative may sign this form. However, only certain individuals may qualify as the Applicant's Personal Representative for purposes of this Authorization. An Applicant's Representative must have the requisite knowledge and information regarding the Applicant'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 free medicines, may not be named a Personal Representative. If Applicant's Personal Representative is a consumer assistance or charitable organization, please list name of entity and purpose of entity under Relationship to Applicant.

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 applicant's information to the Foundation and its contracted third parties. The Foundation urges all entities disclosing information about the applicant to consult with legal counsel prior to relying on this form.