



See a Social Security Number? Say Something!  
Report Privacy Problems to <https://public.resource.org/privacy>  
Or call the IRS Identity Theft Hotline at 1-800-908-4490



## Return of Private Foundation

or Section 4947(a)(1) Trust Treated as Private Foundation

Do not enter Social Security numbers on this form as it may be made public.

Information about Form 990-PF and its separate instructions is at [www.irs.gov/form990pf](http://www.irs.gov/form990pf).

2013

Open to Public Inspection

For calendar year 2013 or tax year beginning

, and ending

Name of foundation <b>ABBVIE PATIENT ASSISTANCE FOUNDATION</b>		A Employer identification number <b>26-1215559</b>
Number and street (or P.O. box number if mail is not delivered to street address) <b>D031C AP31-3NW, 1 N WAUKEGAN ROAD</b>	Room/suite	B Telephone number <b>847-938-2906</b>
City or town, state or province, country, and ZIP or foreign postal code <b>NORTH CHICAGO, IL 60064</b>		C If exemption application is pending, check here <input type="checkbox"/>
G Check all that apply: <input type="checkbox"/> Initial return <input type="checkbox"/> Final return <input type="checkbox"/> Address change <input type="checkbox"/> Initial return of a former public charity <input type="checkbox"/> Amended return <input checked="" type="checkbox"/> Name change		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		E If private foundation status was terminated under section 507(b)(1)(A), check here <input type="checkbox"/>
I Fair market value of all assets at end of year (from Part II, col. (c), line 16) \$ <b>53,271,158</b>	J Accounting method: <input checked="" type="checkbox"/> Cash <input type="checkbox"/> Accrual <input type="checkbox"/> Other (specify) _____	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 (The total of amounts in columns (b), (c), and (d) may not necessarily equal the amounts in column (a).)		(a) Revenue and expenses per books	(b) Net investment income	(c) Adjusted net income	(d) Disbursements for charitable purposes (cash basis only)
1 Contributions, gifts, grants, etc., received		810,053,325.		N/A	
2 Check <input type="checkbox"/> If the foundation is not required to attach Sch. B					
3 Interest on savings and temporary cash investments					
4 Dividends and interest from securities					
5a Gross rents					
b Net rental income or (loss)					
6a Net gain or (loss) from sale of assets not on line 10					
b Gross sales price for all assets on line 6a					
7 Capital gain net income (from Part IV, line 2)			0.		
8 Net short-term capital gain					
9 Income modifications					
10a Gross sales less returns and allowances					
b Less. Cost of goods sold					
c Gross profit or (loss)					
11 Other income					
12 Total. Add lines 1 through 11		810,053,325.	0.		
13 Compensation of officers, directors, trustees, etc.		0.	0.		0.
14 Other employee salaries and wages					
15 Pension plans, employee benefits					
16a Legal fees					
b Accounting fees					
c Other professional fees					
17 Interest					
18 Taxes					
19 Depreciation and depletion					
20 Occupancy					
21 Travel, conferences, and meetings					
22 Printing and publications					
23 Other expenses <b>STMT 1</b>		4,614,575.	0.		4,614,575.
24 Total operating and administrative expenses. Add lines 13 through 23		4,614,575.	0.		4,614,575.
25 Contributions, gifts, grants paid		783,366,952.			783,366,952.
26 Total expenses and disbursements. Add lines 24 and 25		787,981,527.	0.		787,981,527.
27 Subtract line 26 from line 12:					
a Excess of revenue over expenses and disbursements		22,071,798.			
b Net investment income (if negative, enter -0-)			0.		
c Adjusted net income (if negative, enter -0-)				N/A	

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
Assets	1 Cash - non-interest-bearing .....	403,567.	5,478,020.	5,478,020.
	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 .....	30,396,248.	47,793,138.	47,793,138.
	9 Prepaid expenses and deferred charges .....			
	10a Investments - U.S. and state government obligations .....			
	b Investments - corporate stock .....			
	c Investments - corporate bonds .....			
	Liabilities	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 - see the instructions. Also, see page 1, item 1) .....		30,799,815.	53,271,158.	53,271,158.
17 Accounts payable and accrued expenses .....			399,545.	
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) .....	0.	399,545.		
Net Assets or Fund Balances	Foundations that follow SFAS 117, check here and complete lines 24 through 26 and lines 30 and 31. <input type="checkbox"/>			
	24 Unrestricted .....			
	25 Temporarily restricted .....			
	26 Permanently restricted .....			
	Foundations that do not follow SFAS 117, check here and complete lines 27 through 31. <input checked="" type="checkbox"/>			
	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 .....	30,799,815.	52,871,613.	
	30 Total net assets or fund balances .....	30,799,815.	52,871,613.	
	31 Total liabilities and net assets/fund balances .....	30,799,815.	53,271,158.	

## 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	30,799,815.
2 Enter amount from Part I, line 27a .....	2	22,071,798.
3 Other increases not included in line 2 (itemize) ▶	3	0.
4 Add lines 1, 2, and 3 .....	4	52,871,613.
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	52,871,613.

**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) 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	(l) Gains (Col. (h) gain minus col. (k), but not less than -0-) or Losses (from col. (h))
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 the 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))
2012	651,002,624.	969,141.	671.731589
2011	599,264,263.	542,670.	1,104.288542
2010	487,187,374.	626,704.	777.380349
2009	338,809,732.	759,255.	446.239711
2008	161,089,088.	340,773.	472.716700

2 Total of line 1, column (d)	2	3,472.356891
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	694.471378
4 Enter the net value of noncharitable-use assets for 2013 from Part X, line 5	4	2,202,229.
5 Multiply line 4 by line 3	5	1,529,385,008.
6 Enter 1% of net investment income (1% of Part I, line 27b)	6	0.
7 Add lines 5 and 6	7	1,529,385,008.
8 Enter qualifying distributions from Part XII, line 4	8	787,981,527.

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 <input type="checkbox"/> 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 <input type="checkbox"/> and enter 1% of Part I, line 27b		1	0.
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-)		2	0.
3 Add lines 1 and 2		3	0.
4 Subtitle A (income) tax (domestic section 4947(a)(1) trusts and taxable foundations only. Others enter -0-)		4	0.
5 Tax based on investment income. Subtract line 4 from line 3. If zero or less, enter -0-		5	0.
6 Credits/Payments:			
a 2013 estimated tax payments and 2012 overpayment credited to 2013	6a		
b Exempt foreign organizations - tax withheld at source	6b		
c Tax paid with application for extension of time to file (Form 8868)	6c		
d Backup withholding erroneously withheld	6d		
7 Total credits and payments. Add lines 6a through 6d	7		0.
8 Enter any penalty for underpayment of estimated tax. Check here <input type="checkbox"/> if Form 2220 is attached	8		
9 Tax due. If the total of lines 5 and 8 is more than line 7, enter amount owed	9		0.
10 Overpayment. If line 7 is more than the total of lines 5 and 8, enter the amount overpaid	10		
11 Enter the amount of line 10 to be: Credited to 2014 estimated tax <input type="checkbox"/> Refunded <input type="checkbox"/>	11		

**Part VII-A Statements Regarding Activities**

	Yes	No
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?		X
b Did it spend more than \$100 during the year (either directly or indirectly) for political purposes (see instructions for the definition)? 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.		X
c Did the foundation file Form 1120-POL for this year?		X
d Enter the amount (if any) of tax on political expenditures (section 4955) imposed during the year: (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? If "Yes," attach a detailed description of the activities.		X
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		X
4a Did the foundation have unrelated business gross income of \$1,000 or more during the year?		X
b If "Yes," has it filed a tax return on Form 990-T for this year? N/A		
5 Was there a liquidation, termination, dissolution, or substantial contraction during the year? If "Yes," attach the statement required by General Instruction T.		X
6 Are the requirements of section 508(e) (relating to sections 4941 through 4945) satisfied either: • By language in the governing instrument, or • 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?	X	
7 Did the foundation have at least \$5,000 in assets at any time during the year? If "Yes," complete Part II, col. (c), and Part XV	X	
8a Enter the states to which the foundation reports or with which it is registered (see instructions) IL		
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	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 2013 or the taxable year beginning in 2013 (see instructions for Part XIV)? If "Yes," complete Part XIV	X	
10 Did any persons become substantial contributors during the tax year? If "Yes," attach a schedule listing their names and addresses		X

Form 990-PF (2013)

**Part VII-A Statements Regarding Activities (continued)**

11	At any time during the year, did the foundation, directly or indirectly, own a controlled entity within the meaning of section 512(b)(13)? If "Yes," attach schedule (see instructions).	11		X
12	Did the foundation make a distribution to a donor advised fund over which the foundation or a disqualified person had advisory privileges? If "Yes," attach statement (see instructions)	12		X
13	Did the foundation comply with the public inspection requirements for its annual returns and exemption application?	13	X	
Website address <b>WWW.ABBVIEPAF.ORG</b>				
14	The books are in care of <b>THE FOUNDATION</b> Telephone no. <b>847-938-2906</b>			
Located at <b>D031C AP31-3NW 1 N WAUKEGAN RD, NORTH CHICAGO, IL</b> ZIP+4 <b>60064</b>				
15	Section 4947(a)(1) nonexempt charitable trusts filing Form 990-PF in lieu of Form 1041 - Check here <input type="checkbox"/> and enter the amount of tax-exempt interest received or accrued during the year <b>15</b> N/A			
16	At any time during calendar year 2013, did the foundation have an interest in or a signature or other authority over a bank, securities, or other financial account in a foreign country? See the instructions for exceptions and filing requirements for Form TD F 90-22.1. If "Yes," enter the name of the foreign country <b>16</b> Yes No X			

**Part VII-B Statements Regarding Activities for Which Form 4720 May Be Required**

File Form 4720 if any item is checked in the "Yes" column, unless an exception applies.

	Yes	No
1a During the year did the foundation (either directly or indirectly):		
(1) Engage in the sale or exchange, or leasing of property with a disqualified person? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
(2) Borrow money from, lend money to, or otherwise extend credit to (or accept it from) a disqualified person? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
(3) Furnish goods, services, or facilities to (or accept them from) a disqualified person? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
(4) Pay compensation to, or pay or reimburse the expenses of, a disqualified person? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
(5) Transfer any income or assets to a disqualified person (or make any of either available for the benefit or use of a disqualified person)? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
(6) Agree to pay money or property to a government official? (Exception. Check "No" if the foundation agreed to make a grant to or to employ the official for a period after termination of government service, if terminating within 90 days.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
b If any answer is "Yes" to 1a(1)-(6), did any of the acts fail to qualify under the exceptions described in Regulations section 53.4941(d)-3 or in a current notice regarding disaster assistance (see instructions)? <b>N/A</b>	1b	
Organizations relying on a current notice regarding disaster assistance check here <input type="checkbox"/>		
c Did the foundation engage in a prior year in any of the acts described in 1a, other than excepted acts, that were not corrected before the first day of the tax year beginning in 2013? <b>1c</b>		X
2 Taxes on failure to distribute income (section 4942) (does not apply for years the foundation was a private operating foundation defined in section 4942(j)(3) or 4942(j)(5)):		
a At the end of tax year 2013, did the foundation have any undistributed income (lines 6d and 6e, Part XIII) for tax year(s) beginning before 2013? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
If "Yes," list the years <b>2a</b>		
b Are there any years listed in 2a for which the foundation is not applying the provisions of section 4942(a)(2) (relating to incorrect valuation of assets) to the year's undistributed income? (If applying section 4942(a)(2) to all years listed, answer "No" and attach statement - see instructions.) <b>N/A</b>	2b	
c If the provisions of section 4942(a)(2) are being applied to any of the years listed in 2a, list the years here. <b>2c</b>		
3a Did the foundation hold more than a 2% direct or indirect interest in any business enterprise at any time during the year? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
b If "Yes," did it have excess business holdings in 2013 as a result of (1) any purchase by the foundation or disqualified persons after May 26, 1969; (2) the lapse of the 5-year period (or longer period approved by the Commissioner under section 4943(c)(7)) to dispose of holdings acquired by gift or bequest; or (3) the lapse of the 10-, 15-, or 20-year first phase holding period? (Use Schedule C, Form 4720, to determine if the foundation had excess business holdings in 2013.) <b>N/A</b>	3b	
4a Did the foundation invest during the year any amount in a manner that would jeopardize its charitable purposes? <b>4a</b>		X
b Did the foundation make any investment in a prior year (but after December 31, 1969) that could jeopardize its charitable purpose that had not been removed from jeopardy before the first day of the tax year beginning in 2013? <b>4b</b>		X

Form 990-PF (2013)







**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	2,235,765.
c	Fair market value of all other assets	1c	
d	Total (add lines 1a, b, and c)	1d	2,235,765.
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	2,235,765.
4	Cash deemed held for charitable activities. Enter 1 1/2% of line 3 (for greater amount, see instructions)	4	33,536.
5	Net value of noncharitable-use assets. Subtract line 4 from line 3. Enter here and on Part V, line 4	5	2,202,229.
6	Minimum investment return. Enter 5% of line 5	6	110,111.

**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 2013 from Part VI, line 5	2a	
b	Income tax for 2013. (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	787,981,527.
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	787,981,527.
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	787,981,527.

**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.

Form 990-PF (2013)

**Part XIII Undistributed Income** (see instructions)

N/A

	(a) Corpus	(b) Years prior to 2012	(c) 2012	(d) 2013
<b>1</b> Distributable amount for 2013 from Part XI, line 7				
<b>2</b> Undistributed income, if any, as of the end of 2013				
<b>a</b> Enter amount for 2012 only				
<b>b</b> Total for prior years:				
<b>3</b> Excess distributions carryover, if any, to 2013:				
<b>a</b> From 2008				
<b>b</b> From 2009				
<b>c</b> From 2010				
<b>d</b> From 2011				
<b>e</b> From 2012				
<b>f</b> Total of lines 3a through e				
<b>4</b> Qualifying distributions for 2013 from Part XII, line 4: <b>▶</b> \$				
<b>a</b> Applied to 2012, but not more than line 2a				
<b>b</b> Applied to undistributed income of prior years (Election required - see instructions)				
<b>c</b> Treated as distributions out of corpus (Election required - see instructions)				
<b>d</b> Applied to 2013 distributable amount				
<b>e</b> Remaining amount distributed out of corpus				
<b>5</b> Excess distributions carryover applied to 2013 (If an amount appears in column (d), the same amount must be shown in column (a).)				
<b>6</b> Enter the net total of each column as indicated below:				
<b>a</b> Corpus. Add lines 3f, 4c, and 4e. Subtract line 5				
<b>b</b> Prior years' undistributed income. Subtract line 4b from line 2b				
<b>c</b> 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				
<b>d</b> Subtract line 6c from line 6b. Taxable amount - see instructions				
<b>e</b> Undistributed income for 2012. Subtract line 4a from line 2a. Taxable amount - see instr.				
<b>f</b> Undistributed income for 2013. Subtract lines 4d and 5 from line 1. This amount must be distributed in 2014				
<b>7</b> Amounts treated as distributions out of corpus to satisfy requirements imposed by section 170(b)(1)(F) or 4942(g)(3)				
<b>8</b> Excess distributions carryover from 2008 not applied on line 5 or line 7				
<b>9</b> Excess distributions carryover to 2014. Subtract lines 7 and 8 from line 6a				
<b>10</b> Analysis of line 9:				
<b>a</b> Excess from 2009				
<b>b</b> Excess from 2010				
<b>c</b> Excess from 2011				
<b>d</b> Excess from 2012				
<b>e</b> Excess from 2013				

**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 2013, 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

b 85% of line 2a

c Qualifying distributions from Part XII, line 4 for each year listed

d Amounts included in line 2c not used directly for active conduct of exempt activities

e Qualifying distributions made directly for active conduct of exempt activities.

Subtract line 2d from line 2c

3 Complete 3a, b, or c for the alternative test relied upon:

a "Assets" alternative test - enter:

(1) Value of all assets

(2) Value of assets qualifying under section 4942(j)(3)(B)(i)

b "Endowment" alternative test - enter 2/3 of minimum investment return shown in Part X, line 6 for each year listed

c "Support" alternative test - enter:

(1) Total support other than gross investment income (interest, dividends, rents, payments on securities loans (section 512(a)(5)), or royalties)

(2) Support from general public and 5 or more exempt organizations as provided in section 4942(j)(3)(B)(iii)

(3) Largest amount of support from an exempt organization

(4) Gross investment income

Tax year	Prior 3 years			(e) Total
(a) 2013	(b) 2012	(c) 2011	(d) 2010	
0.	0.	0.	0.	0.
0.	0.	0.	0.	0.
787,981,527.	651,002,624.	599,264,263.	487,187,374.	2,525,435,788.
0.	0.	0.	0.	0.
787,981,527.	651,002,624.	599,264,263.	487,187,374.	2,525,435,788.
53,271,158.	30,799,815.	26,269,677.	21,717,131.	132,057,781.
53,271,158.	30,799,815.	26,269,677.	21,717,131.	132,057,781.
				0.
802,240,228.	648,120,873.	604,125,175.	492,857,634.	2,547,343,910.
			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 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 or e-mail address 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)

<b>3 Grants and Contributions Paid During the Year or Approved for Future Payment</b>				
Recipient	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
Name and address (home or business)				
<b>a Paid during the year</b>				
OVER 155,000 ELIGIBLE INDIVIDUALS (LIST AVAILABLE UPON REQUEST) N/A N/A	NONE	N/A	Provide various pharmaceutical and medical nutrition products at no charge to eligible individuals	783,366,952.
<b>Total</b>			<b>3a</b>	783,366,952.
<b>b Approved for future payment</b>				
NONE				
<b>Total</b>			<b>3b</b>	0.

**Part XVI-A Analysis of Income-Producing Activities**

Enter gross amounts unless otherwise indicated.

Enter gross amounts unless otherwise indicated.		Unrelated business income		Excluded by section 512, 513, or 514		(e)
		(a) Business code	(b) Amount	(c) Exclu- sion code	(d) Amount	Related or exempt function income
<b>1</b>	Program service revenue:					
a	_____					
b	_____					
c	_____					
d	_____					
e	_____					
f	_____					
g	Fees and contracts from government agencies					
<b>2</b>	Membership dues and assessments					
<b>3</b>	Interest on savings and temporary cash investments					
<b>4</b>	Dividends and interest from securities					
<b>5</b>	Net rental income or (loss) from real estate:					
a	Debt-financed property					
b	Not debt-financed property					
<b>6</b>	Net rental income or (loss) from personal property					
<b>7</b>	Other investment income					
<b>8</b>	Gain or (loss) from sales of assets other than inventory					
<b>9</b>	Net income or (loss) from special events					
<b>10</b>	Gross profit or (loss) from sales of inventory					
<b>11</b>	Other revenue:					
a	_____					
b	_____					
c	_____					
d	_____					
e	_____					
<b>12</b>	Subtotal. Add columns (b), (d), and (e)		0.		0.	0.
<b>13</b>	Total. Add line 12, columns (b), (d), and (e)					0.

(See worksheet in line 13 instructions to verify calculations.)

## **Part XVI-B Relationship of Activities to the Accomplishment of Exempt Purposes**

[illegible]

## Information Regarding Transfers To and Transactions and Relationships With Noncharitable Exempt Organizations





<b>1</b> Did the organization directly or indirectly engage in any of the following with any other organization described in section 501(c) of the Code (other than section 501(c)(3) organizations) or in section 527, relating to political organizations?		Yes	No
<b>a</b> Transfers from the reporting foundation to a noncharitable exempt organization of:			
(1) Cash		1a(1)	X
(2) Other assets		1a(2)	X
<b>b</b> Other transactions:			
(1) Sales of assets to a noncharitable exempt organization		1b(1)	X
(2) Purchases of assets from a noncharitable exempt organization		1b(2)	X
(3) Rental of facilities, equipment, or other assets		1b(3)	X
(4) Reimbursement arrangements		1b(4)	X
(5) Loans or loan guarantees		1b(5)	X
(6) Performance of services or membership or fundraising solicitations		1b(6)	X
<b>c</b> Sharing of facilities, equipment, mailing lists, other assets, or paid employees		1c	X
<b>d</b> If the answer to any of the above is "Yes," complete the following schedule. Column (b) should always show the fair market value of the goods, other assets, or services given by the reporting foundation. If the foundation received less than fair market value in any transaction or sharing arrangement, show in column (d) the value of the goods, other assets, or services received.			

[illegible]

**2a** Is the foundation directly or indirectly affiliated with, or related to, one or more tax-exempt organizations described in section 501(c) of the Code (other than section 501(c)(3)) or in section 527? ☐ Yes ☒ No


b If "Yes," complete the following schedule.		
(a) Name of organization	(b) Type of organization	(c) Description of relationship
N/A		

Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief, this is true, correct, and complete. Declaration of preparer (other than taxpayer) is based on all information of which preparer has any knowledge.

**Sign Here**    

Signature of officer or trustee \_\_\_\_\_ Date 15/15/14 Title President

May the IRS discuss this return with the preparer shown below (see instr.)? ☒ Yes ☐ No

<b>Paid Preparer Use Only</b>	Print/Type preparer's name  KIMBERLY ANDERSON, CPA	Preparer's signature  KIMBERLY ANDERSON, CPA	Date  04/23/14	Check <input type="checkbox"/> if self-employed	PTIN  P00188889
	Firm's name ► CLIFTONLARSONALLEN LLP			Firm's EIN ► 41-0746749	
	Firm's address ► PO BOX 1347 RACINE, WI 53401-1347			Phone no. (262) 637-9351	

Form 990-PF (2013)

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

▶ Attach to Form 990, Form 990-EZ, or Form 990-PF.  
▶ Information about Schedule B (Form 990, 990-EZ, or 990-PF) and  
its instructions is at [www.irs.gov/form990](http://www.irs.gov/form990).

OMB No. 1545-0047

**2013**

Name of the organization

ABBVIE 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 foundation

Check 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 the greater 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, total 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 total 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 its Form 990-PF, Part I, line 2, 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) (2013)

Name of organization	Employer identification number
ABBVIE PATIENT ASSISTANCE FOUNDATION	26-1215559

**Part I Contributors** (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
1	ABBOTT LABORATORIES  100 ABBOTT PARK ROAD  ABBOTT PARK, IL 60064-3500	\$ 2,861,748.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
2	ABBOTT LABORATORIES  100 ABBOTT PARK ROAD  ABBOTT PARK, IL 60064-3500	\$ 299,483.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
3	ABBVIE INC.  D031C AP31-3NW, 1 N WAUKEGAN ROAD  NORTH CHICAGO, IL 60064	\$ 797,902,094.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
4	ABBVIE INC.  D031C AP31-3NW, 1 N WAUKEGAN ROAD  NORTH CHICAGO, IL 60064	\$ 8,990,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
			Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
			Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)



Name of organization	Employer identification number
ABBVIE PATIENT ASSISTANCE FOUNDATION	26-1215559

**Part II** **Noncash Property** (see instructions). Use duplicate copies of Part II if additional space is needed.

(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
1	VARIOUS NUTRITIONAL PRODUCTS	\$ 2,861,748.	VARIOUS
3	VARIOUS MEDICATIONS	\$ 797,902,094.	VARIOUS
		\$	
		\$	
		\$	
		\$	
		\$	
		\$	

Name of organization	Employer identification number
ABBVIE PATIENT ASSISTANCE FOUNDATION	26-1215559

**Part III** Exclusively religious, charitable, etc., individual contributions to section 501(c)(7), (8), or (10) organizations that total 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) ▶ \$

Use duplicate copies of Part III if additional space is needed.

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held
	(e) Transfer of gift		
	Transferee's name, address, and ZIP + 4		Relationship of transferor to transferee
	(e) Transfer of gift		
	Transferee's name, address, and ZIP + 4		Relationship of transferor to transferee
	(e) Transfer of gift		
	Transferee's name, address, and ZIP + 4		Relationship of transferor to transferee
	(e) Transfer of gift		
	Transferee's name, address, and ZIP + 4		Relationship of transferor to transferee
	(e) Transfer of gift		
	Transferee's name, address, and ZIP + 4		Relationship of transferor to transferee



## OFFICE OF THE SECRETARY OF STATE

---

JESSE WHITE • Secretary of State

DECEMBER 3, 2012

6579-041-6

C T CORPORATION SYSTEM  
600 S SECOND ST  
SPRINGFIELD, IL 62704

RE ABBVIE PATIENT ASSISTANCE FOUNDATION

DEAR SIR OR MADAM:

ENCLOSED YOU WILL FIND THE ARTICLES OF AMENDMENT FOR THE ABOVE NAMED CORPORATION.

FEES IN THIS CONNECTION HAVE BEEN RECEIVED AND CREDITED.

SINCERELY,

JESSE WHITE  
SECRETARY OF STATE  
DEPARTMENT OF BUSINESS SERVICES  
CORPORATION DIVISION  
TELEPHONE (217) 782-6961

FORM NFP 110.30 (rev. Dec. 2003)  
ARTICLES OF AMENDMENT  
General Not For Profit Corporation Act

Jesse White, Secretary of State  
Department of Business Services  
501 S. Second St., Rm. 350  
Springfield, IL 62756  
217-782-1832  
www.cyberdriveillinois.com

**FILED**

**DEC 03 2012**

JESSE WHITE  
SECRETARY OF STATE

Remit payment in the form of a  
check or money order payable  
to Secretary of State.

File #

6579-041-6

Filing Fee: \$25

Approved: W

----- Submit in duplicate ----- Type or Print clearly in black ink ----- Do not write above this line -----

1. Corporate Name (See Note 1 on back.): Abbott Patient Assistance Foundation

2. Manner of Adoption of Amendment:

The following amendment to the Articles of Incorporation was adopted on May 25, 2012 in the man-  
ner indicated below (check one only):  
Month, Day & Year

☐ By affirmative vote of a majority of the directors in office, at a meeting of the board of directors, in accordance with  
Section 110.15. (See Note 2 on back.)

☒ By written consent, signed by all the directors in office, in compliance with Sections 110.15 and 108.45. (See Note 3  
on back.)

☐ By members at a meeting of members entitled to vote by the affirmative vote of the members having not less than  
the minimum number of votes necessary to adopt such amendment, as provided by this Act, the Articles of  
Incorporation or the bylaws, in accordance with Section 110.20. (See Note 4 on back.)

☐ By written consent signed by members entitled to vote having not less than the minimum number of votes necessary  
to adopt such amendment, as provided by this Act, the Articles of Incorporation, or the bylaws, in compliance with  
Sections 107.10 and 110.20. (See Note 5 on back.)

3. Text of Amendment:

(a.) When an amendment effects a name change, insert the new corporate name below. Use 3(b.) below for all other  
amendments. \*Article 1: The Name of the Corporation is:

AbbVie Patient Assistance Foundation

New Name

(b.) All amendments other than name change.

If the amendment affects the corporate purpose, the amended purpose is required to be set forth in its entirety. If  
there is not sufficient space to add the full text of the amendment, attach additional sheets of this size.

Name change effective date 1/1/2013

4. The undersigned Corporation has caused these Articles to be signed by a duly authorized officer who affirms, under penalties of perjury, that the facts stated herein are true and correct.

All signatures must be in BLACK INK.

Dated December 23 2012 Abbott Patient Assistance Foundation  
Month & Day Year Exact Name of Corporation  
John A. Berry  
Any Authorized Officer's Signature  
John A. Berry, Secretary  
Name and Title (type or print)

5. If there are no duly authorized officers, the persons designated under Section 101.10(b)(2) must sign below and print name and title.

The undersigned affirms, under penalties of perjury, that the facts stated herein are true.

Dated \_\_\_\_\_  
Month & Day Year

_____ Signature	_____ Name and Title (print)
_____ Signature	_____ Name and Title (print)
_____ Signature	_____ Name and Title (print)
_____ Signature	_____ Name and Title (print)

#### NOTES

1. State the true and exact corporate name as it appears on the records of the Secretary of State BEFORE any amendment herein is reported.
2. Directors may adopt amendments without member approval only when the corporation has no members, or no members entitled to vote pursuant to §110.15.
3. Director approval may be:
  - a. by vote at a director's meeting (either annual or special), or
  - b. by consent, in writing, without a meeting.
4. All amendments not adopted under Sec. 110.15 require that:
  - a. the board of directors adopt a resolution setting forth the proposed amendment, and
  - b. the members approve the amendment.

Member approval may be:

- a. by vote at a members meeting (either annual or special), or
- b. by consent, in writing, without a meeting.

To be adopted, the amendment must receive the affirmative vote or consent of the holders of at least two-thirds of the outstanding members entitled to vote on the amendment (but if class voting applies, also at least a two-thirds vote within each class is required).

The Articles of Incorporation may supersede the two-thirds vote requirement by specifying any smaller or larger vote requirement not less than a majority of the outstanding votes of such members entitled to vote, and not less than a majority within each class when class voting applies (Sec. 110.20)

5. When member approval is by written consent, all members must be given notice of the proposed amendment at least five days before the consent is signed. If the amendment is adopted, members who have not signed the consent must be promptly notified of the passage of the amendment. (Sec. 107.10 & 110.20)



PATIENT ASSISTANCE FOUNDATION

## **AbbVie Patient Assistance Foundation Application for Androgel® (testosterone gel) 1.62% and 1.0%**

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

### **Checklist for submitting an application:**

- ☐ Ensure all sections of the application are completed. 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.
- ☐ Enclose a copy of government issued ID (Driver License, State ID, Military ID, etc)
- ☐ Include prescription on prescriber's Rx paper

### **Fax or mail the completed application and documentation to:**

AbbVie Patient Assistance Foundation  
P.O. Box 66550  
St. Louis, MO 63166-6550  
Phone: 1-800-222-6885 or 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.



PATIENT ASSISTANCE FOUNDATION

**Application For Androgel® (testosterone gel) 1.62% and 1.0%**

AbbVie Patient Assistance Foundation • P.O. Box 66550 St. Louis, MO 63166-6550 • Phone: 1-800-222-6885 • FAX: 1-800-276-9901

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

**HEALTHCARE PROVIDER INFORMATION**

DEA Number:	Physician Name: (First)	(Last)	
Address:	City:	State:	Zip:
Email Address:	Office Contact:	Phone:	Fax:

**PATIENT INFORMATION – Please complete to fullest extent possible. If an item does not apply, please mark N/A on that line**

SSN: (Last 4 digits only)	XXX-XX- <input type="text"/>	Patient Name: (First)	(Last)	
Address:	Home Phone:	Work Phone:		
City:	State:	Zip:	Date of Birth: <input type="text"/> / <input type="text"/> / <input type="text"/>	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Number of people in household (include self):	<input type="text"/>	Total Monthly Income for your entire household:	<input type="text"/>	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.

**INSURANCE INFORMATION – Please include a copy of patient's Insurance Card and Prescription Card (front and back)**

	Medical Coverage	Prescription Coverage for Androgel	Eligibility Status E=Eligible P=Pending I=Ineligible	Policy Number	Contact and Phone
Medicare	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Medicare Part D	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Medicaid	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Private Insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			
State Elderly Drug Assistance	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Veterans Assistance	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Disabled: <input type="checkbox"/> Yes <input type="checkbox"/> No			Veteran: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Other:					

I understand that any assistance in the form of product at no cost is contingent upon my ability to meet the eligibility criteria for the AbbVie Patient Assistance 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 AbbVie Patient Assistance Foundation at P.O. Box 66550 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.

**Signature of Patient or Legal Guardian:****Date:****REPRESENTATIVE FOR PURPOSES OF THE PROGRAM (If applicable)**

I permit the AbbVie 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:

**PATIENT CLINICAL INFORMATION**Patient diagnosis (ICD.9 code) Patient allergies: ☐ No ☐ KnownPlease list the names of other medications the patient is currently taking: ☐ None**PRESCRIPTION - MEDICATION MUST BE SHIPPED TO THE PATIENT'S HOME**

AndroGel® (testosterone gel) • AndroGel® 1.62 % Pump Topical • AndroGel® 1% Topical

- Use prescribers blank form & submit with application
- Enclose a copy of a government issued ID of the patient when ordering the product listed above: Driver License, State ID, Military ID, etc.

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

Signature of Physician:			
(Must be MD / DO; no PAC / NP)	<input type="checkbox"/> Substitution Allowed	<input type="checkbox"/> Dispense as Written	Date

1. Authorization for Release of Health Information: By signing this form, I represent to the AbbVie 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 AbbVie 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 AbbVie 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 AbbVie 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 AbbVie Patient Assistance Foundation is not made in exchange for any explicit or implicit agreement or understanding that AbbVie Product will be used, purchased, leased, ordered, prescribed, recommended, or arranged for or provided formulary or other preferential or qualifying status. I understand that I may not delegate signature authority. I certify that treatment with this medication is medically necessary.

**Notice to Health Care Providers and Insurers:** This form of authorization may not comply with all applicable Federal and state laws governing disclosure of the 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.



PATIENT ASSISTANCE FOUNDATION

## **AbbVie Patient Assistance Foundation Application for Creon® (pancrelipase) Delayed Release Capsules**

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

### **Checklist for submitting an application:**

- ☐ Ensure all sections of the application are completed. 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:**

AbbVie Patient Assistance Foundation  
P.O. Box 66550  
St. Louis, MO 63166-6550  
Phone: 1-800-222-6885 or 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.





PATIENT ASSISTANCE FOUNDATION

**Application For Creon® (pancrelipase) Delayed Release Capsules**

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

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

**HEALTHCARE PROVIDER INFORMATION**

DEA Number: \_\_\_\_\_ Physician Name: (First) \_\_\_\_\_ (Last) \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Email Address: \_\_\_\_\_ Office Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**PATIENT INFORMATION – Please complete to fullest extent possible. If an item does not apply, please mark N/A on that line**

SSN: (Last 4 digits only) XXX-XX-\_\_\_\_ Patient Name: (First) \_\_\_\_\_ (Last) \_\_\_\_\_  
Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender: ☐ Male ☐ Female  
Number of people in household (include self): \_\_\_\_\_ 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.

**INSURANCE INFORMATION. Please include a copy of patient's Insurance Card and Prescription Card (front and back)**

	Medical Coverage	Prescription Coverage for Creon	Eligibility Status E=Eligible P=Pending I=Ineligible	Policy Number	Contact and Phone
Medicare	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Medicare Part D	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Medicaid	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Private Insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			
State Elderly Drug Assistance	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			
State Children Health Insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Veterans Assistance	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Disabled: <input type="checkbox"/> Yes <input type="checkbox"/> No Veteran: <input type="checkbox"/> Yes <input type="checkbox"/> No					
Other:					

I understand that any assistance in the form of product at no cost is contingent upon my ability to meet the eligibility criteria for the AbbVie 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 AbbVie Patient Assistance Foundation at P O Box 66550 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.

Signature of Patient or Legal Guardian: \_\_\_\_\_

Date: \_\_\_\_\_

**REPRESENTATIVE FOR PURPOSES OF THE PROGRAM (If applicable)**

I permit the AbbVie 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: \_\_\_\_\_

**PATIENT CLINICAL INFORMATION**

Patient diagnosis (ICD-9 code) \_\_\_\_\_ Patient allergies: ☐ No Known \_\_\_\_\_  
Please list the names of other medications the patient is currently taking: ☐ None \_\_\_\_\_

**PRESCRIPTION - MEDICATION**

Creon® (pancrelipase) Delayed-Release Capsules	Instructions	Quantity (Product dispensed in 100 ct stock bottles)	Refills
<input type="checkbox"/> 3,000 Lipase Units <input type="checkbox"/> 6,000 Lipase Units <input type="checkbox"/> 12,000 Lipase Units <input type="checkbox"/> 24,000 Lipase Units			

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

Signature of Physician: \_\_\_\_\_

(Must be MD / DO / PAC / NP)

☐ Substitution Allowed☐ Dispense as written

Date \_\_\_\_\_

1. Authorization for Release of Health Information: By signing this form, I represent to the AbbVie 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 AbbVie 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 AbbVie 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 AbbVie 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 AbbVie Patient Assistance Foundation is not made in exchange for any explicit or implicit agreement or understanding that AbbVie Product will be used, purchased, leased, ordered, prescribed, recommended, or arranged for or provided formulary or other preferential or qualifying status. I understand that I may not delegate signature authority. I certify that treatment with this medication is medically necessary.

**Notice to Health Care Providers and Insurers:** This form of authorization may not comply with all applicable Federal and state laws governing disclosure of the 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.



PATIENT ASSISTANCE FOUNDATION

## Patient Assistance Application for HUMIRA® (adalimumab)

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

### Checklist for submitting an application:

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

### Fax or mail the completed application and documentation to:

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

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

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

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

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



PATIENT ASSISTANCE FOUNDATION

## Patient Assistance Application for HUMIRA® (adalimumab)

The AbbVie 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:

ABBVIE 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 (Please circle specific diagnosis code(s))

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"/> Psoriatic Arthritis (696.0)	<input type="checkbox"/> Polyarticular Juvenile Idiopathic Arthritis [JIA] (714.30)
<input type="checkbox"/> Ankylosing Spondylitis (720.0)	<input type="checkbox"/> Plaque Psoriasis (696.1)
<input type="checkbox"/> Ulcerative Colitis (556.3, 556.5, 556.6, 556.8, 556.9)	Date of Diagnosis: _____
If this patient is eligible to receive medication through the AbbVie 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

<b>Rheumatoid Arthritis, Ankylosing Spondylitis, Psoriatic Arthritis, and Polyarticular JIA if <math>\geq 30</math>kg(66 lbs)</b>			
<input type="checkbox"/> HUMIRA Pen 40 mg/0.8mL	40 mg SC inj. every other week	84 day supply	Refills:
<input type="checkbox"/> HUMIRA Pre-Filled Syringe 40 mg/0.8mL	40 mg SC inj. every other week	84 day supply	Refills:
<b>Polyarticular JIA 15kg(33 lbs) to &lt;30kg(66 lbs) only</b>			
<input type="checkbox"/> HUMIRA Pre-Filled Syringe 20 mg/0.4mL	20 mg SC inj. every other week	84 day supply	Refills:
<b>Crohn's Disease or Ulcerative Colitis</b>			
<b>STARTING THERAPY</b>			
<input type="checkbox"/> Crohn's Disease/Ulcerative Colitis Starter Package (HUMIRA Pen 40 mg/0.8mL)	<input type="checkbox"/> Four 40 mg SC inj. Day 1, Two 40 mg SC inj. Day 15, #6 pens	No Refills	
	<input type="checkbox"/> Two 40 mg SC inj. Day 1, Two 40 mg SC inj. Day 2, Two 40 mg SC inj. Day 15, #6 pens	No Refills	
<input type="checkbox"/> HUMIRA Pre-Filled Syringe 40 mg/0.8mL	<input type="checkbox"/> Four 40 mg SC inj. Day 1, Two 40 mg SC inj. Day 15, #6 syringes	No Refills	
	<input type="checkbox"/> Two 40 mg SC inj. Day 1, Two 40 mg SC inj. Day 2, Two 40 mg SC inj. Day 15, #6 syringes	No Refills	
<b>ONGOING THERAPY</b>			
<input type="checkbox"/> HUMIRA Pen 40 mg/0.8mL	40 mg SC inj. every other week	84 day supply	Refills:
<input type="checkbox"/> HUMIRA Pre-Filled Syringe 40 mg/0.8mL	40 mg SC inj. every other week	84 day supply	Refills:
<b>Plaque Psoriasis</b>			
<b>STARTING THERAPY</b>			
<input type="checkbox"/> Psoriasis Starter Package (HUMIRA Pen 40 mg/0.8mL)	Two 40 mg SC inj. for first dose (Day 1), then one 40 mg SC inj. one week after first dose (Day 8), then one 40 mg SC inj. three weeks after first dose (Day 22), #4 pens	No Refills	
<input type="checkbox"/> HUMIRA Pre-Filled Syringe 40 mg/0.8mL	Two 40 mg SC inj. for first dose (Day 1), then one 40 mg SC inj. one week after first dose (Day 8), then one 40 mg SC inj. three weeks after first dose (Day 22), #4 syringes	No Refills	
<b>ONGOING THERAPY</b>			
<input type="checkbox"/> HUMIRA Pen 40 mg/0.8mL	40 mg SC inj. every other week	84 day supply	Refills:
<input type="checkbox"/> HUMIRA Pre-Filled Syringe 40 mg/0.8mL	40 mg SC inj. every other week	84 day supply	Refills:
Other <input type="checkbox"/> HUMIRA	SIG: _____	Qty: _____	Refills: _____

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

### PHYSICIAN CERTIFICATION

Physician Signature: <input type="checkbox"/> _____ (no stamps)	(Substitution Permitted)	Date	Physician Signature: <input type="checkbox"/> _____ (no stamps)	(Dispense as Written)	Date
--	--------------------------	------	--	-----------------------	------

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

I verify that the information provided is current, complete and accurate to the best of my knowledge and certify that I am authorized to receive medications at the shipping location identified in this application. I verify that my State License is currently in good standing. I further certify that I will notify the Foundation in writing immediately if the status of my State License Number registration changes. If this applicant is eligible for the Foundation's patient assistance program (the "PAP") for HUMIRA, I understand that the Foundation will send the medication to the designated shipping location, which could include my office or the patient's home. The Foundation reserves the right to request additional information if needed and to change or discontinue the PAP at any time, without notice. By signing this form, I certify that I am prescribing the aforementioned medication for an individual participating in the PAP. I acknowledge that I shall not seek reimbursement for any medication dispensed hereunder from any government program or third party insurer. I also understand that the applicant's acceptance into the PAP is not made in exchange for any explicit or implicit agreement or understanding that AbbVie Product will be used, purchased, leased, ordered, prescribed, recommended, or arranged for or provided formulary or other preferential or qualifying status. By signing this form, I authorize the Foundation and its representatives to transmit this prescription form electronically, by facsimile, or by mail to a pharmacy designated by the Foundation for the dispensing of the medication called for herein. I understand that I may not delegate signature authority. I certify that treatment with this medication is medically necessary.



PATIENT ASSISTANCE FOUNDATION

# Patient Assistance Application for HUMIRA® (adalimumab)

The AbbVie 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:

ABBVIE 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. Include detailed list of medical expenses for household, including medications, office visits, insurance premiums, medical bills, etc.)

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

### Medicare Questions:

- Are you eligible for Medicare? ☐ Yes ☐ No If No, anticipated date of Medicare eligibility (if within the year)? \_\_\_\_\_
- Are you enrolled into a Medicare Prescription Drug Plan? ☐ Yes ☐ No ☐ Unsure
- Are you eligible for extra help (financial assistance from Social Security) with medication costs under Medicare Part D?  
☐ Yes ☐ No ☐ Unsure
- If Medicare eligible, please provide the value of your assets: \$ \_\_\_\_\_

(Assets include checking and savings accounts, CD's, stocks and bonds, savings bonds, mutual funds, IRAs and other investments, cash at home or anywhere else, and the value of your life insurance policies if turned in for cash right now. Do not include your home, vehicles, burial plots, or personal possessions.)

## FINANCIAL INFORMATION (Proof of income required)

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

Source of Income: ☐ Wages ☐ SSDI ☐ SSI ☐ Unemployment ☐ Pension ☐ Other: \_\_\_\_\_

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

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

## REPRESENTATIVE INFORMATION

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

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



PATIENT ASSISTANCE FOUNDATION

## Patient Assistance Application for HUMIRA® (adalimumab)

The AbbVie 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:

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

### For Eligible Patient Assistance Patients Only:

I understand that any assistance in the form of product at no cost is contingent upon my ability to meet the eligibility criteria for the PAP as determined by the Foundation. In the event that I am eligible for the PAP, I acknowledge that this assistance is temporary and that I may be asked to reapply at designated intervals by the Foundation. I also understand that the PAP may be changed or discontinued at any time without any notice to me. I agree that I will not seek reimbursement for any products dispensed under the Foundation from any government program or third party insurer. I certify that the information I have provided in this form is accurate and complete. I understand that by completing this form I am not guaranteed eligibility to receive medication at no cost from the Foundation. I agree that I will notify the Foundation if my insurance or financial situation changes.

Patient's Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

#### Personal Representative Authorization (if Applicable):

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

Patient's Personal Representative's Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Date: \_\_\_\_\_

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



PATIENT ASSISTANCE FOUNDATION

## **Application for Kaletra® (lopinavir/ritonavir) and Norvir® (ritonavir)**

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

### **Checklist for submitting an application:**

- ☐ Ensure all sections of the application are completed. Make a copy before sending as no documents will be returned.
- ☐ 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:**

AbbVie 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. If the 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.

For alternative shipping options, please contact the AbbVie Patient Assistance Foundation at 1-800-222-6885.



PATIENT ASSISTANCE FOUNDATION

**Application for Kaletra® (lopinavir/ritonavir) and Norvir® (ritonavir)**

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

PATIENT INFORMATION

Patient Name \_\_\_\_\_ Gender: Male ☐ Female ☐ Telephone Number \_\_\_\_\_

Patient Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SSN (Last four digits only): XXX-XX- \_\_\_\_\_

Are you enrolled in Medicare? ☐ Yes ☐ No If YES, check all that apply: ☐ Part A ☐ Part B ☐ Part DDo you have private insurance coverage for prescriptions? ☐ Yes ☐ No Are you covered by Medicaid? ☐ Yes ☐ NoAre you enrolled in ADAP? ☐ Yes ☐ No Have you been ☐ Denied ☐ Waitlisted ☐ Pending ☐ Not Applied

Total Monthly Income for your entire household \$ \_\_\_\_\_

I understand that any assistance in the form of product at no cost is contingent upon my ability to meet the eligibility criteria for the AbbVie Patient Assistance 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 AbbVie 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 high quality service, 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 (If applicable)**

I permit the AbbVie 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: \_\_\_\_\_

**Medicine Requested**Product: \_\_\_\_\_ Strength: \_\_\_\_\_ Sig: \_\_\_\_\_ Reorders allowed: up to 1 year

PRESCRIBER INFORMATION

Name and Professional Designation of Prescriber \_\_\_\_\_ DEA# (if none available, State License Number) \_\_\_\_\_ SLN Expiration Date \_\_\_\_\_

Shipping Address (no PO boxes please) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Office contact Person \_\_\_\_\_ Telephone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

1. Authorization for Release of Health Information: By signing this form, I represent to the AbbVie 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 AbbVie Patient Assistance Foundation and its contracted third parties.
2. Physician: 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 AbbVie 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 AbbVie 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 AbbVie Patient Assistance Foundation is not made in exchange for any explicit or implicit agreement or understanding that AbbVie Product will be used, purchased, leased, ordered, prescribed, recommended, or arranged for or provided formulary or other preferential or qualifying status. I understand that I may not delegate signature authority. I certify that treatment with this medication is medically necessary.

Prescriber's Signature (no stamps): \_\_\_\_\_ 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.



PATIENT ASSISTANCE FOUNDATION

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

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

### **Checklist for submitting an application:**

- ☐ Ensure all sections of the application are completed. Make a copy before sending as no documents will be returned.
- ☐ 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:**

AbbVie 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 at least 7 business days prior to the patient requiring further medication.

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





PATIENT ASSISTANCE FOUNDATION

# Application For Lupron Depot® and Lupron Depot-PED® (leuprolide acetate for depot suspension)

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

PATIENT INFORMATION

Patient Name		Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>	Telephone Number
Patient Address		City	State Zip
Date of Birth:		SSN (Last four digits only):	XXX-XX-
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			
Do you have private insurance for prescriptions? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have private medical insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Are you covered through 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. Acceptable documents include: Federal Tax Return, SSA 1099, W2, pay stubs or benefits award letter.	
<small>I understand that any assistance in the form of product at no cost is contingent upon my ability to meet the eligibility criteria for the AbbVie Patient Assistance 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 AbbVie 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 high quality service, 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.</small>			
Patient's Signature:		Date:	
Number of people in your household (including yourself)		Number in household under 18	

**Representative For Purposes of Program (If applicable)**

I permit the AbbVie 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:

**Medicine Requested**

Lupron Depot 3.75 mg <input type="checkbox"/>	Lupron Depot 11.25 mg 3 month <input type="checkbox"/>	Lupron Depot 45mg 6 month <input type="checkbox"/>	Lupron Depot PED 7.5 mg <input type="checkbox"/>
Lupron Depot 7.5 mg <input type="checkbox"/>	Lupron Depot 22.5 mg 3 month <input type="checkbox"/>	Lupron Depot PED 11.25mg 3 month <input type="checkbox"/>	Lupron Depot PED 11.25 mg <input type="checkbox"/>
	Lupron Depot 30mg 4 month <input type="checkbox"/>	Lupron Depot PED 30mg 3 month <input type="checkbox"/>	Lupron Depot PED 15 mg <input type="checkbox"/>

PRESCRIBER INFORMATION

Name and Professional Designation of Prescriber		DEA# (if none available, State License Number)		SLN Expiration Date
Shipping Address (No PO boxes please)		City	State	Zip
Mailing Address		City	State	Zip
Office Contact Person		Telephone Number	Fax Number	
<p>1. Authorization for Release of Health Information: By signing this form, I represent to the AbbVie 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 AbbVie Patient Assistance Foundation and its contracted third parties.</p> <p>2. Physician: 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 AbbVie 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 AbbVie 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 AbbVie Patient Assistance Foundation is not made in exchange for any explicit or implicit agreement or understanding that AbbVie Product will be used, purchased, leased, ordered, prescribed, recommended, or arranged for or provided formulary or other preferential or qualifying status. I understand that I may not delegate signature authority. I certify that treatment with this medication is medically necessary.</p>				
Prescriber's Signature (no stamps):		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.



PATIENT ASSISTANCE FOUNDATION

## **AbbVie Patient Assistance Foundation Application for Marinol<sup>®</sup> (dronabinol)**

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

### **Checklist for submitting an application:**

- ☐ Ensure all sections of the application are completed. 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:**

AbbVie 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.



PATIENT ASSISTANCE FOUNDATION

**Application For Marinol<sup>®</sup> (dronabinol)**

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

**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 ☐ Marinol<sup>®</sup>  
*The product listed above must be shipped to the patient's address*

**Patient diagnosis (ICD-9 code):**

1. Authorization for Release of Health Information: By signing this form, I represent to the AbbVie 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 AbbVie 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 AbbVie 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 AbbVie 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 AbbVie Patient Assistance Foundation is not made in exchange for any explicit or implicit agreement or understanding that AbbVie Product will be used, purchased, leased, ordered, prescribed, recommended, or arranged for or provided formulary or other preferential or qualifying status. I understand that I may not delegate signature authority. I certify that treatment with this medication is medically necessary.

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.
--	---

**LIST ALL SOURCES OF GROSS MONTHLY AMOUNTS PER HOUSEHOLD**

Salary/Wages (All Sources)	\$	<b>ATTACH</b>	Disability	\$	<b>ATTACH</b>
Pension/Retirement	\$	<b>PROOF</b>	Alimony/Child Support	\$	<b>PROOF</b>
Social Security	\$	<b>OF INCOME</b>	Unemployment Compensation	\$	<b>OF INCOME</b>

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**

I understand that any assistance in the form of product at no cost is contingent upon my ability to meet the eligibility criteria for the AbbVie Patient Assistance 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 AbbVie Patient Assistance Foundation at P.O. Box 66550 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.

Signature of Patient or Legal Guardian:	Date:
---	-------



PATIENT ASSISTANCE FOUNDATION

**Marinol® Prescription and Order Form**

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

<b>Section 1 - Physician and Prescription Information</b>					
Physician Name:		DEA/State License #:		Phone: (    )	Fax: (    )
Address: (no P.O. Box)			City:	State:	Zip:
<b>Prescription</b>		<b>Instructions</b>	<b>Quantity</b>	<b>Day Supply</b>	<b>Refills</b>
Marinol® <input type="checkbox"/> 2.5 mg <input type="checkbox"/> 5 mg <input type="checkbox"/> 10 mg				<input type="checkbox"/> 30 <input type="checkbox"/> 60 <input type="checkbox"/> 90	
<p align="center"><i>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</i></p>					
<b>Physician Signature:</b> (must be MD / DO no PAC / NP) <input type="checkbox"/> _____ / _____ <input type="checkbox"/> _____ (substitution allowed)                      (date)                      (dispense as written)					
<b>Section 2 - Patient Information</b>					
Patient Name:			SS #, Green Card, VISA:		
Street Address:			Date of Birth:		
City:		State:	Zip:	Phone: (    )	
<b>Medication Information</b>					
Patient allergies: <input type="checkbox"/> No Known _____ Please list the names of other medications the patient is currently taking: <input type="checkbox"/> 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 Medical Nutrition Patient Assistance Program Application**

The Abbott Medical Nutrition Program is a program of the AbbVie Patient Assistance Foundation that provides products at no cost to eligible 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 program's purpose of providing products at no cost to individuals in need.

The Abbott Medical Nutrition Patient Assistance Program is designed to supplement medical nutrition product needs.

Abbott Nutrition Products available through the program do not include all packaging configurations and flavors.

If the product you or your health care professional has requested is not available, you will be provided with product that most closely meets the ingredient composition of the product specified in the initial request.

**Prior to submitting an application, we suggest that you contact the program by calling 1-866-801-5657 as program availability is subject to change.**

### **Checklist for submitting an application:**

- ☐ Ensure all sections of the application are completed. Make a copy before sending as no documents will be returned.
- ☐ 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 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.
- ☐ Contact 1-866-801-5657 to confirm program availability for the requested product

### **Fax or mail the completed application and documentation to:**

Abbott Medical Nutrition Patient Assistance Program

PO Box 579

Somerville, NJ 08876

**Fax: 866-734-7353**

Phone: 866-801-5657

Upon receipt of a completed application, the patient will be notified of program eligibility. The approved supply of product will be shipped to the patient's home unless otherwise specified. Reorder timeframes vary by product. Please contact us to reorder your approved product. It is the responsibility of the prescriber's office or the patient to reorder.

Please contact us at 1-866-801-5657 Mon-Fri 8am-5pm CST for additional assistance.



# Abbott Medical Nutrition Patient Assistance Program Application

AbbVie Patient Assistance Foundation • PO Box 579 • Somerville NJ 08876

Phone: (866) 801-5657 • Fax: (866) 734-7353

PATIENT INFORMATION

Patient Name

Gender: Male ☐ Female ☐

Telephone Number

Patient Address (No PO boxes please)

City

State

Zip

Date of Birth:

SSN (Last four digits only):

XXX-XX-

Are you enrolled in Medicare? ☐ Yes ☐ No If YES, check all that apply: ☐ Part A ☐ Part B ☐ Part D

Do you have private insurance coverage for Nutrition Products? ☐ Yes ☐ No Are you covered by 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.

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 Medical Nutrition Patient Assistance Program ("Program"). In the event that I am eligible for patient assistance, I acknowledge that this assistance is temporary and that I may be asked to reapply at designated intervals by the Program. I also understand that the Program 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 Program 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 Program. I agree that I will notify the Program if my insurance or financial situation changes. The Program 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 Program (should I qualify). I know I may cancel this authorization at any time by writing to the AbbVie Patient Assistance Foundation at P.O. Box <XXX> Somerville, NJ 08876. If I cancel this Authorization, I can no longer participate in the Program. This authorization shall be valid for 10 years from the date of the signature on this form. I authorize the Program to share my information with Abbott, AbbVie and the AbbVie Patient Assistance Foundation for the following purposes: (i) to determine eligibility for the Program, (ii) to account for my withdrawal if I decide to stop participating in the Program, (iii) to administer and maintain high quality service, and (iv) as otherwise required or permitted by law. I agree that the AbbVie Patient Assistance Foundation does not have any liability in providing Program 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 (If applicable)

I permit the Abbott Medical Nutrition Patient Assistance Program 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 Program, 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.

Patient's Representative Signature:

Relationship:

Date:

## Product Requested (If the product requested is not available, you will be provided with product that most closely meets the ingredient composition of the requested product.)

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

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

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

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

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.

PRESCRIBER INFORMATION

Name and Professional Designation of Prescriber

DEA# (if none available, State License Number)

SLN Expiration Date

Shipping Address (No PO boxes please)

City

State

Zip

Mailing Address

City

State

Zip

Office Contact Person

Telephone Number

Fax Number

1. Authorization for Release of Health Information: By signing this form, I represent to the Abbott Medical Nutrition Patient Assistance Program 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 Medical Nutrition Patient Assistance Program 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 Medical Nutrition Patient Assistance Program (the "Program") in writing immediately if the status of my State License Number registration changes. If this applicant is eligible for the Program assistance, I understand that the Program will send the nutrition product directly to the patient's home unless I request that it be sent to my office for dispensing to the patient. The Program 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 Program. 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 Program 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 (no stamps):

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

## AbbVie Patient Assistance Foundation Application

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

### Checklist for submitting an application:

- ☐ Ensure all sections of the application are completed. Make a copy before sending as no documents will be returned.
- ☐ 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:

AbbVie Patient Assistance Foundation  
 PO Box 270  
 Somerville, NJ 08876  
 Fax: 1-866-898-1473  
 Phone: 1-800-222-6885

Upon receipt of a completed application, the prescriber and the patient will be notified of program eligibility. If the 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.



PATIENT ASSISTANCE FOUNDATION

**AbbVie Patient Assistance Foundation Application**

AbbVie Patient Assistance Foundation • PO Box 270 • Somerville NJ 08876 • Phone: 1-800-222-6885 • Fax: 1-866-898-1473

PATIENT INFORMATION

Patient Name _____		Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>	Telephone Number _____	
Patient Address _____		City _____	State _____	Zip _____
Date of Birth: _____		SSN (Last four digits only): XXX- _____		
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				
Do you have private insurance coverage for prescriptions? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Are you covered through 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. Acceptable documents include: Federal Tax Return, SSA 1099, W2, pay stubs or benefits award letter.		
<small>I understand that any assistance in the form of product at no cost is contingent upon my ability to meet the eligibility criteria for the AbbVie Patient Assistance 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 AbbVie 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 high quality service, 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.</small>				
Patient's Signature: _____		Date: _____		
Number of people in your household (including yourself) _____		Number in household under 18 _____		

**Representative For Purposes of Program (If applicable)**

I permit the AbbVie 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 \_\_\_\_\_ Relationship \_\_\_\_\_ Date: \_\_\_\_\_

**Medicine Requested**

Product: _____	Strength: _____	Sig: _____	Reorders allowed: <u>up to 1 year</u>
Product: _____	Strength: _____	Sig: _____	Reorders allowed: <u>up to 1 year</u>

PRESCRIBER INFORMATION

Name and Professional Designation of Prescriber _____		DEA# (if none available, State License Number) _____		SLN Expiration Date _____
Shipping Address _____		City _____	State _____	Zip _____
Mailing Address _____		City _____	State _____	Zip _____
Office Contact Person _____		Telephone Number _____	Fax Number _____	
<b>1. Authorization for Release of Health Information:</b> By signing this form, I represent to the AbbVie 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 AbbVie Patient Assistance Foundation and its contracted third parties.				
<b>2. Physician:</b> 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 AbbVie 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 AbbVie 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 AbbVie Patient Assistance Foundation is not made in exchange for any explicit or implicit agreement or understanding that AbbVie Product will be used, purchased, leased, ordered, prescribed, recommended, or arranged for or provided formulary or other preferential or qualifying status. I understand that I may not delegate signature authority. I certify that treatment with this medication is medically necessary.				
Prescriber's Signature (no stamps): _____		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.





PATIENT ASSISTANCE FOUNDATION

## Patient Assistance Application for Zemplar® (paricalcitol)

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

### Checklist for submitting an application:

- ☐ Ensure all sections of the application are completed. Failure to complete required information will delay the review process.
- ☐ Provide front and back copies of all prescription insurance card(s).
- ☐ Provide proof of income (tax return, W2, pay stub) for all in household.
  - o If there is no household income (\$0) due to job loss or other circumstance, you do not need to provide income documents.
- ☐ Physician's signature is required at the bottom of the 1st page.
- ☐ Patient's signature is required at the bottom of the 3rd page.

### Fax or mail the completed application and documentation to:

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

AbbVie Patient Assistance Foundation  
P.O. Box 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 note, if approved, medication will be scheduled for shipment to the specified location on the application.**

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



PATIENT ASSISTANCE FOUNDATION

## Patient Assistance Application for Zemplar® (paricalcitol)

The AbbVie 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:

ABBVIE 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 #:	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 AbbVie Patient Assistance Foundation, ship to: (No P.O. Boxes)	
<input type="checkbox"/> Patient <input type="checkbox"/> Physician Office <b>NOTE: Injectable products must be shipped to Physician's office</b>	
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 (include code(s)) _____	
<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			
Route of Administration: Oral		Route of Administration IV	
Directions for Use: _____		Directions for Use: _____	
Quantity to be Dispensed:	Refills:	Quantity to be Dispensed:	Refills:
<input type="checkbox"/> 90 day supply	<input type="checkbox"/> 1 year	<input type="checkbox"/> 90 day supply	<input type="checkbox"/> 1 year
<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____

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

### PHYSICIAN CERTIFICATION

<b>Physician Signature:</b> <input type="checkbox"/> _____ (no stamps) (Substitution Permitted) Date	<b>Physician Signature:</b> <input type="checkbox"/> _____ (no stamps) (Dispense as Written) Date
<b>Authorization for Release of Health Information:</b> By signing this form, I represent to the AbbVie Patient Assistance Foundation (the "Foundation") that I have obtained all necessary Federal and state authorizations and consents from my patient to allow me to release health information to the Foundation and its contracted third parties.	
<b>Physician/Care Coordinator Verification:</b> 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 AbbVie 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 AbbVie Product will be used, purchased, leased, ordered, prescribed, recommended, or arranged for or provided formulary or other preferential or qualifying status. By signing this form, I authorize the Foundation and its representatives to transmit this prescription form electronically, by facsimile, or by mail to a pharmacy designated by the Foundation for the dispensing of the medication called for herein. I understand that I may not delegate signature authority. I certify that treatment with this medication is medically necessary.	



PATIENT ASSISTANCE FOUNDATION

# Patient Assistance Application for Zemplar® (paricalcitol)

The AbbVie 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:

ABBVIE PATIENT ASSISTANCE FOUNDATION • P.O. BOX 399 • 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): _ _ _ _	
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	SECONDARY INSURANCE
Insurance Company:	Insurance Company:
Insurance Co. Phone:	Insurance Co. Phone:
Policy #:	Policy #:
Group #:	Group #:
Policyholder Name:	Policyholder Name:
Relationship to Policyholder:	Relationship to Policyholder:
Policyholder DOB:	Policyholder DOB:

**Medicare Questions:**

- Are you eligible for Medicare? ☐ Yes ☐ No If No, anticipated date of Medicare eligibility (if within the year)? \_\_\_\_\_
- Are you enrolled into a Medicare Prescription Drug Plan? ☐ Yes ☐ No ☐ Unsure
- Are you eligible for extra help (financial assistance from Social Security) with medication costs under Medicare Part D?  
☐ Yes ☐ No ☐ Unsure
- If Medicare eligible, please provide the value of your assets: \$ \_\_\_\_\_

(Assets include checking and savings accounts, CD's, stocks and bonds, savings bonds, mutual funds, IRAs and other investments, cash at home or anywhere else, and the value of your life insurance policies if turned in for cash right now. Do not include your home, vehicles, burial plots, or personal possessions.)

## FINANCIAL INFORMATION (Proof of income required)

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

Source of Income: ☐ Wages ☐ SSDI ☐ SSI ☐ Unemployment ☐ Pension ☐ Other: \_\_\_\_\_

Please provide current income documentation (tax return, pay stub, etc.) to avoid 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 AbbVie Patient Assistance Foundation to speak with the following person about this application and permit such person(s) to sign any related documents on my behalf for purposes of this Program:

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



PATIENT ASSISTANCE FOUNDATION

## Patient Assistance Application for Zemplar<sup>®</sup> (paricalcitol)

*The AbbVie 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:

ABBVIE 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, AbbVie Inc. or third parties contracted by AbbVie, and the AbbVie Patient Assistance Foundation (the "Foundation") or third parties contracted by the Foundation. The Foundation will use my information for purposes of determining patient assistance eligibility. I understand that I need to give my authorization to take part in the Foundation's patient assistance program (the "PAP") (should I qualify). However, if I do not provide this authorization, my decision will not affect my ability to obtain treatment from my health care providers or decisions about payment, enrollment, or eligibility for benefits made by my insurance companies. I know I may cancel this authorization at any time by writing to the AbbVie Patient Assistance Foundation at P.O. Box 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 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 Applicant 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 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.

FORM 990-PF	OTHER EXPENSES			STATEMENT	1
DESCRIPTION	(A) EXPENSES PER BOOKS	(B) NET INVEST- MENT INCOME	(C) ADJUSTED NET INCOME	(D) CHARITABLE PURPOSES	
SHIPPING AND DISTRIBUTION	2,985,678.	0.		2,985,678.	
ADMINISTRATIVE	26,248.	0.		26,248.	
OUTSIDE SERVICES	1,602,649.	0.		1,602,649.	
TO FORM 990-PF, PG 1, LN 23	4,614,575.	0.		4,614,575.	

FORM 990-PF	PART VIII - LIST OF OFFICERS, DIRECTORS TRUSTEES AND FOUNDATION MANAGERS	STATEMENT	2
-------------	---	-----------	---

NAME AND ADDRESS	TITLE AND AVRG HRS/WK	COMPEN- SATION	EMPLOYEE BEN PLAN CONTRIB	EXPENSE ACCOUNT
THAD SMITH D-031C AP31-3NW, 1 WAUKEGAN ROAD NORTH CHICAGO, IL 600646197	VICE PRESIDENT 10.00	0.	0.	0.
DENIS TIAN D-031C AP31-3NW, 1 WAUKEGAN ROAD NORTH CHICAGO, IL 600646197	TREASURER 1.00	0.	0.	0.
DALE JOHNSON D-031C AP31-3NW, 1 WAUKEGAN ROAD NORTH CHICAGO, IL 600646197	DIRECTOR 1.00	0.	0.	0.
JOHN PILOTTE D-031C AP31-3NW, 1 WAUKEGAN ROAD NORTH CHICAGO, IL 600646197	PRESIDENT 1.00	0.	0.	0.
KELLY INGOLD D-031C AP31-3NW, 1 WAUKEGAN ROAD NORTH CHICAGO, IL 600646197	DIRECTOR 1.00	0.	0.	0.
KEVIN DOLAN D-031C AP31-3NW, 1 WAUKEGAN ROAD NORTH CHICAGO, IL 600646197	DIRECTOR 1.00	0.	0.	0.
ANGELA SEKSTON D-031C AP31-3NW, 1 WAUKEGAN ROAD NORTH CHICAGO, IL 600646197	DIRECTOR 1.00	0.	0.	0.

ABBVIE PATIENT ASSISTANCE FOUNDATION

26-1215559

KATHLEEN SCHEIDT D-031C AP31-3NW, 1 WAUKEGAN ROAD NORTH CHICAGO, IL 600646197	SECRETARY 1.00	0.	0.	0.
STEVEN SCROGHAM D-031C AP31-3NW, 1 WAUKEGAN ROAD NORTH CHICAGO, IL 600646197	ASSISTANT SECRETARY 1.00	0.	0.	0.
TABETHA SKARBK D-031C AP31-3NW, 1 WAUKEGAN ROAD NORTH CHICAGO, IL 600646197	ASSISTANT TREASURER 1.00	0.	0.	0.
RUSSELL GARICH D-031C AP31-3NW, 1 WAUKEGAN ROAD NORTH CHICAGO, IL 600646197	DIRECTOR 1.00	0.	0.	0.
DARYL DORCY D-031C AP31-3NW, 1 WAUKEGAN ROAD NORTH CHICAGO, IL 600646197	DIRECTOR 1.00	0.	0.	0.
KEVIN BUCKBEE D-031C AP31-3NW, 1 WAUKEGAN ROAD NORTH CHICAGO, IL 600646197	DIRECTOR 1.00	0.	0.	0.

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

0.	0.	0.
----	----	----