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Return of Private Foundation

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

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► Information about Form 990-PF and its separate Instructions is at www.irs.gov/form990pf.

For calendar year 2014 or tax year beginning

, and ending

Name of foundation

ABBVIE PATIENT ASSISTANCE FOUNDATION

Number and street (or P O box number if mail is not delivered to street address)

A Employer identification number

D031C AP31-3NW, 1 N WAUKEGAN ROAD

26-1215559

City or town, state or province, country, and ZIP or foreign postal code

NORTH CHICAGO, IL 60064

Room/suite

B Telephone number

847-937-8353

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

C If exemption application is pending, check here ► D 1. Foreign organizations, check here ► 2. Foreign organizations meeting the 85% test, check here and attach computation ► E If private foundation status was terminated under section 507(b)(1)(A), check here ► F If the foundation is in a 60-month termination under section 507(b)(1)(B), check here ►

H Check type of organization: Section 501(c)(3) exempt private foundation
 Section 4947(a)(1) nonexempt charitable trust Other taxable private foundation

I Fair market value of all assets at end of year J Accounting method: Cash Accrual
 (from Part II, col. (c), line 16) Other (specify) _____

► \$ 52,915,068. (Part I, column (d) must be on cash basis)

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	857,122,356.		N/A	
Revenue	2 Check ► <input type="checkbox"/> if the foundation is not required to attach Sch. B Interest on savings and temporary cash investments				
	3 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 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 Gross sales less returns				
	10a and allowances				
	b Less Cost of goods sold				
	c Gross profit or (loss)				
	11 Other income				
	12 Total. Add lines 1 through 11	857,122,356.	0.		
Operating and Administrative Expenses	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 STMT 1	4,143,166.	0.		4,143,166.
	24 Total operating and administrative expenses. Add lines 13 through 23	4,143,166.	0.		4,143,166.
	25 Contributions, gifts, grants paid	853,356,401.			853,356,401.
	26 Total expenses and disbursements. Add lines 24 and 25	857,499,567.	0.		857,499,567.
	27 Subtract line 26 from line 12:	-377,211.			
	a Excess of revenue over expenses and disbursements				
	b Net investment income (if negative, enter -0)		0.		
	c Adjusted net income (if negative, enter -0)			N/A	

Part II Balance Sheets <small>Attached schedules and amounts in the description column should be for end-of-year amounts only</small>		Beginning of year	End of year	
		(a) Book Value	(b) Book Value	(c) Fair Market Value
Assets	1 Cash - non-interest-bearing	5,478,020.	1,433,054.	1,433,054.
	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	47,793,138.	51,482,014.	51,482,014.
	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 I)	53,271,158.	52,915,068.	52,915,068.
	17 Accounts payable and accrued expenses	399,545.	420,666.	
	18 Grants payable			
Net Assets or Fund Balances	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)	399,545.	420,666.	
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	52,871,613.	52,494,402.	
	30 Total net assets or fund balances	52,871,613.	52,494,402.	
	31 Total liabilities and net assets/fund balances	53,271,158.	52,915,068.	

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	52,871,613.
2 Enter amount from Part I, line 27a	2	-377,211.
3 Other increases not included in line 2 (itemize) ►	3	0.
4 Add lines 1, 2, and 3	4	52,494,402.
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	52,494,402.

Part IV Capital Gains and Losses for Tax on Investment Income

(a) List and describe the kind(s) of property sold (e.g., real estate, 2-story brick warehouse; or common stock, 200 shs. MLC Co.)			(b) How acquired P - Purchase D - Donation	(c) Date acquired (mo., day, yr.)	(d) Date sold (mo., day, yr.)
1a					
b	NONE				
c					
d					
e					
(e) Gross sales price	(f) Depreciation allowed (or allowable)	(g) Cost or other basis plus expense of sale	(h) Gain or (loss) (e) plus (f) minus (g)		
a					
b					
c					
d					
e					
Complete only for assets showing gain in column (h) and owned by the foundation on 12/31/69			(i) Gains (Col. (h) gain minus col. (k), but not less than -0-) or Losses (from col. (h))		
(i) F.M.V. as of 12/31/69	(j) Adjusted basis as of 12/31/69	(k) Excess of col. (i) over col. (j), if any			
a					
b					
c					
d					
e					
2 Capital gain net income or (net capital loss)	{ If gain, also enter in Part I, line 7 If (loss), enter -0- in Part I, line 7 }		2		
3 Net short-term capital gain or (loss) as defined in sections 1222(5) and (6): If gain, also enter in Part I, line 8, column (c). If (loss), enter -0- in Part I, line 8	{ 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))
2013	787,981,527.	2,202,229.	357.810894
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

2 Total of line 1, column (d)

2 3,357.451085

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

3 671.490217

4 Enter the net value of noncharitable-use assets for 2014 from Part X, line 5

4 3,741,560.

5 Multiply line 4 by line 3

5 2,512,420,936.

6 Enter 1% of net investment income (1% of Part I, line 27b)

6 0.

7 Add lines 5 and 6

7 2,512,420,936.

8 Enter qualifying distributions from Part XII, line 4

8 857,499,567.

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.	1 2 3 4 5	0.
Date of ruling or determination letter: _____ (attach copy of letter if necessary-see instructions)			0.
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		0.
c All other domestic foundations enter 2% of line 27b. Exempt foreign organizations enter 4% of Part I, line 12, col. (b).			0.
2	Tax under section 511 (domestic section 4947(a)(1) trusts and taxable foundations only. Others enter -0-)		0.
3	Add lines 1 and 2	0.	
4	Subtitle A (income) tax (domestic section 4947(a)(1) trusts and taxable foundations only. Others enter -0-)	0.	
5	Tax based on investment income. Subtract line 4 from line 3. If zero or less, enter -0-	0.	
6 Credits/Payments:			
a	2014 estimated tax payments and 2013 overpayment credited to 2014	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 2015 estimated tax	11	Refunded

Part VII-A Statements Regarding Activities

	Yes	No
1a		x
1b		x
1c		x
2		x
3		x
4a		x
4b		
5		x
6	x	
7	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 <i>General Instruction G</i> ? If "No," attach explanation	
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 2014 or the taxable year beginning in 2014 (see instructions for Part XIV)? If "Yes," complete Part XIV	
10	Did any persons become substantial contributors during the tax year? If "Yes," attach a schedule listing their names and addresses	

Part VII-A Statements Regarding Activities (continued)

11	<input checked="" type="checkbox"/>
12	<input checked="" type="checkbox"/>
13	<input checked="" type="checkbox"/>
14	The books are in care of ► <u>THE FOUNDATION</u> Telephone no. ► <u>847-937-8353</u> Located at ► <u>D031C AP31-3NW 1 N WAUKEGAN RD, NORTH CHICAGO, IL</u> ZIP+4 ► <u>60064</u>
15	Section 4947(a)(1) nonexempt charitable trusts filing Form 990-PF in lieu of Form 1041 - Check here and enter the amount of tax-exempt interest received or accrued during the year ► <u>15</u> N/A
16	At any time during calendar year 2014, 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 FinCEN Form 114, (formerly TD F 90-22.1). If "Yes," enter the name of the foreign country ► <u> </u> Yes <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/>

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

	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)? Organizations relying on a current notice regarding disaster assistance check here ► <u> </u> N/A 1b		
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 2014? 1c <input checked="" type="checkbox"/>		
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)): At the end of tax year 2014, did the foundation have any undistributed income (lines 6d and 6e, Part XIII) for tax year(s) beginning before 2014? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
If "Yes," list the years ► <u> </u>		
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.) <u> </u> N/A 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. ► <u> </u>		
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 2014 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 2014.) <u> </u> N/A 3b		
4a Did the foundation invest during the year any amount in a manner that would jeopardize its charitable purposes? <u> </u> N/A 4a		
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 2014? <u> </u> N/A 4b		

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Part VII-B Statements Regarding Activities for Which Form 4720 May Be Required (continued)

5a During the year did the foundation pay or incur any amount to:

(1) Carry on propaganda, or otherwise attempt to influence legislation (section 4945(e))? Yes No

(2) Influence the outcome of any specific public election (see section 4955); or to carry on, directly or indirectly, any voter registration drive? Yes No

(3) Provide a grant to an individual for travel, study, or other similar purposes? Yes No

(4) Provide a grant to an organization other than a charitable, etc., organization described in section 4945(d)(4)(A)? (see instructions) Yes No

(5) Provide for any purpose other than religious, charitable, scientific, literary, or educational purposes, or for the prevention of cruelty to children or animals? Yes No

b If any answer is "Yes" to 5a(1)-(5), did any of the transactions fail to qualify under the exceptions described in Regulations section 53.4945 or in a current notice regarding disaster assistance (see instructions)?

Organizations relying on a current notice regarding disaster assistance check here

N/A



5b

c If the answer is "Yes" to question 5a(4), does the foundation claim exemption from the tax because it maintained expenditure responsibility for the grant? N/A

 Yes No

If "Yes," attach the statement required by Regulations section 53.4945-5(d).

6a Did the foundation, during the year, receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?

 Yes No

b Did the foundation, during the year, pay premiums, directly or indirectly, on a personal benefit contract?

If "Yes" to 6b, file Form 8870.

 Yes No

7a At any time during the tax year, was the foundation a party to a prohibited tax shelter transaction?

 Yes No

b If "Yes," did the foundation receive any proceeds or have any net income attributable to the transaction?

N/A

7b

Part VIII Information About Officers, Directors, Trustees, Foundation Managers, Highly Paid Employees, and Contractors

1 List all officers, directors, trustees, foundation managers and their compensation.

(a) Name and address	(b) Title, and average hours per week devoted to position	(c) Compensation (If not paid, enter -0-)	(d) Contributions to employee benefit plans and deferred compensation	(e) Expense account, other allowances
SEE STATEMENT 2		0.	0.	0.

2 Compensation of five highest-paid employees (other than those included on line 1). If none, enter "NONE."

(a) Name and address of each employee paid more than \$50,000	(b) Title, and average hours per week devoted to position	(c) Compensation	(d) Contributions to employee benefit plans and deferred compensation	(e) Expense account, other allowances
NONE				

Total number of other employees paid over \$50,000



0

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

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

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


0

Part IX-A | Summary of Direct Charitable Activities

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

Expenses

1	N/A	
2		
3		
4		

Part IX-B | Summary of Program-Related Investments

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

Amount

1	N/A	
2		
3		

All other program-related investments. See instructions.

3		
Total. Add lines 1 through 3		0.

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	0.
b	Average of monthly cash balances	3,798,538.
c	Fair market value of all other assets	
d	Total (add lines 1a, b, and c)	3,798,538.
e	Reduction claimed for blockage or other factors reported on lines 1a and 1c (attach detailed explanation)	0.
2	Acquisition indebtedness applicable to line 1 assets	0.
3	Subtract line 2 from line 1d	3,798,538.
4	Cash deemed held for charitable activities. Enter 1 1/2% of line 3 (for greater amount, see instructions)	56,978.
5	Net value of noncharitable-use assets. Subtract line 4 from line 3. Enter here and on Part V, line 4	3,741,560.
6	Minimum investment return. Enter 5% of line 5	187,078.

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 2014 from Part VI, line 5		2a	
b	Income tax for 2014. (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:		1a	857,499,567.
a	Expenses, contributions, gifts, etc. - total from Part I, column (d), line 26		1b	0.
b	Program-related investments - total from Part IX-B		2	
2	Amounts paid to acquire assets used (or held for use) directly in carrying out charitable, etc., purposes		3a	
3	Amounts set aside for specific charitable projects that satisfy the:		3b	
a	Suitability test (prior IRS approval required)		4	857,499,567.
b	Cash distribution test (attach the required schedule)		5	0.
4	Qualifying distributions. Add lines 1a through 3b. Enter here and on Part V, line 8, and Part XIII, line 4		6	857,499,567.
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			
6	Adjusted qualifying distributions. Subtract line 5 from line 4			

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

Part XIII Undistributed Income (see instructions)

N/A

	(a) Corpus	(b) Years prior to 2013	(c) 2013	(d) 2014
1 Distributable amount for 2014 from Part XI, line 7				
2 Undistributed income, if any, as of the end of 2014				
a Enter amount for 2013 only				
b Total for prior years:				
3 Excess distributions carryover, if any, to 2014:				
a From 2009				
b From 2010				
c From 2011				
d From 2012				
e From 2013				
f Total of lines 3a through e				
4 Qualifying distributions for 2014 from Part XII, line 4: ► \$				
a Applied to 2013, but not more than line 2a				
b Applied to undistributed income of prior years (Election required - see instructions)				
c Treated as distributions out of corpus (Election required - see instructions)				
d Applied to 2014 distributable amount				
e Remaining amount distributed out of corpus				
5 Excess distributions carryover applied to 2014 (If an amount appears in column (d), the same amount must be shown in column (a).)				
6 Enter the net total of each column as indicated below:				
a Corpus. Add lines 3f, 4c, and 4e. Subtract line 5				
b Prior years' undistributed income. Subtract line 4b from line 2b				
c Enter the amount of prior years' undistributed income for which a notice of deficiency has been issued, or on which the section 4942(a) tax has been previously assessed				
d Subtract line 6c from line 6b. Taxable amount - see instructions				
e Undistributed income for 2013. Subtract line 4a from line 2a. Taxable amount - see instr.				
f Undistributed income for 2014. Subtract lines 4d and 5 from line 1. This amount must be distributed in 2015				
7 Amounts treated as distributions out of corpus to satisfy requirements imposed by section 170(b)(1)(F) or 4942(g)(3) (Election may be required - see instructions)				
8 Excess distributions carryover from 2009 not applied on line 5 or line 7				
9 Excess distributions carryover to 2015. Subtract lines 7 and 8 from line 6a				
10 Analysis of line 9:				
a Excess from 2010				
b Excess from 2011				
c Excess from 2012				
d Excess from 2013				
e Excess from 2014				

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11-24-14

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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 2014, 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

Tax year	Prior 3 years			(e) Total
	(a) 2014	(b) 2013	(c) 2012	
0.	0.	0.	0.	0.
0.	0.	0.	0.	0.

857,499,567. 787,981,527. 651,002,624. 599,264,263. 2,895,747,981.

b 85% of line 2a

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

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

857,499,567. 787,981,527. 651,002,624. 599,264,263. 2,895,747,981.

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

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

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

52,915,068.	53,271,158.	30,799,815.	26,269,677.	163,255,718.
-------------	-------------	-------------	-------------	--------------

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

52,915,068.	53,271,158.	30,799,815.	26,269,677.	163,255,718.
-------------	-------------	-------------	-------------	--------------

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

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

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)

857,122,356.	810,053,325.	656,333,976.	604,125,175.	2,927,634,832.
--------------	--------------	--------------	--------------	----------------

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

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

(3) Largest amount of support from an exempt organization

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

(4) Gross investment income

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)

3 Grants and Contributions Paid During the Year or Approved for Future Payment				
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)				
a Paid during the year				
115,161 ELIGIBLE INDIVIDUALS (LIST AVAILABLE UPON REQUEST)	NONE	N/A	PROVIDE VARIOUS PHARMACEUTICAL AND MEDICAL NUTRITION PRODUCTS AT NO CHARGE TO ELIGIBLE INDIVIDUALS	853,356,401.
N/A				
N/A				
Total			► 3a	853,356,401.
b Approved for future payment				
NONE				
Total			► 3b	0.

Part XVI-A Analysis of Income-Producing Activities

Enter gross amounts unless otherwise indicated.

1 Program service revenue:

- a _____
- b _____
- c _____
- d _____
- e _____
- f _____

g Fees and contracts from government agencies

2 Membership dues and assessments**3 Interest on savings and temporary cash investments****4 Dividends and interest from securities****5 Net rental income or (loss) from real estate:**

- a Debt-financed property
- b Not debt-financed property

6 Net rental income or (loss) from personal property**7 Other investment income****8 Gain or (loss) from sales of assets other than inventory****9 Net income or (loss) from special events****10 Gross profit or (loss) from sales of inventory****11 Other revenue:**

- a _____
- b _____
- c _____
- d _____
- e _____

12 Subtotal. Add columns (b), (d), and (e)

0. 0. 0.

13 Total. Add line 12, columns (b), (d), and (e)

13 0.

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

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

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

Line No. Explain below how each activity for which income is reported in column (e) of Part XVI-A contributed importantly to the accomplishment of the foundation's exempt purposes (other than by providing funds for such purposes).

423621	11-24-14
Form 990-PF (2014)	
12	
09140423 768001 039-04148400 2014.03020 ABBVIE PATIENT ASSISTANCE F 039-0MQ1	

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

Schedule of Contributors

OMB No. 1545-0047

► 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.

2014

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, contributions totaling \$5,000 or more (in money or property) from any one contributor. Complete Parts I and II. See instructions for determining a contributor's total contributions.

Special Rules

For an organization described in section 501(c)(3) 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), that checked Schedule A (Form 990 or 990-EZ), Part II, line 13, 16a, or 16b, and that received from any one contributor, during the year, total contributions 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 an organization described in section 501(c)(7), (8), or (10) filing Form 990 or 990-EZ that received from any one contributor, during the year, total contributions of more than \$1,000 exclusively for religious, charitable, scientific, literary, or educational purposes, or for the prevention of cruelty to children or animals. Complete Parts I, II, and III.

For an organization described in section 501(c)(7), (8), or (10) filing Form 990 or 990-EZ that received from any one contributor, during the year, contributions exclusively for religious, charitable, etc., purposes, but no such contributions totaled 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 totaling \$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) (2014)

Name of organization

ABBVIE PATIENT ASSISTANCE FOUNDATION

Employer identification number

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	\$ 1,310,839.	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	\$ 77,080.	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	\$ 855,734,437.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" 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.)
		\$	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.)

423452 11-05-14

Schedule B (Form 990, 990-EZ, or 990-PF) (2014)

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	\$ 1,310,839.	VARIOUS
3	VARIOUS MEDICATIONS	\$ 855,734,437.	VARIOUS
		\$	
		\$	
		\$	
		\$	
		\$	

423453 11-05-14

Schedule B (Form 990, 990-EZ, or 990-PF) (2014)

Name of organization

Employer identification number

ABBVIE PATIENT ASSISTANCE FOUNDATION

26-1215559

Part III *Exclusively religious, charitable, etc., contributions to organizations described in section 501(c)(7), (8), or (10) that total more than \$1,000 for the year from any one contributor. 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 info. 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	
(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	
(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	

ABBVIE PATIENT ASSISTANCE FOUNDATION

26-1215559

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	2,879,438.	0.		2,879,438.
ADMINISTRATIVE	19,624.	0.		19,624.
OUTSIDE SERVICES	1,244,104.	0.		1,244,104.
TO FORM 990-PF, PG 1, LN 23	4,143,166.	0.		4,143,166.

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.
DENIS TIAN D-031C AP31-3NW, 1 WAUKEGAN ROAD NORTH CHICAGO, IL 600646197	TREASURER 1.00		0.	0.
JOHN PILOTTE D-031C AP31-3NW, 1 WAUKEGAN ROAD NORTH CHICAGO, IL 600646197	DIRECTOR 1.00		0.	0.
KATHLEEN SCHEIDT D-031C AP31-3NW, 1 WAUKEGAN ROAD NORTH CHICAGO, IL 600646197	ASSISTANT SECRETARY 1.00		0.	0.
STEVEN SCROGHAM D-031C AP31-3NW, 1 WAUKEGAN ROAD NORTH CHICAGO, IL 600646197	SECRETARY 1.00		0.	0.
TABETHA SKARBEK D-031C AP31-3NW, 1 WAUKEGAN ROAD NORTH CHICAGO, IL 600646197	ASSISTANT TREASURER 1.00		0.	0.
RUSSELL GARICH D-031C AP31-3NW, 1 WAUKEGAN ROAD NORTH CHICAGO, IL 600646197	DIRECTOR 1.00		0.	0.

ABBVIE PATIENT ASSISTANCE FOUNDATION

26-1215559

KEVIN BUCKBEE D-031C AP31-3NW, 1 WAUKEGAN ROAD NORTH CHICAGO, IL 600646197	DIRECTOR 1.00	0.	0.	0.
MICHAEL BOYD 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.
TRACIE HAAS D-031C AP31-3NW, 1 WAUKEGAN ROAD NORTH CHICAGO, IL 600646197	PRESIDENT 2.00	0.	0.	0.
TOTALS INCLUDED ON 990-PF, PAGE 6, PART VIII		0.	0.	0.



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.
- Attach current proof of income (tax return, W2, pay stub) for all in household.
- Patient's signature/date is required on the application in two separate sections.
- 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 270
Somerville, NJ 08876
Phone: 1-800-222-6885
FAX: 1-800-276-9901**

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



PATIENT ASSISTANCE FOUNDATION

Application For AndroGel® (testosterone gel) 1.62% and 1.0%

AbbVie Patient Assistance Foundation • P.O. Box 270 Somerville, NJ 08876 • 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-	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 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: _____

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 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

PHYSICIAN CERTIFICATION

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"), 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.

Physician Signature: Physician Signature:

(no stamps)

(Substitution Permitted)

Date

(no stamps)

(Dispense as Written)

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.

AUTHORIZATION FOR DISCLOSURE OF INFORMATION

I understand that the purpose of this authorization ("Authorization") is to give my permission for the disclosure and use of my protected health information to the extent it is required under state and federal law. I request and authorize my healthcare providers and healthcare insurers that have provided treatment, payment or services to me or for me to disclose any information regarding my health, treatment, and coverage that pertains to payment for medication to the AbbVie Patient Assistance Foundation, AbbVie Inc., its affiliates, or third parties contracted by the AbbVie Patient Assistance Foundation, (collectively, the "Foundation") for the following purposes: (i) to determine my eligibility for the Foundation's patient assistance program ("PAP"), (ii) if necessary, to account for and assist with my withdrawal from the PAP and/or transfer to a separate private or public payer program, and (iii) to administer and maintain the high quality of the PAP. I understand that once the Foundation receives my health information, it may communicate with my health care providers and insurers to determine my PAP eligibility. I understand that I am not required to sign this Authorization and that no health care provider or insurer will condition treatment, payment, enrollment or eligibility for benefits on whether I sign this Authorization. However, I understand that if I do not sign this Authorization, I cannot take part in the PAP (should I qualify I understand that I may cancel this authorization at any time by writing to the AbbVie Patient Assistance Foundation at P.O. Box 270, Somerville, NJ, 08876 as well as by notifying my health care providers and insurers. If I cancel this Authorization, I can no longer participate in certain aspects of the PAP. Once the Foundation receives and processes my cancellation request, the Foundation will not use my health information going forward. I understand that cancelling my Authorization will not affect any use of my health information that occurred before my request was processed. This authorization shall be valid for 10 years from the date of the signature on this form (unless a shorter period is prescribed by state law). I understand that, unless otherwise restricted by state law, my health information released under this Authorization is subject to re-disclosure by Foundation and will no longer be protected by HIPAA.

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

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

Relationship: _____



PATIENT ASSISTANCE FOUNDATION

PATIENT CERTIFICATION FOR PATIENT ASSISTANCE (Required)

PATIENT CERTIFICATION FOR PATIENT ASSISTANCE:

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

Patient's Name: _____

Signature: _____

Date: _____

(If applicable)

Representative Name : _____

Signature: _____

Date: _____

Relationship: _____

PERSONAL REPRESENTATIVE REPRESENTATION (if applicable)

Personal Representative Representation (if applicable):

Note: A Patient's Personal Representative may sign this Form on behalf of the Patient. However, only certain individuals may qualify as the Patient's Personal Representative. A State law prescribes who can be a Personal Representative for purposes of this Authorization.

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

Representative Name _____

Relationship: _____

Signature: _____

Date: _____

ADDITIONAL PERMISSION FOR PURPOSES OF THE PROGRAM (optional)

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

Name: _____

Relationship: _____

Phone Number: _____

Patient Signature: _____

Date: _____



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.
- Attach current proof of income (tax return, W2, pay stub) for all in household.
- Patient's signature/date is required on the application in two separate sections.
- 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 270
Somerville, NJ 08876
Phone: 1-800-222-6885
FAX: 1-800-276-9901**

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



PATIENT ASSISTANCE FOUNDATION

Application For Creon® (pancrelipase) Delayed Release Capsules

AbbVie Patient Assistance Foundation • P.O. Box 270 Somerville, NJ 08876 • 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-	Patient Name: (First)	(Last)
---------------------------	---------	-----------------------	--------

Address:	Home Phone:	Work Phone:
----------	-------------	-------------

City:	State:	Zip:	Date of Birth: ____/____/____	Gender: <input type="checkbox"/> Male <input type="checkbox"/> 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: Yes No

Other:

PATIENT CLINICAL INFORMATION					
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Patient diagnosis (ICD.9 code)	Patient allergies: <input type="checkbox"/> No Known
--------------------------------	--

Please list the names of other medications the patient is currently taking: <input type="checkbox"/> None	
---	--

PRESCRIPTION - MEDICATION		Instructions	Quantity (Product dispensed in 100 ct stock bottles)	Refills
Creon® (pancrelipase) Delayed-Release Capsules				
<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			
<input type="checkbox"/> 36,000 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

PHYSICIAN CERTIFICATION					
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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"), 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.

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

AUTHORIZATION FOR DISCLOSURE OF INFORMATION

I understand that the purpose of this authorization ("Authorization") is to give my permission for the disclosure and use of my protected health information to the extent it is required under state and federal law. I request and authorize my healthcare providers and healthcare insurers that have provided treatment, payment or services to me or for me to disclose any information regarding my health, treatment, and coverage that pertains to payment for medication to the AbbVie Patient Assistance Foundation, AbbVie Inc., its affiliates, or third parties contracted by the AbbVie Patient Assistance Foundation, (collectively, the "Foundation") for the following purposes: (i) to determine my eligibility for the Foundation's patient assistance program ("PAP"), (ii) if necessary, to account for and assist with my withdrawal from the PAP and/or transfer to a separate private or public payer program, and (iii) to administer and maintain the high quality of the PAP. I understand that once the Foundation receives my health information, it may communicate with my health care providers and insurers to determine my PAP eligibility. I understand that I am not required to sign this Authorization and that no health care provider or insurer will condition treatment, payment, enrollment or eligibility for benefits on whether I sign this Authorization. However, I understand that if I do not sign this Authorization, I cannot take part in the PAP (should I qualify I understand that I may cancel this authorization at any time by writing to the AbbVie Patient Assistance Foundation at P.O. Box 270, Somerville, NJ, 08876 as well as by notifying my health care providers and insurers. If I cancel this Authorization, I can no longer participate in certain aspects of the PAP. Once the Foundation receives and processes my cancellation request, the Foundation will not use my health information going forward. I understand that cancelling my Authorization will not affect any use of my health information that occurred before my request was processed. This authorization shall be valid for 10 years from the date of the signature on this form (unless a shorter period is prescribed by state law). I understand that, unless otherwise restricted by state law, my health information released under this Authorization is subject to re-disclosure by Foundation and will no longer be protected by HIPAA.

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

(If applicable)

Representative Name : _____ **Signature:** _____ **Date:** _____

Relationship: _____



PATIENT ASSISTANCE FOUNDATION

PATIENT CERTIFICATION FOR PATIENT ASSISTANCE (Required)

PATIENT CERTIFICATION FOR PATIENT ASSISTANCE:

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

Patient's Name: _____

Signature: _____

Date: _____

(If applicable)

Representative Name : _____

Signature: _____

Date: _____

Relationship: _____

PERSONAL REPRESENTATIVE REPRESENTATION (if applicable)

Personal Representative Representation (if applicable):

Note: A Patient's Personal Representative may sign this Form on behalf of the Patient. However, only certain individuals may qualify as the Patient's Personal Representative. A State law prescribes who can be a Personal Representative for purposes of this Authorization.

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

Representative Name _____

Relationship: _____

Signature: _____

Date: _____

ADDITIONAL PERMISSION FOR PURPOSES OF THE PROGRAM (optional)

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

Name: _____

Relationship: _____

Phone Number: _____

Patient Signature: _____

Date: _____

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: <input type="checkbox"/> Male <input type="checkbox"/> Female	Telephone Number
	Patient Address	City	State
	Date of Birth:	SSN (Last four digits only): XXX- <input type="text"/>	Zip
	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 <input type="text" value="\$"/>	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.	
	<p>I understand that any assistance in the form of product at no cost is contingent upon my ability to meet the eligibility criteria for the 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.</p>		
	Patient's Signature:	Date:	
	Number of people in your household (including yourself) <input type="text"/>	Number in household under 18 <input type="text"/>	

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: up to 1 year
Product: _____	Strength: _____	Sig: _____	Reorders allowed: up to 1 year

Name and Professional Designation of Prescriber	DEA# (if none available, State License Number)	SLN Expiration Date
Shipping Address	City	State
Mailing Address	City	State
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

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.
 - 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 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"/> Other
<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 Physician Office Patient Shipping Address (if different from physician/patient address):

PHYSICIAN'S ORDERS

Rheumatoid Arthritis, Ankylosing Spondylitis, Psoriatic Arthritis, and Polyarticular JIA if $\geq 30\text{kg}(66\text{ lbs})$

<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

Polyarticular JIA 15kg(33 lbs) to $<30\text{kg}(66\text{ lbs})$ only

<input type="checkbox"/> HUMIRA Pre-Filled Syringe 20 mg/0.4mL	20 mg SC inj. every other week	84 day supply	Refills
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Crohn's Disease or Ulcerative Colitis

STARTING THERAPY

<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 <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 <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

ONGOING THERAPY

<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

Plaque Psoriasis

STARTING THERAPY

<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

ONGOING THERAPY

<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 HUMIRA SIG Qty Refills

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

PHYSICIAN CERTIFICATION

Physician Signature:

(no stamps)

(Substitution Permitted)

Date

Physician Signature:

(no stamps)

(Dispense as Written)

Date

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

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



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) <input type="text"/> <input type="text"/> <input type="text"/>
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

<input type="checkbox"/> I have no insurance coverage <input type="checkbox"/> 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	
Insurance Company:	Insurance Company:
Insurance Co. Phone	Insurance Co. Phone:
Policy #:	Policy #
Group #	Group #
Policyholder Name	
Relationship to Policyholder:	
Policyholder DOB.	
SECONDARY INSURANCE	

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: <input type="checkbox"/> Male <input type="checkbox"/> Female	Telephone Number	
	Patient Address	City	State	Zip
	Date of Birth:	SSN (Last four digits only): XXX-XX- <input type="text"/>		
	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 by Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Are you enrolled in ADAP? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you been <input type="checkbox"/> Denied <input type="checkbox"/> Waitlisted <input type="checkbox"/> Pending <input type="checkbox"/> Not Applied		
	Total Monthly Income for your entire household <input type="text"/>		\$	
	<p>I understand that any assistance in the form of product at no cost is contingent upon my ability to meet the eligibility criteria for the 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.</p>			
	Patient's Signature: <input type="text"/>		Date: <input type="text"/>	
	Number of people in your household (including yourself) <input type="text"/>		Number in household under 18 <input type="text"/>	

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

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): <input type="text"/>		Date: <input type="text"/>	

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.



Application for Lupron Depot® and Lupron Depot-PED® (leuprolide acetate for depot suspension) and Lupaneta Pack® (leuprolide acetate for depot suspension and norethindrone acetate tablets)

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.



**Application for Lupron Depot® and Lupron Depot-PED® (leuprolide acetate for depot suspension) and
Lupaneta Pack® (leuprolide acetate for depot suspension and norethindrone acetate tablets)**

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

PATIENT INFORMATION	Patient Name	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	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.	
	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
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"/> Lupaneta Pack 3.75mg 1 month kit GYN <input type="checkbox"/> Lupaneta Pack 11.25mg 3 month kit GYN <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
	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 Application for Moderiba® (ribavirin)

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), if applicable.
- 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 2nd page.

Fax or mail the completed application and documentation to:

AbbVie Patient Assistance Foundation
P.O. Box 8109
Somerville, NJ 08876
Fax: 1-866-574-1644
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

THIS PAGE TO BE COMPLETED BY PHYSICIAN

Patient Assistance Application for Moderiba® (ribavirin)

ABBVIE PATIENT ASSISTANCE FOUNDATION • P.O. BOX 8109 • SOMERVILLE, NJ 08876 • Phone 1-800-222-6885 • Fax 1-866-574-1644

PHYSICIAN INFORMATION MD DO Other _____ HCP Specialty Hepatology ID Gastro Primary Care Other _____

Physician Name.

Office Name _____ Office Contact Name _____

Address _____ City/State/Zip _____

Phone _____ Fax: _____

State License # _____ DEA #. _____ NPI/Insurance Provider # _____

PATIENT HISTORY AND SHIPPING PREFERENCE

Patient's Name _____ DOB _____ HCV genotype (circle). 1 2 3 4 5 6

Patient Diagnosis (ICD-9 Code) 070.54 Chronic hep C 070.70 Unspecified hep C Other _____ Other Medications No other medications Allergies (List) No known allergiesIf this patient is eligible to receive medication through the AbbVie Patient Assistance Foundation, ship to Physician Office Patient

PHYSICIAN'S ORDERS	DIRECTIONS	SHIPMENT	REFILLS
<input type="checkbox"/> Modenba® (nbavirin) Dose Pack 600mg 1 box of 4 weekly cartons (56 count)	_____	90 day supply	Refills _____
<input type="checkbox"/> Moderiba® (nbavirin) Dose Pack 800mg 1 box of 4 weekly cartons (56 count)	_____	90 day supply	Refills _____
<input type="checkbox"/> Modenba® (nbavirin) Dose Pack 1000mg 1 box of 4 weekly cartons (56 count)	_____	90 day supply	Refills _____
<input type="checkbox"/> Modenba® (nbavirin) Dose Pack 1200mg 1 box of 4 weekly cartons (56 count)	_____	90 day supply	Refills _____
<input type="checkbox"/> Modenba® (nbavirin) Bottle 200 mg Bottle of 168 tablets	_____	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**PATIENT INFORMATION**Physician Signature:

(no stamps) (Substitution Permitted) Date

Physician Signature:

(no stamps) (Dispense as Written) Date

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

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

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



PATIENT ASSISTANCE FOUNDATION

THIS PAGE TO BE COMPLETED BY PATIENT

Patient Assistance Application for Moderiba® (ribavirin)

ABBVIE PATIENT ASSISTANCE FOUNDATION • P.O. BOX 8109 • SOMERVILLE, NJ 08876 • Phone: 1-800-222-6885 • Fax 1-866-574-1644

PATIENT INFORMATION

Patient Name	Sex. <input type="checkbox"/> M <input type="checkbox"/> F
DOB	SSN (last four digits ONLY): <input type="text"/> <input type="text"/> <input type="text"/>
Address (No P.O. Box)	
Daytime Phone	City/State/Zip
Physician Name	Physician Phone
Current Monthly Household Income \$	Number in Household (circle) 1 2 3 4 5 6
Attach the most current copies of income documentation for you and all dependents. <small>Acceptable documents include Federal Tax Return, SSA 1099, W2, pay stubs or benefits award letter. If there is no household income (\$0) due to job loss or other circumstance, you do not need to provide income documents.</small>	

INSURANCE INFORMATION <small>Please provide details of your insurance OR attach copies of the front and back of your insurance cards.</small>	
<input type="checkbox"/> I have no insurance coverage <input type="checkbox"/> I have insurance coverage	
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	
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 Prescription Drug Plan	
Are you eligible for extra help (financial assistance from Social Security) with medication costs under Medicare Part D? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	
If Medicare eligible, please provide the value of your assets: \$ <small>(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.)</small>	

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

PATIENT CERTIFICATION AND AUTHORIZATION FOR DISCLOSURE OF INFORMATION			
<p>I request and authorize the sharing of any information regarding my health, treatment, and coverage that pertains to payment for Moderiba 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 8109 Somerville, NJ 08876. 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.</p> <p>I understand that any assistance in the form of product at no cost is contingent upon my ability to meet the eligibility criteria for the 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.</p>			
Patient's Name: _____		Signature: _____	Date: _____

Personal Representative Authorization (if applicable): <small>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.</small>			
Representative's Name: _____		Relationship: _____	Signature: _____ Date: _____

REPRESENTATIVE FOR PURPOSES OF THE PROGRAM (if applicable)			
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: _____



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 NOTE: Injectable products must be shipped to Physician's office	
Shipping Address (if different from patient address).	

PRESCRIPTION INFORMATION

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

Physician Signature: <input type="checkbox"/> _____	Physician Signature: <input type="checkbox"/> _____
(no stamps)	(no stamps)
(Substitution Permitted)	(Dispense as Written)
Date	Date
Authorization for Release of Health Information: 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.	
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 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:



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Patient Certification and Authorization for Disclosure of Information

I request and authorize the sharing of any information regarding my health, treatment, and coverage that pertains to payment for 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.



PATIENT ASSISTANCE FOUNDATION

AbbVie Patient Assistance Foundation Application for Marinol® (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® (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	<input checked="" type="checkbox"/> Marinol®							
<i>The product listed above must be shipped to the patient's address</i>								
Patient diagnosis (ICD.9 code):								
<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/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.</p>								
Signature of Physician:				Date				
PATIENT INFORMATION – Please complete to fullest extent possible. If an item does not apply, please mark N/A on that line.								
Social Security / ID No:	Patient Name: (First)			(Last)				
Address:	Home Phone: ()			Work Phone: ()				
City:	State:	Zip:						
US Resident: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of Birth: ____/____/____			Gender: <input type="checkbox"/> Male <input checked="" type="checkbox"/> Female				
Veteran: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Disabled: <input type="checkbox"/> Yes <input checked="" 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)	\$ ATTACH	Disability			\$ ATTACH			
Pension/Retirement	\$ PROOF	Alimony/Child Support			\$ PROOF			
Social Security	\$ OF INCOME	Unemployment Compensation			\$ OF INCOME			
Total Gross Monthly Household Income:								
INSURANCE INFORMATION – Please include a copy of patient's Insurance Card and Prescription Card (front and back)								
	Medical Coverage (circle one)	Prescription Drug Coverage for Requested Product (circle one)	Eligibility Status E=Eligible P=Pending I=Ineligible (reason)	Policy Number	Phone Number	Contact Person		
Medicare	Y N	Y N			()			
Medicare Part D	Y N	Y N			()			
Medicaid	Y N	Y N			()			
Private Insurance	Y N	Y N			()			
State Elderly Drug Assistance	Y N	Y N			()			
State Children Health Insurance	Y N	Y N			()			
Veterans Assistance	Y N	Y N			()			
Other	Y N	Y N			()			
APPLICANT DECLARATION								
<p>I understand that any assistance in the form of product at no cost is contingent upon my ability to meet the eligibility criteria for the 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.</p>								
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

Section 1 - Physician and Prescription Information				
Physician Name:	DEA/State License #:		Phone: ()	Fax: ()
Address (no P.O. Box)		City:	State:	Zip:
Prescription	Instructions	Quantity	Day Supply	Refills
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	
<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>				
Physician Signature: (must be MD / DO no PAC / NP) <input type="checkbox"/> _____ / _____ / _____ <input type="checkbox"/> _____ (substitution allowed) (date) (dispense as written)				
Section 2 - Patient Information				
Patient Name:		SS #, Green Card, VISA.		
Street Address:		Date of Birth:		
City.	State.	Zip:	Phone: ()	
Medication Information				
Patient allergies: <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.