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 page 1.

☐ Patient’s signature is required at the bottom of page 3 and page 4.

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: [MD] [DO] [Other: ] [Rheum] [Derm] [Gastro] [Other: ]
Office Name:
Address:
Phone:
State License #:
Tax ID#:
NPI/Insurance Provider #:

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

Patient’s Name: DOB:
Allergies (List): No known allergies

PHYSICIAN’S ORDERS

Rheumatoid Arthritis, Ankylosing Spondylitis, Psoriatic Arthritis, and Polyarticular JIA if ≥30kg (66 lbs)
- HUMIRA Pen 40 mg/0.8mL
  - 40 mg SC inj. every other week
  - 84 day supply
  - Refills:

Polyarticular JIA 15kg (33 lbs) to <30kg (66 lbs) only
- HUMIRA Pre-Filled Syringe 20 mg/0.4mL
  - 20 mg SC inj. every other week
  - 84 day supply
  - Refills:

Crohn’s Disease or Ulcerative Colitis

STARTING THERAPY
- Crohn’s Disease/Ulcerative Colitis Starter Package (HUMIRA Pen 40 mg/0.8mL)
  - Four 40 mg SC inj. Day 1, Two 40 mg SC inj. Day 15, #6 pens
  - No Refills

- HUMIRA Pre-Filled Syringe 40 mg/0.8mL
  - Four 40 mg SC inj. Day 1, Two 40 mg SC inj. Day 15, #6 syringes
  - No Refills

ONGOING THERAPY
- HUMIRA Pen 40 mg/0.8mL
  - 40 mg SC inj. every other week
  - 84 day supply
  - Refills:

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

Plaque Psoriasis

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

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

ONGOING THERAPY
- HUMIRA Pen 40 mg/0.8mL
  - 40 mg SC inj. every other week
  - 84 day supply
  - Refills:

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

Other [HUMIRA]
SIG:
Qty:

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 [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 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 with this medication is medically necessary.

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ABBVIE PATIENT ASSISTANCE FOUNDATION ● P.O. BOX 789 ● SAN BRUNO, CA 94066. For questions, please call 1-800-222-6885.

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### PATIENT INFORMATION

<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Name:</td>
<td></td>
</tr>
<tr>
<td>Sex:</td>
<td>M □</td>
</tr>
<tr>
<td>DOB:</td>
<td></td>
</tr>
<tr>
<td>SSN (last four digits ONLY):</td>
<td>1 1 1</td>
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<tr>
<td>Address (No P.O. Box):</td>
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</tr>
<tr>
<td>City/State/Zip:</td>
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<tr>
<td>Daytime Phone:</td>
<td></td>
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<tr>
<td>Evening Phone:</td>
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<tr>
<td>Treating Physician Name:</td>
<td></td>
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<tr>
<td>Treating Physician Phone:</td>
<td></td>
</tr>
<tr>
<td>Treating Physician Fax:</td>
<td></td>
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<tr>
<td>Primary Care Physician Name:</td>
<td></td>
</tr>
<tr>
<td>Primary Care Physician Phone:</td>
<td></td>
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<tr>
<td>Other Medications (List):</td>
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</tbody>
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### INSURANCE INFORMATION

- I have no insurance coverage
- I have insurance coverage that does not adequately cover HUMIRA (Please provide details below or attach a copy of the insurance card. Include detailed list of medical expenses for household, including medications, office visits, insurance premiums, medical bills, etc.)

#### PRIMARY INSURANCE

<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
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</thead>
<tbody>
<tr>
<td>Insurance Company:</td>
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<tr>
<td>Insurance Co. Phone:</td>
<td></td>
</tr>
<tr>
<td>Policy #:</td>
<td></td>
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<tr>
<td>Group #:</td>
<td></td>
</tr>
<tr>
<td>Policyholder Name:</td>
<td></td>
</tr>
<tr>
<td>Relationship to Policyholder:</td>
<td></td>
</tr>
<tr>
<td>Policyholder DOB:</td>
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</tbody>
</table>

#### SECONDARY INSURANCE

<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
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</thead>
<tbody>
<tr>
<td>Insurance Company:</td>
<td></td>
</tr>
<tr>
<td>Insurance Co. Phone:</td>
<td></td>
</tr>
<tr>
<td>Policy #:</td>
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<tr>
<td>Group #:</td>
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<tr>
<td>Policyholder Name:</td>
<td></td>
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<tr>
<td>Relationship to Policyholder:</td>
<td></td>
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<tr>
<td>Policyholder DOB:</td>
<td></td>
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</tbody>
</table>

**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.
- □ Yes □ No □ Unsure. If Medicare eligible, please provide the value of your assets: $______________

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

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### FINANCIAL INFORMATION (Proof of income required)

<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Monthly Household Income:</td>
<td>$______________</td>
</tr>
<tr>
<td># in Household (circle):</td>
<td>1 2 3 4 5 6</td>
</tr>
<tr>
<td>Source of Income:</td>
<td>Wages □ SSDI □ SSI □ Unemployment □ Pension □ Other: ____________</td>
</tr>
</tbody>
</table>

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: _______________
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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:__________________
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AUTHORIZATION FOR DISCLOSURE OF INFORMATION

I understand that the purpose of this authorization (“Authorization”) is to give my permission for the disclosure and use of my protected health information 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 789, San Bruno, CA, 94066 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: ____________________________

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.