

# Abbott Patient Assistance Program Application • Instruction Page

The Abbott Patient Assistance Program is designed to assist financially disadvantaged individuals. All applications are reviewed on a case-by-case basis. Eligibility is based on current Federal Poverty Guidelines adjusted for household size. The provision of free medication is a philanthropic activity sponsored by Abbott Laboratories. Therefore, the Abbott Patient Assistance Program is considered the payer of last resort.

Please complete the entire application. Failure to complete any section or to provide all required documentation will delay the review process. Incomplete applications will be returned for further information.

**Part I. Information From Prescriber:** To be completed by the prescriber. Please carefully review the certifications and then sign and date the application.

The health care professional responsible for completing the application and associated documentation shall provide such information in accordance with all applicable Federal and state laws, including, but not limited to, the Health Insurance Portability and Accountability Act of 1996.

Part II. Applicant Information: To be completed by the applicant or applicant's representative.

- 1. Monthly household income is required. Income includes salary, pension, Social Security income, etc. for all members in the household.
- 2. Documentation of income is required. Documentation includes a Federal tax return, W2, pay stub, Social Security Benefit Letter, etc., for all members in the household.
- 3. A copy of Medicare card or letter of Medicaid and/or Social Security denial, or QMB / SLMB statement is required, if applicable.
- 4. Please carefully review the applicant certification and then sign and date the application. Provide documentation of authorization if party signing for applicant is someone other than a relative of applicant.

### Please ensure that the application is complete.

Fax or mail the completed application and associated documentation to Abbott for eligibility review.

## **Approval & Shipment**

The prescriber's office and applicant will be notified of applicant eligibility. Upon approval into the Abbott Patient Assistance Program, a supply of medication will be shipped to the prescriber's office for dispensing to the applicant.

#### **Refill & Requalification**

It is the responsibility of the prescriber or office staff to contact Abbott 3 weeks prior to the applicant requiring further medication. If within the applicant's defined eligibility period, an additional supply of medication will be shipped to the prescriber's office. If not within the eligibility period, the prescriber will be sent a re-enrollment application on behalf of the applicant.

**Questions & Comments** 

Please contact us:

Phone: 1-800-222-6885 Fax: 1-866-898-1473 (toll-free) Hours: Mon-Fri 8am-5pm CST

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



# **Abbott Patient Assistance Program Application**

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For Abbott use only

Request #:

Abbott Patient Assistance Program • 200 Abbott Park Road D-31C AP52S-1 • Abbott Park IL 60064-6214 Phone 1-800-222-6885 • • FAX 1-866-898-1473

## Part I: INFORMATION FROM PRESCRIBER

A. <u>PRESCRIBER INFORMATION</u> OF	Please check circle to indicate char	nge of address.			
State License #:	DEA#:				
Last Name:	First Name:				
Professional Designation: Primary	Specialty:	Gender: OM OF			
Office Shipping Address (No PO Box):					
City:	State:	ZIP:			
Office Mailing Address:					
City:	State:	ZIP:			
Office Contact:					
Phone:	Fax:				
B. PRESCRIPTION INFORMATION		<u>_</u>			
Product: Strength	n: Sig:	Refills: 1 year			
C. <u>CERTIFICATIONS</u> 1. Authorization for Release of Health Information:					
care institutions are not eligible. Appl  A. CONTACT INFORMATION O Plea  Social Security #:	that the information provided is current, co abbott Patient Assistance Program, I under at. Abbott reserves the right to request addithout notice. By signing this form, I certify ting in the Abbott Patient Assistance Program to the transport of the reunder from any government program abbott Patient Assistance Program is not moduct will be used, purchased, leased, or or other preferential or qualifying status.  Interview (STAMPS NOT ACCEPTED)  Date:  Steed to by the applicant or applicant's represent must have valid Social Security not see the change.	mplete and accurate to the best stand that Abbott will send the ditional information if needed and that I am prescribing the ram. I acknowledge that I shall m or third party insurer. I also nade in exchange for any explicit dered, prescribed,  sentative. Patients in health umber to participate.  of address.  Gender: OM OF			
Last Name: Address: (No PO Box):	First Name:	Middle Initial:			
City:	State:	ZIP:			
Phone:		<u> </u>			
B. FINANCIAL INFORMATION — DO NO	OT SEND ORIGINALS				
Attach the most current copies of income documents for you and all dependent persons in the household.					
Acceptable documents include Federal tax return, SSA-1099, W2, pay stubs or benefits award letter.					
Number of people in household including yourself.  Number of children in household under age 18.					
•					
Pension \$	Medicare Eligible only, please cor	mplete this shaded section.			
Social Security \$	Total Value of Assets\$ Assets considered include: check	ring and savings accounts			
Disability \$	certificates of deposit, stocks & b				
Unemployment \$ mutual funds, IRAs or other investments, cash at home or					
		stments, cash at home or			
Child Support / Alimony \$ Interest / Dividends \$	mutual funds, IRAs or other inves anywhere else and the value of lif turned in your policies for cash ri	tments, cash at home or e insurance policies if you			
Monthly income for all in household: Salary /Wages \$		-			

# **Abbott Patient Assistance Program Application**

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Please Print Applicant Name Below:

Abbott Patient Assistance Program • 200 Abbott Park Road D-31C AP52S-1 • Abbott Park IL 60064-6214 Phone 1-800-222-6885 • • • FAX 1-866-898-1473

Part II: APPLICANT INFORMATION, continued

^	PRESCRIPTION (		INICODMATION
U.	PRESCRIPTION (	JUVERAGE	INFURINATION

Medicare	Does applic	cant have Medicare? OYes ONo			
	If yes	Check all that apply: OPart A OPart B OPart D			
	If Part D	Does the Rx benefit provide coverage for the requested medication(s)? OYes ONo			
	II Fall D	Plan name:			
Medicaid	Has applica	ant applied for financial assistance (Medicaid, SSI, etc)?			
	If you	Has the applicant been denied assistance?  OYes ONo			
	If yes	OPending OQMB OSLMB			
	If yes	Provide copy of denial dated within 2 years.			
	Does applicant have prescription coverage through Medicaid?  OYes ONo				
	If yes	Does the applicant have Medicaid coverage for the requested medication(s)? OYes ONo			
	Does applic	cant have prescription coverage through other state/government program (i.e., SPAP,			
Other State/		OYes ONo			
Government		ONot Applied OApplication Pending OWaitlisted OAccepted ODenied			
	If yes	Does the Rx benefit provide (partial or full) coverage for the requested medication(s)?			
		OYes ONo			
Private	Does applic	cant have prescription coverage through private insurance/HMO?  OYes ONo			
	If was	Does it provide (partial or full) coverage for the requested medication(s)?  OYes ONo			
	If yes	Plan name:			

## D. REPRESENTATIVE FOR PURPOSES OF PROGRAM

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

### E. CERTIFICATION

In the event that I am eligible for the Abbott Patient Assistance Program (PAP), I acknowledge that this assistance is temporary and I may be asked to reapply at designated intervals. I also understand that the Program may be changed or discontinued at any time. I agree that I will not seek reimbursement for any products dispensed under the Program from any government program or third party insurer. I acknowledge that the Abbott PAP may send me additional information about the Program, or information about alternate or additional financial assistance. I certify that the information I have provided in this Application is correct and complete.

Applicant's Signature:		Date:	

Note Applicant's Representative: If the Applicant is unable to sign, or has designated signature authority, the Applicant's Representative may sign this Application. However, only certain individuals may qualify as the Applicant's Representative for purposes of this Application. 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. An appropriate consent from the Applicant, attesting to the Representative's possession of this knowledge or information must be on file with Abbott if the Applicant's Representative is someone other than a relative of the Applicant. 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 Representative.

Signature of Applicant's Representative:		Date	):	Relationship:		

Note: If a consumer assistance or charitable organization, please list name of entity and purpose of entity under Relationship.

