





## 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](http://www.helpingpatients.org) or [www.pparx.org](http://www.pparx.org)



# Abbott Patient Assistance Program Application

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. PRESCRIBER INFORMATION Please check circle to indicate change of address.

State License #:		DEA#:	
Last Name:		First Name:	
Professional Designation:	Primary Specialty:	Gender: <input type="radio"/> M <input type="radio"/> F	
<b>Office Shipping</b> Address (No PO Box):			
City:		State:	ZIP:
<b>Office Mailing</b> Address:			
City:		State:	ZIP:
Office Contact:			
Phone:		Fax:	

### B. PRESCRIPTION INFORMATION

Product:	Strength:	Sig:	Refills: 1 year
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### C. CERTIFICATIONS

- 1. Authorization for Release of Health Information:** By signing this Application, I represent to Abbott that I have obtained all necessary Federal and state consents from my patient to allow me to release health information to the Abbott Patient Assistance Program.
- 2. Prescriber/Care Coordinator Verification:** I verify that the information provided is current, complete and accurate to the best of my knowledge. If this applicant is eligible for the Abbott Patient Assistance Program, I understand that Abbott will send the medication to my office for dispensing to the applicant. Abbott reserves the right to request additional information if needed and to change or discontinue this program at any time, without notice. By signing this form, I certify that I am prescribing the aforementioned medication for an individual participating in the Abbott Patient Assistance Program. I acknowledge that I shall not seek reimbursement for any medication dispensed hereunder from any government program or third party insurer. I also understand that the applicant's acceptance into the Abbott Patient Assistance Program is not made in exchange for any explicit or implicit agreement or understanding that Abbott Product will be used, purchased, leased, ordered, prescribed, recommended, or arranged for or provided formulary or other preferential or qualifying status.

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

Prescriber's Signature:	Date:
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## Part II: APPLICANT INFORMATION

Note: Part II of the Application must be attested to by the applicant or applicant's representative. Patients in health care institutions are not eligible. **Applicant must have valid Social Security number to participate.**

### A. CONTACT INFORMATION Please check circle to indicate change of address.

Social Security #:		Date of Birth:		Gender: <input type="radio"/> M <input type="radio"/> F	
Last Name:		First Name:		Middle Initial:	
Address: (No PO Box):					
City:			State:	ZIP:	
Phone:					

### B. FINANCIAL INFORMATION — DO NOT 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.**

<input type="text"/>	Number of people in household including yourself.	<input type="text"/>	Number of children in household under age 18.
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Monthly income for all in household:		<b>Medicare Eligible only, please complete this shaded section.</b> <b>Total Value of Assets \$ _____</b> <b>Assets considered include: checking and savings accounts, certificates of deposit, stocks &amp; bonds, savings bonds, mutual funds, IRAs or other investments, cash at home or anywhere else and the value of life insurance policies if you turned in your policies for cash right now. Do not include your home, vehicles, burial plots or personal possessions.</b>
Salary /Wages	\$ _____	
Pension	\$ _____	
Social Security	\$ _____	
Disability	\$ _____	
Unemployment	\$ _____	
Child Support / Alimony	\$ _____	
Interest / Dividends	\$ _____	
<b>Total</b>	\$ _____	



# Abbott Patient Assistance Program Application

Please Print Applicant Name Below:

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Phone 1-800-222-6885 • • • FAX 1-866-898-1473

## Part II: APPLICANT INFORMATION, continued

### C. PRESCRIPTION COVERAGE INFORMATION

Medicare	Does applicant have Medicare? <span style="float:right"><input type="radio"/>Yes <input type="radio"/>No</span>	
	If yes	Check all that apply: <span style="float:right"><input type="radio"/>Part A <input type="radio"/>Part B <input type="radio"/>Part D</span>
	If Part D	Does the Rx benefit provide coverage for the requested medication(s)? <span style="float:right"><input type="radio"/>Yes <input type="radio"/>No</span> Plan name:
Medicaid	Has applicant applied for financial assistance (Medicaid, SSI, etc)? <span style="float:right"><input type="radio"/>Yes <input type="radio"/>No</span>	
	If yes	Has the applicant been denied assistance? <span style="float:right"><input type="radio"/>Yes <input type="radio"/>No</span> <span style="float:right"><input type="radio"/>Pending <input type="radio"/>QMB <input type="radio"/>SLMB</span>
	If yes	Provide copy of denial dated within 2 years.
	Does applicant have prescription coverage through Medicaid? <span style="float:right"><input type="radio"/>Yes <input type="radio"/>No</span>	
Other State/ Government	If yes Does the applicant have Medicaid coverage for the requested medication(s)? <span style="float:right"><input type="radio"/>Yes <input type="radio"/>No</span>	
	Does applicant have prescription coverage through other state/government program (i.e., SPAP, ADAP)? <span style="float:right"><input type="radio"/>Yes <input type="radio"/>No</span> <span style="float:right"><input type="radio"/>Not Applied <input type="radio"/>Application Pending <input type="radio"/>Waitlisted <input type="radio"/>Accepted <input type="radio"/>Denied</span>	
Private	Does applicant have prescription coverage through private insurance/HMO? <span style="float:right"><input type="radio"/>Yes <input type="radio"/>No</span>	
	If yes	Does it provide (partial or full) coverage for the requested medication(s)? <span style="float:right"><input type="radio"/>Yes <input type="radio"/>No</span> 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.

<b>Applicant's Signature:</b>	Date:
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**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.

<b>Signature of Applicant's Representative:</b>	Date:	Relationship:
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**Note:** If a consumer assistance or charitable organization, please list name of entity and purpose of entity under Relationship.





## Partnership for Prescription Assistance

### PhRMA's Commitment to Patient Safety:

Good communications are the key to safe and effective use of medications. There is information you should be sure to provide to your doctor, and information you should be sure to find out about your medicine.

#### Tell each doctor you consult about:

**All your symptoms and answer all questions as accurately as you can.** This will help the doctor determine your proper treatment.

**All the medicine you take**, including non-prescription products such as aspirin or laxatives. Keep a list of your medicines, if necessary, or take the containers with you to show the doctor. This is especially important on your first visit to a doctor or if, when traveling, you need to consult someone who is not your regular doctor.

**Any bad reaction you have had to a medicine.** Adverse reactions, or side effects, may appear as blurred vision, dizziness, nausea, skin rash, or other unusual feelings you did not experience before you took the medicine.

**If you routinely drink even small amounts of alcohol each day**—such as wine with meals. Your doctor may advise against this while you are taking prescription medication.

### My Health Information

#### Using This Form

- Fill out all of the information that you know. Call a loved one or your health care provider if you need help or have questions concerning your medical information.
- Make three copies of both sides of the completed record. Keep one copy in your wallet or purse, provide one to a family member or friend, and share the other with your health care providers and pharmacists at all visits.
- You should update this record when:
  - Your contact information, insurance provider, health care provider or pharmacy changes.
  - Your medical condition changes.
  - You start or stop taking a medicine.
  - Your health care provider changes the dose of your medicine.
  - You visit the health care provider or pharmacist.

Personal Information		Pharmacy/Drug Store	
Name		Name of Store	
Date of Birth		Pharmacist	
Phone Number		Address	
Address		Phone Number	
Emergency Contact		My Allergies (e.g., medications, food)	
Name		Be sure to list adverse reactions and side effects caused by allergies	
Relationship			
Phone Number			
Insurance Provider (if applicable)		My Medical History	
Name		Be sure to include all medical conditions (e.g., illnesses, surgeries).	
Type (e.g., PPO, HMO)			
Member ID Number			
Contact Number			
Primary Care Physician		Other Physician(s)	
Name			
Address			
Phone Number			

## WHAT YOU SHOULD ASK YOUR DOCTOR

Ask your doctor these questions about your prescription medicines:

What is the name of the medicine and what is it supposed to do?

How and when should it be taken?

How long should I continue to take it?

Are there any precautions I should observe while taking the medicine? For example, are there foods or beverages I should avoid while taking the medicine. Any other medicines I should not take? Any limitations on driving vehicles or other activities?

What side effects may occur? Are there any serious side effects that should be reported to the doctor? What should I do if minor side effects occur?

How long should I wait before reporting to the doctor if my symptoms do not improve?

Can the prescription be refilled? Should I check with the doctor before refilling it?

Is there any written information available about the drug?

Use this record to keep track of your medicines. Consult your health care provider to make sure the information you provide is accurate. And be sure to provide a family member, and your health care provider and pharmacist with a copy of the information.

	Name of Medicine	Dose	Frequency (how often and when)	Purpose	Directions/Notes
• Be sure to include all prescription medicines, over-the-counter drugs, vitamins and herbal supplements.					
1					
2					
3					
4					
5					
6					
7					