abbvie PATIENT ASSISTANCE FOUNDATION

NOTE: THIS CERTIFICATION IS NOW INCLUDED WITHIN THE PROGRAM APPLICATION AVAILABLE AT WWW.ABBVIEPAF.ORG

PATIENT CERTIFICATION FOR HUMIRA® (adalimumab)

FOR PATIENTS WITH A MEDICARE PRESCRIPTION DRUG PLAN

PATIENT CERTIFICATION FOR PATIENTS WITH A MEDICARE PRESCRIPTION DRUG PLAN	
Patient Name:	
Date of Birth:	SSN (Last four digits only): XXX-XX- __ __ __ __
Prescriber Name:	Drug Requested: **HUMIRA**

Please read the following attestations and sign below if you are enrolled in a Medicare Prescription Drug Plan that offers prescription drug coverage for the requested medication under your Medicare Prescription Drug Plan for the year.

In the event that I am eligible for AbbVie Patient Assistance Foundation (the "Foundation") assistance, I acknowledge that Foundation assistance is not permanent and I may be asked to reapply annually by the Foundation. I also understand that the Foundation assistance may be changed or be discontinued at year-end 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. Specifically:

1. I understand that I will be eligible to obtain the requested medication through the Foundation for a calendar year term, assuming I continue to meet the Foundation's eligibility criteria.
2. I agree that I will not purchase this medication under my Medicare plan that provides prescription drug coverage while enrolled in this program and through the end of the calendar year of my Foundation enrollment.
3. I agree that I will not submit claims nor seek true out-of-pocket (TrOOP) credit for any of the requested medication provided under the Foundation while enrolled in this program and through the end of the calendar year of my Foundation enrollment.
4. I agree that I will provide written notification to my Medicare Prescription Drug Plan of my approval to receive a supply of the requested medication at no cost outside of the Medicare Part D benefit through the Foundation. The notification is to ensure that payment for the product is not made by my Medicare plan, that no part of the costs of the product is credited toward my TrOOP balance, and that my plan can undertake appropriate drug utilization review and medication therapy management program activities.
5. I will notify the Foundation immediately if my prescription drug coverage changes.

Patient's Name (printed):	**Signature:**	**Date:**

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 (printed):	**Representative Signature:**
Relationship to Patient:	**Date:**

PHONE: 1-800-222-6885 ● FAX: 1-866-250-2803
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