abbvie PATIENT ASSISTANCE FOUNDATION

Patient Assistance Attestation

The AbbVie Patient Assistance Foundation provides medications at no cost to individuals who meet specific program eligibility criteria.

PLEASE COMPLETE ALL SECTIONS, SIGN, AND FAX THIS FORM TO 1-800-276-9901 OR MAIL TO:
ABBVIE PATIENT ASSISTANCE FOUNDATION ● P.O. Box 270 ● Somerville, NJ ● 08876.
FOR QUESTIONS, PLEASE CALL 1-800-222-6885.

Medicare Part D Attestation

Patient Name:		
Date of Birth:	SSN (Last four digits only):	
Prescriber Name:	Drug Requested:	Patient ID:

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 the AbbVie Patient Assistance Foundation (the "Foundation"), 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 the remainder of the calendar year, 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 for the remainder of the calendar year.
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 for the remainder of the calendar year.
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 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 Patient'.

Patient's Personal Representative's Name (printed):	**Signature:**
Relationship to Patient:	**Date:**