Abbott Patient Assistance Foundation's Kaletra® (lopinavir/ritonavir) & Norvir® (ritonavir) Patient Assistance Application

The Abbott Patient Assistance Foundation provides Abbott 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 Abbott 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. Incomplete applications will be returned for further information.
- ☐ Physician's signature/date is required on the application.
- ☐ Patient's signature/date is required at the bottom of the application.
- ☐ For Norvir Assistance: Financial information section is not required.

Fax or mail the completed application and documentation to:

Abbott Patient Assistance Foundation
PO Box 270
Somerville, NJ 08876
Fax: 1-866-483-1305
Phone: 1-800-222-6883

Upon receipt of a completed application, the physician and patient will be notified of program eligibility. A supply of medication will be shipped to the prescriber's office. It is the responsibility of the physician to reorder 3 weeks prior to the patient requiring further medication.

Please contact us at 1-800-222-6885 Mon-Fri 8am-5pm CST for additional assistance.

For alternative shipping options, please contact the Abbott Patient Assistance Foundation at 1-800-222-6885.

©2008 Abbott Laboratories and the Abbott Patient Assistance Foundation | 490-183612 | August 2008 | Printed in U.S.A

Abbott
Patient Assistance Foundation

Kaletra® (lopinavir/ritonavir) & Norvir® (ritonavir) Patient Assistance Application

Abbott Patient Assistance Foundation • PO Box 270 • Somerville NJ 08876
Phone:1-800-222-6885 • Fax: 1-866-483-1305

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

Part I: INFORMATION FROM PRESCRIBER

A. PRESCRIBER INFORMATION

☐ Please check box to indicate change of address.

State License #: Expiration Date DEA#:

First Name: M.I. Last Name:

Professional Designation: Primary Specialty:

Office Shipping Address: City: State: ZIP:

Office Mailing Address: City: State: ZIP:

Office Contact and Title: Phone: Fax:

B. PRODUCT INFORMATION

Product: _____ Strength: _____ Sig: _____ Reorders Allowed: Up to 1 year

C. CERTIFICATIONS

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

1. Authorization for Release of Health Information: By signing this form, I represent to the Abbott Patient Assistance 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 Abbott Patient Assistance Foundation and its contracted third parties.
2. Physician/Care Coordinator Verification: 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 Abbott Patient Assistance Foundation (the "Foundation") in writing immediately if the status of my State License Number registration changes. If this applicant is eligible for the Abbott Patient Assistance Foundation assistance, I understand that the Foundation will send the medication to my office for dispensing to the patient. The Foundation reserves the right to request additional information if needed and to change or discontinue the assistance at any time, without notice. By signing this form, I certify that I am prescribing the aforementioned medication for an individual participating in the Foundation. 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 acceptanceby the Abbott Patient Assistance Foundation 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. I understand that I may not delegate signature authority. I certify that treatment with this medication is medically necessary.

Prescriber's Signature: _____ Date_____

Part II: PATIENT INFORMATION

A. PATIENT INFORMATION

☐ Please check box to indicate change of address

Social Security #: First Name: M.I. Last Name:

Address: (No PO Box): City: State: ZIP:

Phone: Gender: ☐ M ☐ F Date of Birth:

B. FINANCIAL INFORMATION — For Kaletra Assistance Only

Monthly income for all in household: Salary/Wages $ _____ Disability $ _____ Social Security $ _____ Other $ _____

Circle # of people in household including yourself: 1 2 3 4 5

C. PRESCRIPTION COVERAGE INFORMATION

Private Drug Coverage Insurance	Medicare	Medicaid	Other State/Government – ADAP
☐ Yes ☐ No	☐ Yes, If yes, list total assets, not including home, vehicles, or burial plot $_____ ☐ No ☐ Medicare Part A ☐ Medicare Part B ☐ Medicare Part D (name): _____	☐ Yes ☐ No Circle # in household under 18 years old. 0 1 more	☐ Yes ☐ No ☐Pending ☐Waitlisted ☐Denied

D. REPRESENTATIVE FOR PURPOSES OF PROGRAM

I permit the Abbott Patient Assistance Foundation 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: _____ Phone # _____

E. CERTIFICATION

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 Abbott Patient Assistance Foundation. In the event that I am eligible for Foundation assistance, I acknowledge that this assistance is temporary and that I may be asked to reapply at designated intervals by the Foundation. I also understand that the Foundation assistance may change or be discontinued at any time 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. I certify that the information I have provided in this form is accurate and complete. I understand that by completing this form I am not guaranteed eligibility to receive medication from the Foundation. I agree that I will notify the Foundation if my insurance or financial situation changes.

Patient's Name (printed):_____ Patient's 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 Applicant.

Patient's Representative Signature: _____ Relationship: _____ Date: _____

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 applicant's information to the Foundation and its contracted third parties. The Foundation urges all entities disclosing information about the applicant to consult with legal counsel prior to relying on this form.

©2008 Abbott Laboratories and the Abbott Patient Assistance Foundation | 490-183612 | August 2008 | Printed in U.S.A