Abbott Patient Assistance Foundation’s Lupron Depot® and Lupron Depot-PED® (leuprolide acetate for depot suspension) Patient Assistance Program (PAP) Application

The Abbott Patient Assistance Foundation provides free Abbott medicines, medical nutrition, and diabetes care products 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 free products 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.
☐ Attach proof of income (tax return, W2, pay stub) for all in household.
☐ Prescriber’s signature/date is required on the application.
☐ Patient’s signature/date is required at the bottom of the application.
☐ Provide a copy of Medicare card or letter of Medicaid and/or Social Security denial, if applicable.

Fax or mail the completed application and documentation to:

Abbott Patient Assistance Foundation
PO Box 181010
Louisville, KY 40261
Fax: 1-866-884-5909
Phone: 1-866-441-4138

Upon receipt of a completed application, the prescriber 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 prescriber or office staff to reorder 3 weeks prior to the patient requiring further medication.

Please contact us at 1-866-441-4138 Mon-Fri 8:30am-6pm EST for additional assistance.
A. PRESCRIBER INFORMATION

- **State License #:**
- **Expiration Date:**
- **DEA#:**

<table>
<thead>
<tr>
<th>First Name:</th>
<th>M.I.</th>
<th>Last Name:</th>
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<tbody>
<tr>
<td>Professional Designation:</td>
<td>Primary Specialty:</td>
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**Office Shipping Address:**
- **City:**
- **State:**
- **ZIP:**

**Office Contact and Title:**
- **Phone:**
- **Fax:**

**Office Mailing Address:**
- **City:**
- **State:**
- **ZIP:**

**Office Shipping Address:**
- **City:**
- **State:**
- **ZIP:**

**Professional Designation:**
- **Primary Specialty:**

**State License #:**
- **Expiration Date:**
- **DEA#:**

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B. PRODUCT INFORMATION

- **Lupron Depot 3.75mg**
- **Lupron Depot 11.25mg**
- **Lupron Depot 7.5 mg**
- **Lupron Depot 22.5 mg**
- **Lupron Depot 3 month 11.25mg**
- **Lupron Depot 4 month 30mg**
- **Lupron Depot PED 7.5mg**
- **Lupron Depot PED 15mg**

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C. CERTIFICATIONS

**Prescriber's Signature:**
- **Date:**

A. PATIENT INFORMATION

- **Social Security #:**
- **Address: (No PO Box):**
- **Phone:**
- **Gender: **
- **F**
- **M**
- **Date of Birth:**

**Do Not Send Originals**

- **Monthly income for all household:**
  - **Salary/Wages:**
  - **Disability:**
  - **Social Security:**
  - **Other:**

**Circle # of people in household including yourself:**

1 2 3 4 5

B. FINANCIAL INFORMATION

- **Private Drug Coverage Insurance:**
  - **Yes**
  - **No**

- **If yes, list total assets, not including home, vehicles, or burial plot:**

**Other State/Government**

- **Yes**
- **No**

If, yes, please indicate type:

C. PRESCRIPTION COVERAGE INFORMATION

- **Private Drug Coverage Insurance:**
  - **Yes**
  - **No**

- **If, yes, list total assets, not including home, vehicles, or burial plot:**

**Other State/Government**

- **Yes**
- **No**

If, yes, please indicate type:

D. REPRESENTATIVE FOR PURPOSES OF PROGRAM

- **Name:**
- **Relationship:**
- **Phone #:**

E. CERTIFICATION

I understand that any assistance in the form of free product is contingent upon my ability to meet the eligibility criteria for the Abbott Patient Assistance Foundation. 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 may change or discontinue assistance at any time, without notice. I certify that I shall not seek reimbursement for any medication dispensed hereunder from any government program or third party insurer. I understand that the applicant's acceptance into 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, or arranged for or provided by another organization or vendor. I certify that I may not delegate signature authority. I understand that treatment with this medication is medically necessary.

Patient’s Name (printed): __________________________  Patient’s Signature: __________________________  Date:________________________

Personal Representative Authorization (if Applicable):

I certify that the individual named is a Personal Representative of the applicant: __________________________________________________________________________

Patient’s Representative Signature: __________________________________________________________  Relationship: __________________________  Date: __________________________

Notice to Health Care Providers: 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.

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