



# **Abbott Patient Assistance Foundation's Lupron Depot<sup>®</sup> and Lupron Depot-PED<sup>®</sup> (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**
☐ 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**

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

**C. CERTIFICATIONS**

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

- 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.
- 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 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, 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: \_\_\_\_\_

**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: <input type="checkbox"/> M <input type="checkbox"/> F | Date of Birth: |            |

**B. FINANCIAL INFORMATION**

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.

**DO NOT SEND ORIGINALS**

|                                      |                       |                     |                                                                 |
|--------------------------------------|-----------------------|---------------------|-----------------------------------------------------------------|
| Monthly income for all in household: | Salary/Wages \$ _____ | Disability \$ _____ | Circle # of people in household including yourself<br>1 2 3 4 5 |
|                                      | Social \$ _____       | Other \$ _____      |                                                                 |

**C. PRESCRIPTION COVERAGE INFORMATION**

| Private Drug Coverage Insurance                                  | Medicare                                                                                                                                      | Medicaid                                                 | Other State/Government                                   |
|------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------|
| <input type="checkbox"/> Yes <input type="checkbox"/> No         | <input type="checkbox"/> Yes, If yes, list total assets, not including home, vehicles, or burial plot \$ _____<br><input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If enrolled are injectables covered by pharmacy benefits? Yes No | <input type="checkbox"/> Medicare Part A <input type="checkbox"/> Medicare Part B <input type="checkbox"/> Medicare Part D (name): _____      | Children under 18 in household 0 1 2 3 more              | If, yes, please indicate type:                           |

**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 free product 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 free 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 Program, including a health care provider or pharmacy receiving the free medicines, 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.