



Abbott Patient Assistance Foundation's Application for Lupron Depot[®] and Lupron Depot-PED[®] (leuprolide acetate for depot suspension)

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. Make a copy before sending as no documents will be returned.
- Attach current proof of income (tax return, W2, pay stub) for all in household.
- Patient's signature/date is required on the application.
- Prescriber's signature/date is required on 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 270
Somerville, NJ 08876
Fax: (866) 483-1305
Phone: (800) 222-6885

Upon receipt of a completed application, the prescriber and patient will be notified of program eligibility. If patient is eligible for assistance, a supply of medication will be shipped to the prescriber's office. It is the responsibility of the prescriber or office staff to reorder at least 7 business days prior to the patient requiring further medication.

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



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

PATIENT INFORMATION

Patient Name, Gender, Telephone Number, Patient Address, City, State, Zip, Date of Birth, SSN, Medicare enrollment, Insurance information, Total Monthly Income, Signature, Date, Household size.

Representative For Purposes of Program (If applicable)

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:

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. Patient's Representative Signature: Relationship: Date:

Medicine Requested

Lupron Depot 3.75 mg, Lupron Depot 7.5 mg, Lupron Depot 11.25 mg 3 month, Lupron Depot 22.5 mg 3 month, Lupron Depot 30mg 4 month, Lupron Depot 45mg 6 month, Lupron Depot PED 11.25mg 3 month, Lupron Depot PED 30mg 3 month, Lupron Depot PED 7.5 mg, Lupron Depot PED 11.25 mg, Lupron Depot PED 15 mg

PRESCRIBER INFORMATION

Name and Professional Designation of Prescriber, DEA#, SLN Expiration Date, Shipping Address, Mailing Address, Office Contact Person, Telephone Number, Fax Number, Authorization for Release of Health Information, Prescriber's Signature, 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.