



**Abbott Patient Assistance
Foundation Application
for
AndroGel[®] (testosterone gel) 1%,
AndroGel[®] (testosterone gel) 1.62%
Creon[®] (pancrelipase delayed release capsules)
Prometrium[®] (progesterone, USP)**

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.
- 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.
- If requesting Androgel,
 - o Include prescription on prescribers Rx blank
 - o Enclose a copy of government issued ID (i.e. drivers license, state id, etc)

**Fax or mail the completed application and documentation
to:**

Abbott Patient Assistance Foundation
P.O. Box 66550
St. Louis, MO 63166-6550
Phone: 1-800-256-8918
FAX: 1-800-276-9901

Please contact us at 1-800-256-8918, Monday thru Friday 8:00 am to 5:00 pm Central Time for additional assistance.

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Applications are available by calling 1-800-256-8918 or visiting www.abbottpatientassistancefoundation.org

HEALTHCARE PROVIDER INFORMATION								
DEA Number:		Physician Name: (First)			(Last)			
Address:		City:		State:	Zip:			
Email Address:		Office Contact:		Phone:	Fax:			
MEDICATION INFORMATION – Please complete Prescription/Order Form on second page								
Requested product: <input type="checkbox"/> AndroGel [®]		<input type="checkbox"/> CREON [®]		<input type="checkbox"/> PROMETRIUM [®]				
<i>The product listed above must be shipped to the patient's address</i>		<i>The products listed above may be shipped to either:</i>						
		Licensed Prescriber's Office <input type="checkbox"/>		Patient's Address <input type="checkbox"/>				
Patient diagnosis (ICD.9 code) :								
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 or the patient's home. 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 by 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.								
Signature of Physician:					Date			
PATIENT INFORMATION – Please complete to fullest extent possible. If an item does not apply, please mark N/A on that line.								
SSN (Last 4 Digits): XXX-XX-		Patient Name: (First)		(Last)				
Address:		Home Phone:		Work Phone:				
City:		State:		Zip:				
US Resident: <input type="checkbox"/> Yes <input type="checkbox"/> No		Date of Birth: ____/____/____		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female				
Veteran: <input type="checkbox"/> Yes <input type="checkbox"/> No		Disabled: <input type="checkbox"/> Yes <input type="checkbox"/> No						
FINANCIAL INFORMATION – Please attach a copy of household's most recent year tax return (1040, 1040EZ, 1099, etc.)								
Total # of people in household (include self): _____		Total Assets per Household: _____						
		Includes bank account, IRA, annuity, stocks, bonds, etc.						
LIST ALL SOURCES OF GROSS MONTHLY AMOUNTS PER HOUSEHOLD								
Salary/Wages (All Sources)	\$	ATTACH		Disability	\$	ATTACH		
Pension/Retirement	\$	PROOF		Alimony/Child Support	\$	PROOF		
Social Security	\$	OF INCOME		Unemployment Compensation	\$	OF INCOME		
Total Gross <u>Monthly</u> Household Income:								
INSURANCE INFORMATION – Please include a copy of patient's Insurance Card and Prescription Card (front and back)								
	Medical Coverage(circle one)		Prescription Drug Coverage for Requested Product (circle one)		Eligibility Status E=Eligible P=Pending I=Ineligible (reason)	Policy Number	Phone Number	Contact Person
Medicare	Y N		Y N				()	
Medicare Part D	Y N		Y N				()	
Medicaid	Y N		Y N				()	
Private Insurance	Y N		Y N				()	
State Elderly Drug Assistance	Y N		Y N				()	
State Children Health Insurance	Y N		Y N				()	
Veterans Assistance	Y N		Y N				()	
Other:	Y N		Y N				()	
APPLICANT DECLARATION								
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. The Foundation will use my information for purposes of determining patient assistance eligibility. I understand that I need to give my authorization to take part in the Foundation's Patient Assistance Program ("PAP") (should I qualify). I know I may cancel this authorization at any time by writing to the Abbott Patient Assistance Foundation at P.O. Box 66550 St. Louis, MO 63166-6550. If I cancel this Authorization, I can no longer participate in the PAP. This authorization shall be valid for 10 years from the date of the signature on this form. I authorize the Foundation to use my information: (i) to determine eligibility for the PAP, (ii) to account for my withdrawal if I decide to stop participating in the PAP, (iii) to administer and maintain the high quality of the PAP, and (iv) as otherwise required or permitted by law. I agree that the Foundation does not have any liability in providing PAP services to me.								
Signature of Patient or Legal Guardian:						Date:		



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Prescription and Order Form

Section 1 - Patient Information				
Patient Name:		SSN (Last 4 Digits): XXX-XX-		
Street Address:		Date of Birth:		
City:	State:	Zip:	Phone: ()	
Product Requested	Instructions	Quantity	Bottles Req.	Refills
CREON[®] (pancrelipase) Delayed-Release Capsules <input type="checkbox"/> 3,000 Lipase Units <input type="checkbox"/> 6,000 Lipase Units <input type="checkbox"/> 12,000 Lipase Units <input type="checkbox"/> 24,000 Lipase Units			100 <i>Product dispensed in 100 ct stock bottles</i>	
PROMETRIUM[®] (progesterone, USP) <input type="checkbox"/> 100MG <input type="checkbox"/> 200MG			100 <i>Product dispensed in 100 ct stock bottles</i>	
AndroGel[®] (testosterone gel) For Androgel the following guidelines apply: <ul style="list-style-type: none"> • Use prescribers blank form & submit with application • Enclose a copy of a government issued ID (Driver License, State ID, Military ID, etc) of the patient • Products will be shipped to the patient's address <p>■ AndroGel[®] 1.62 % Pump Topical</p> <p>AndroGel[®] 1% Topical</p> <p>■ 2.5gm ■ 30 packets per box ■ 5 gm ■ 2x75gm pump (1 metered dose is 1.25gm)</p>				
Physician Signature: <div style="display: flex; justify-content: space-between; align-items: center;"> <div style="border-bottom: 1px solid black; width: 40%;"></div> <div style="text-align: center;">/ /</div> <div style="border-bottom: 1px solid black; width: 40%;"></div> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> (substitution allowed) (date) (dispense as written) </div>				
Section 2 - Physician and Prescription Information				
Physician Name:		DEA/State License #:	Phone: ()	Fax: ()
Address: (no P.O. Box)		City:	State:	Zip:
Medication Information				
Patient allergies: <input type="checkbox"/> No Known _____ Please list the names of other medications the patient is currently taking: <input type="checkbox"/> None _____ _____ _____				

Please fax this form to 1-800-276-9901 or mail to address above
If you are a New York or New Jersey Prescriber, please use an original New York State or New Jersey State Prescription Form.