Abbott Nutrition
Patient Assistance Program Application

The Abbott Nutrition Patient Assistance Program is designed to provide supplemental product at no cost to eligible patients experiencing financial difficulties. Eligible patients must:

(1) Be a U.S. resident and have no healthcare insurance coverage for the requested product;
(2) Have no access to alternative sources of coverage or funding;
(3) Meet financial eligibility criteria; and
(4) Require 100% of their caloric needs from the requested product.

All applications are reviewed on a case-by-case basis to support the Program's purpose of providing products at no cost to individuals in need. Abbott Nutrition products available through the Program are those listed within this application and should be used under medical supervision.

Checklist for submitting an application:

- ☐ Ensure all sections of the application are completed. Make a copy and retain for your records 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.
- ☐ Contact PATHWAY Reimbursement Support 1-800-558-7677 to confirm if patient has coverage

Fax or mail the completed application and documentation to:

Abbott Nutrition Patient Assistance Program
P.O. Box 4280, Gaithersburg, MD 20885-4280
Fax: 866-734-7353
Phone: 866-801-5657

Upon receipt of a completed application, the patient will be notified of program eligibility. The approved supply of product will be shipped to the patient's home unless otherwise specified.

Please contact us at 866-801-5657, Mon-Fri 8:30 am-5pm EST for additional assistance.

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PATIENT INFORMATION

Patient Name _______ Gender: Male ☐ Female ☐ Telephone Number _______

Patient Address (No PO boxes please) _______ City _______ State _______ Zip _______

Date of Birth: _______________ **SSN (Last four digits only):** XXX-XX- ☐

Are you enrolled in Medicare? ☐ Yes ☐ No **If YES, check all that apply:** ☐ Part A ☐ Part B ☐ Part D

Do you have private insurance coverage? ☐ Yes ☐ No **Are you covered by a state Medicaid Program?** ☐ Yes ☐ No

Total Monthly Income for your entire household $ _______

Attach the most current copies of income documentation for you and all dependent persons. Acceptable documents include: Federal Tax Return, SSA 1099, W2, pay stubs or benefits award letter.

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 Nutrition Patient Assistance Program ("Program"). In the event that I am eligible for patient assistance, I acknowledge that this assistance is temporary and that I may be asked to reapply at designated intervals by the Program. I also understand that the Program 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 Program 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 the product from the Program. I agree that I will notify the Program if my insurance or financial situation changes. The Program 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 Program (should I qualify). I know I may cancel this authorization at any time by writing to the Abbott Nutrition Patient Assistance Program at P.O. Box 4280, Gaithersburg, MD 20885-4280. If I cancel this Authorization, I can no longer participate in the Program. This authorization shall be valid for 10 years from the date of the signature on this form. I authorize the Program to share my information with Abbott for the following purposes: (i) to determine eligibility for the Program, (ii) to account for my withdrawal if I decide to stop participating in the Program, (iii) to administer and maintain high quality service, and (iv) as otherwise required or permitted by law. I agree that the Abbott Nutrition Patient Assistance Program does not have any liability in providing Program services to me.

Patient's Signature: _______________ **Date:** _______________

Number of people in your household (including yourself) ☐ **Number in household under 18** ☐

Representative For Purposes of Program (If applicable)

I permit the Abbott Nutrition Patient Assistance Program 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. 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 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.

Patient's Representative Signature: _______________ **Relationship:** _______________ **Date:** _______________

Administration Method and Quantity

Tube or Oral _____________ Estimated Caloric Need of Patient (Daily): ___________ % of Caloric Need to be Met by Product: ____________

Diagnosis

Primary Diagnosis: ____________________________________ **Indications for Use:** ________________________________

Please provide both a primary diagnosis (i.e. HIV/AIDS, cancer, diabetes, etc.) and the indications for use (i.e. involuntary weight loss, cachexia, etc.) that requires the need for nutrition therapy.

Product Requested

- ☐ Ensure Original
- ☐ Ensure Plus
- ☐ Promote
- ☐ Promote with Fiber
- ☐ Glucerna Shake
- ☐ Glucerna 1.2 Cal
- ☐ Hi Cal
- ☐ Jevity 1.2 Cal
- ☐ Nepro with Carb Steady
- ☐ Osmolite 1.2 Cal
- ☐ Perative
- ☐ Pivot 1.5 Cal
- ☐ Pulmocare
- ☐ Suplena
- ☐ TwoCal
- ☐ Vital 1.5 Cal
- ☐ Vital AF 1.2 Cal
- ☐ Vital High Protein
- ☐ EleCare
- ☐ EleCare Jr.
- ☐ PediaSure
- ☐ PediaSure with Fiber
- ☐ PediaSure 1.5 Cal
- ☐ PediaSure Enteral Formula 1.0 Cal with Fiber
- ☐ PediaSure Peptide 1.0 Cal
- ☐ PediaSure Peptide 1.5 Cal
- ☐ Calcilo XD
- ☐ Cyclinex-1
- ☐ Cyclinex-2
- ☐ Glutarex-1
- ☐ Glutarex-2
- ☐ Hominex-1
- ☐ Hominex-2
- ☐ I-Valex-1
- ☐ I-Valex-2
- ☐ Ketonex-1
- ☐ Ketonex-2
- ☐ Phenex-1
- ☐ Phenex-2
- ☐ Pro-Phree
- ☐ Propimex-1
- ☐ Propimex-2
- ☐ ProViMin
- ☐ RCF
- ☐ Tyrex-1
- ☐ Tyrex-2

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PRESCRIBER INFORMATION

Patient Name

Name and Professional Designation of Prescriber | **DEA# (if none available, State License Number)** | **SLN Expiration Date**

Shipping Address (No PO boxes please) | **City** | **State** | **Zip**

Mailing Address | **City** | **State** | **Zip**

Office Contact Person | **Telephone Number** | **Fax Number**

1. **Authorization for Release of Health Information: By signing this form, I represent to the Abbott Nutrition Patient Assistance Program 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 Nutrition Patient Assistance Program 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 Nutrition Patient Assistance Program (the "Program") in writing immediately if the status of my State License Number registration changes. If this applicant is eligible for the Program assistance, I understand that the Program will send the nutrition product directly to the patient's home unless I request that it be sent to my office for dispensing to the patient. The Program 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 Program. 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 Program 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:** ____________________

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