Abbott Patient Assistance Program • Application Instruction Page
Kaletra® (lopinavir/ritonavir) & Norvir® (ritonavir)

The Kaletra & Norvir Patient Assistance Programs provide medications at no charge to individuals in need. All applications are reviewed on a case-by-case basis. Eligibility for the Kaletra Patient Assistance Program is based on Federal Poverty Guidelines adjusted for household size. The provision of free medication is a philanthropic act sponsored by Abbott.

Please complete the entire application. Failure to complete any section will delay the review process. Incomplete applications will be returned for further information.

Part I. Prescriber Information: To be completed by the prescriber. Please carefully review the certifications and then sign and date the application.

The health care professional responsible for completing the application and associated documentation shall provide such information in accordance with all applicable Federal and state laws, including, but not limited to, the Health Insurance Portability and Accountability Act of 1996.

Part II. Applicant Information: To be completed by the applicant or applicant's representative.

1. Please carefully review the applicant certification and then sign and date the application. Provide documentation of authorization if party signing for applicant is someone other than a relative of applicant.
2. Complete Prescription Coverage Information.
3. For Kaletra assistance: Please provide financial information.

Please ensure that the application is complete.
Fax or mail the completed application to Abbott for eligibility review.

Approval & Shipment
The prescriber's office and applicant will be notified of applicant eligibility. Upon approval into the Abbott Patient Assistance Program, a supply of medication will be shipped to the prescriber's office for dispensing to the applicant.

Note: For alternate shipping options please contact the Abbott Patient Assistance Program at 1-800-222-6885.

Refill & Requalification
It is the responsibility of the prescriber or office staff to contact Abbott 3 weeks prior to the applicant requiring further medication. If within the applicant's defined eligibility period, an additional supply of medication will be shipped to the prescriber's office. If not within the eligibility period, the prescriber will be sent a re-enrollment application on behalf of the applicant.

Questions & Comments
Please contact us:
Phone: 1-800-222-6885
Fax: 1-866-483-1305 (toll-free)
Hours: Mon-Fri 8am-5pm CST

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

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Abbott

Abbott Patient Assistance Program Application
Kaletra® (lopinavir/ritonavir) & Norvir® (ritonavir)

For Abbott use only

Request #:_______________

Abbott Patient Assistance Program • 200 Abbott Park Road D-31C AP52S-1 • Abbott Park IL 60064-6214
Phone 1-800-222-6885 • FAX 1-866-483-1305

Part I: INFORMATION FROM PRESCRIBER

A. PRESCRIBER INFORMATION

❍ Please check circle to indicate change of address.

State License #:		DEA#:	
Last Name:		First Name:	
Professional Designation:	Primary Specialty:		Gender: ❍M ❍F
Office Shipping Address (No PO Box):			
City:		State:	ZIP:
Office Mailing Address:			
City:		State:	ZIP:
Office Contact:			
Phone:		Fax:	

B. PRESCRIPTION INFORMATION

Product:	Strength:	Sig:	Refills: 1 year

C. CERTIFICATIONS

1. **Authorization for Release of Health Information:** By signing this Application, I represent to Abbott that I have obtained all necessary Federal and state consents from my patient to allow me to release health information to the Abbott Patient Assistance Program.
2. **Prescriber/Care Coordinator Verification:** I verify that the information provided is current, complete and accurate to the best of my knowledge. If this applicant is eligible for the Abbott Patient Assistance Program, I understand that Abbott will send the medication to my office for dispensing to the applicant. Abbott reserves the right to request additional information if needed and to change or discontinue this program at any time, without notice. By signing this form, I certify that I am prescribing the aforementioned medication for an individual participating in the Abbott Patient Assistance 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 into the Abbott Patient Assistance 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.

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

Prescriber's Signature:	Date:

Part II: APPLICANT INFORMATION

Note: Part II of the Application must be attested to by the applicant or applicant's representative. Patients in health care institutions are not eligible.

A. CONTACT INFORMATION

❍ Please check circle to indicate change of address.

Social Security #:	Date of Birth:	Gender: ❍M ❍F
Last Name:	First Name:	Middle Initial:
Address: (No PO Box):		
City:	State:	ZIP:
Phone:		

B. FINANCIAL INFORMATION – for Kaletra Assistance Only

[ ] **Number of people in household including yourself.** [ ] **Number of children in household under age 18.**

Monthly income for all in household:	
Salary /Wages	$
Pension	$
Social Security	$
Disability	$
Unemployment	$
Child Support / Alimony	$
Interest / Dividends	$
Total	$

Medicare Eligible only, please complete this shaded section.
Total Value of Assets $____________________
Assets considered include: checking and savings accounts, certificates of deposit, stocks & bonds, savings bonds, mutual funds, IRAs or other investments, cash at home or anywhere else and the value of life insurance policies if you turned in your policies for cash right now. Do not include your home, vehicles, burial plots or personal possessions.

Please see full prescribing information available at www.KALETRA.com or by calling Abbott Medical Information at 1-800-633-9110.

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Abbott Patient Assistance Program Application Kaletra® (lopinavir/ritonavir) & Norvir® (ritonavir)	 **Please Print Applicant Name Below:**

Abbott Patient Assistance Program • 200 Abbott Park Road D-31C AP52S-1 • Abbott Park IL 60064-6214
Phone 1-800-222-6885 • FAX 1-866-483-1305

Part II: APPLICANT INFORMATION, continued

C. PRESCRIPTION COVERAGE INFORMATION

Medicare	Does applicant have Medicare?		❍Yes ❍No
	If yes	Check all that apply:	❍Part A ❍Part B ❍Part D
	If Part D	Does the Rx benefit provide coverage for the requested medication(s)?	❍Yes ❍No
		Plan Name:	
Medicaid	Has applicant applied for financial assistance (Medicaid, SSI, etc)?		❍Yes ❍No
	If yes	Has the applicant been denied assistance?	❍Yes ❍No ❍Pending ❍QMB ❍SLMB
	If yes	Provide copy of denial dated within 2 years.	
	Does applicant have prescription coverage through Medicaid?		❍Yes ❍No
	If yes	Does the applicant have Medicaid coverage for the requested medication(s)?	❍Yes ❍No
Other State/ Government	Does applicant have prescription coverage through other state/government program (i.e., SPAP, ADAP)?		❍Yes ❍No ❍Not Applied ❍Application Pending ❍Waitlisted ❍Accepted ❍Denied
	If yes	Does the Rx benefit provide (partial or full) coverage for the requested medication(s)?	❍Yes ❍No
Private	Does the applicant have prescription coverage through private insurance/HMO?		❍Yes ❍No
	If yes	Does it provide (partial or full) coverage for the requested medication(s)?	❍Yes ❍No
		Plan name:	
Current antiretroviral medications:			

D. REPRESENTATIVE FOR PURPOSES OF PROGRAM

I permit the Abbott 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:
Name:	Relationship:

E. CERTIFICATION

In the event that I am eligible for the Abbott Patient Assistance Program (PAP), I acknowledge that this assistance is temporary and I may be asked to reapply at designated intervals. I also understand that the Program may be changed or discontinued at any time. I agree that I will not seek reimbursement for any products dispensed under the Program from any government program or third party insurer. I acknowledge that the Abbott PAP may send me additional information about the Program, or information about alternate or additional financial assistance. I certify that the information I have provided in this Application is correct and complete.

Applicant's Signature:	Date:

Note Applicant's Representative*: If the Applicant is unable to sign, or has designated signature authority, the Applicant's Representative may sign this Application. However, only certain individuals may qualify as the Applicant's Representative for purposes of this Application. 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. An appropriate consent from the Applicant, attesting to the Representative's possession of this knowledge or information must be on file if the Applicant's Representative is someone other than a relative of the Applicant. A person or entity in the supply chain of the product to be received through the PAP, including a health care provider or pharmacy receiving the free medicines, may not be named a Representative.*

Signature of Applicant's Representative:	Date:	Relationship

Note: If a consumer assistance or charitable organization, please list name of entity and purpose of entity under Relationship.

Please see full prescribing information available at www.KALETRA.com or by calling Abbott Medical Information at 1-800-633-9110.
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