Form **990-PF**
Department of the Treasury
Internal Revenue Service

Return of Private Foundation

or Section 4947(a)(1) Trust Treated as Private Foundation

▶ Do not enter Social Security numbers on this form as it may be made public.

▶ Information about Form 990-PF and its separate instructions is at www.irs.gov/form990pf.

OMB No 1545-0052

2013

Open to Public Inspection

For calendar year 2013 or tax year beginning , and ending

Name of foundation

ABBVIE PATIENT ASSISTANCE FOUNDATION

A Employer identification number

26-1215559

Number and street (or P O. box number if mail is not delivered to street address) | Room/suite

D031C AP31-3NW, 1 N WAUKEGAN ROAD

B Telephone number

847-938-2906

City or town, state or province, country, and ZIP or foreign postal code

NORTH CHICAGO, IL 60064

C If exemption application is pending, check here ▶ ☐

G Check all that apply: ☐ Initial return ☐ Initial return of a former public charity ☐ Final return ☐ Amended return ☐ Address change ☒ Name change

D 1. Foreign organizations, check here ▶ ☐

2. Foreign organizations meeting the 85% test, check here and attach computation ▶ ☐

H Check type of organization: ☒ Section 501(c)(3) exempt private foundation ☐ Section 4947(a)(1) nonexempt charitable trust ☐ Other taxable private foundation

E If private foundation status was terminated under section 507(b)(1)(A), check here ▶ ☐

I Fair market value of all assets at end of year (from Part II, col. (c), line 16) ▶$ 53,271,158.

J Accounting method: ☒ Cash ☐ Accrual ☐ Other (specify) (Part I, column (d) must be on cash basis.)

F If the foundation is in a 60-month termination under section 507(b)(1)(B), check here ▶ ☐

Part I Analysis of Revenue and Expenses (The total of amounts in columns (b), (c), and (d) may not necessarily equal the amounts in column (a).)

		(a) Revenue and expenses per books	(b) Net investment income	(c) Adjusted net income	(d) Disbursements for charitable purposes (cash basis only)
Revenue	1 Contributions, gifts, grants, etc., received	810,053,325.		N/A	
	2 Check ▶ ☐ If the foundation is not required to attach Sch. B				
	3 Interest on savings and temporary cash investments				
	4 Dividends and interest from securities				
	5a Gross rents				
	b Net rental income or (loss)				
	6a Net gain or (loss) from sale of assets not on line 10				
	b Gross sales price for all assets on line 6a				
	7 Capital gain net income (from Part IV, line 2)		0.		
	8 Net short-term capital gain				
	9 Income modifications				
	10a Gross sales less returns and allowances				
	b Less. Cost of goods sold				
	c Gross profit or (loss)				
	11 Other income				
	12 **Total.** Add lines 1 through 11	810,053,325.	0.		
Operating and Administrative Expenses	13 Compensation of officers, directors, trustees, etc.	0.	0.		0.
	14 Other employee salaries and wages				
	15 Pension plans, employee benefits				
	16a Legal fees				
	b Accounting fees				
	c Other professional fees				
	17 Interest				
	18 Taxes				
	19 Depreciation and depletion				
	20 Occupancy				
	21 Travel, conferences, and meetings				
	22 Printing and publications				
	23 Other expenses STMT 1	4,614,575.	0.		4,614,575.
	24 **Total operating and administrative expenses.** Add lines 13 through 23	4,614,575.	0.		4,614,575.
	25 Contributions, gifts, grants paid	783,366,952.			783,366,952.
	26 **Total expenses and disbursements.** Add lines 24 and 25	787,981,527.	0.		787,981,527.
	27 Subtract line 26 from line 12:				
	a Excess of revenue over expenses and disbursements	22,071,798.			
	b **Net investment income** (if negative, enter -0-)		0.		
	c **Adjusted net income** (if negative, enter -0-)			N/A	

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Part II Balance Sheets Attached schedules and amounts in the description column should be for end-of-year amounts only

		Beginning of year	End of year	
		(a) Book Value	(b) Book Value	(c) Fair Market Value
Assets	1 Cash - non-interest-bearing	403,567.	5,478,020.	5,478,020.
	2 Savings and temporary cash investments			
	3 Accounts receivable ▶			
	Less: allowance for doubtful accounts ▶			
	4 Pledges receivable ▶			
	Less: allowance for doubtful accounts ▶			
	5 Grants receivable			
	6 Receivables due from officers, directors, trustees, and other disqualified persons			
	7 Other notes and loans receivable ▶			
	Less: allowance for doubtful accounts ▶			
	8 Inventories for sale or use	30,396,248.	47,793,138.	47,793,138.
	9 Prepaid expenses and deferred charges			
	10a Investments - U.S. and state government obligations			
	b Investments - corporate stock			
	c Investments - corporate bonds			
	11 Investments - land, buildings, and equipment: basis ▶			
	Less accumulated depreciation ▶			
	12 Investments - mortgage loans			
	13 Investments - other			
	14 Land, buildings, and equipment: basis ▶			
	Less accumulated depreciation ▶			
	15 Other assets (describe ▶)			
	16 **Total assets** (to be completed by all filers - see the instructions. Also, see page 1, item 1)	30,799,815.	53,271,158.	53,271,158.
Liabilities	17 Accounts payable and accrued expenses		399,545.	
	18 Grants payable			
	19 Deferred revenue			
	20 Loans from officers, directors, trustees, and other disqualified persons			
	21 Mortgages and other notes payable			
	22 Other liabilities (describe ▶)			
	23 **Total liabilities** (add lines 17 through 22)	0.	399,545.	
Net Assets or Fund Balances	**Foundations that follow SFAS 117, check here ▶ ☐ and complete lines 24 through 26 and lines 30 and 31.**			
	24 Unrestricted			
	25 Temporarily restricted			
	26 Permanently restricted			
	Foundations that do not follow SFAS 117, check here ▶ [X] and complete lines 27 through 31.			
	27 Capital stock, trust principal, or current funds	0.	0.	
	28 Paid-in or capital surplus, or land, bldg., and equipment fund	0.	0.	
	29 Retained earnings, accumulated income, endowment, or other funds	30,799,815.	52,871,613.	
	30 **Total net assets or fund balances**	30,799,815.	52,871,613.	
	31 **Total liabilities and net assets/fund balances**	30,799,815.	53,271,158.	

Part III Analysis of Changes in Net Assets or Fund Balances

1	Total net assets or fund balances at beginning of year - Part II, column (a), line 30 (must agree with end-of-year figure reported on prior year's return)	1	30,799,815.
2	Enter amount from Part I, line 27a	2	22,071,798.
3	Other increases not included in line 2 (itemize) ▶	3	0.
4	Add lines 1, 2, and 3	4	52,871,613.
5	Decreases not included in line 2 (itemize) ▶	5	0.
6	Total net assets or fund balances at end of year (line 4 minus line 5) - Part II, column (b), line 30	6	52,871,613.

Part IV Capital Gains and Losses for Tax on Investment Income

	(a) List and describe the kind(s) of property sold (e.g., real estate, 2-story brick warehouse; or common stock, 200 shs. MLC Co.)	(b) How acquired P - Purchase D - Donation	(c) Date acquired (mo., day, yr.)	(d) Date sold (mo., day, yr.)
1a				
b	NONE			
c				
d				
e				

	(e) Gross sales price	(f) Depreciation allowed (or allowable)	(g) Cost or other basis plus expense of sale	(h) Gain or (loss) (e) plus (f) minus (g)
a				
b				
c				
d				
e				

	Complete only for assets showing gain in column (h) and owned by the foundation on 12/31/69			(l) Gains (Col. (h) gain minus col. (k), but not less than -0-) or Losses (from col. (h))
	(i) F.M.V. as of 12/31/69	(j) Adjusted basis as of 12/31/69	(k) Excess of col. (i) over col. (j), if any	
a				
b				
c				
d				
e				

2	Capital gain net income or (net capital loss) { If gain, also enter in Part I, line 7 / If (loss), enter -0- in Part I, line 7 }	2	
3	Net short-term capital gain or (loss) as defined in sections 1222(5) and (6): If gain, also enter in Part I, line 8, column (c). If (loss), enter -0- in Part I, line 8	3	

Part V Qualification Under Section 4940(e) for Reduced Tax on Net Investment Income

(For optional use by domestic private foundations subject to the section 4940(a) tax on net investment income.)

If section 4940(d)(2) applies, leave this part blank.

Was the foundation liable for the section 4942 tax on the distributable amount of any year in the base period? ☐ Yes ☒ No

If "Yes," the foundation does not qualify under section 4940(e). Do not complete this part.

1 Enter the appropriate amount in each column for each year; see the instructions before making any entries.

(a) Base period years Calendar year (or tax year beginning in)	(b) Adjusted qualifying distributions	(c) Net value of noncharitable-use assets	(d) Distribution ratio (col. (b) divided by col. (c))
2012	651,002,624.	969,141.	671.731589
2011	599,264,263.	542,670.	1,104.288542
2010	487,187,374.	626,704.	777.380349
2009	338,809,732.	759,255.	446.239711
2008	161,089,088.	340,773.	472.716700

2	Total of line 1, column (d)	2	3,472.356891
3	Average distribution ratio for the 5-year base period - divide the total on line 2 by 5, or by the number of years the foundation has been in existence if less than 5 years	3	694.471378
4	Enter the net value of noncharitable-use assets for 2013 from Part X, line 5	4	2,202,229.
5	Multiply line 4 by line 3	5	1,529,385,008.
6	Enter 1% of net investment income (1% of Part I, line 27b)	6	0.
7	Add lines 5 and 6	7	1,529,385,008.
8	Enter qualifying distributions from Part XII, line 4	8	787,981,527.

If line 8 is equal to or greater than line 7, check the box in Part VI, line 1b, and complete that part using a 1% tax rate. See the Part VI instructions.

Part VI Excise Tax Based on Investment Income (Section 4940(a), 4940(b), 4940(e), or 4948 - see instructions)

1a	Exempt operating foundations described in section 4940(d)(2), check here ▶ ☐ and enter "N/A" on line 1. Date of ruling or determination letter: _____ (attach copy of letter if necessary-see instructions)		
b	Domestic foundations that meet the section 4940(e) requirements in Part V, check here ▶ ☐ and enter 1% of Part I, line 27b	1	0.
c	All other domestic foundations enter 2% of line 27b. Exempt foreign organizations enter 4% of Part I, line 12, col. (b).		
2	Tax under section 511 (domestic section 4947(a)(1) trusts and taxable foundations only. Others enter -0-)	2	0.
3	Add lines 1 and 2	3	0.
4	Subtitle A (income) tax (domestic section 4947(a)(1) trusts and taxable foundations only. Others enter -0-)	4	0.
5	**Tax based on investment income.** Subtract line 4 from line 3. If zero or less, enter -0-	5	0.
6	Credits/Payments:		
a	2013 estimated tax payments and 2012 overpayment credited to 2013 — 6a		
b	Exempt foreign organizations - tax withheld at source — 6b		
c	Tax paid with application for extension of time to file (Form 8868) — 6c		
d	Backup withholding erroneously withheld — 6d		
7	Total credits and payments. Add lines 6a through 6d	7	0.
8	Enter any **penalty** for underpayment of estimated tax. Check here ☐ if Form 2220 is attached	8	
9	**Tax due.** If the total of lines 5 and 8 is more than line 7, enter **amount owed** ▶	9	0.
10	**Overpayment.** If line 7 is more than the total of lines 5 and 8, enter the **amount overpaid** ▶	10	
11	Enter the amount of line 10 to be: **Credited to 2014 estimated tax** ▶ **Refunded** ▶	11	

Part VII-A Statements Regarding Activities

			Yes	No
1a	During the tax year, did the foundation attempt to influence any national, state, or local legislation or did it participate or intervene in any political campaign?	1a		X
b	Did it spend more than $100 during the year (either directly or indirectly) for political purposes (see instructions for the definition)? *If the answer is "Yes" to 1a or 1b, attach a detailed description of the activities and copies of any materials published or distributed by the foundation in connection with the activities.*	1b		X
c	Did the foundation file **Form 1120-POL** for this year?	1c		X
d	Enter the amount (if any) of tax on political expenditures (section 4955) imposed during the year: (1) On the foundation. ▶ $ 0. (2) On foundation managers. ▶ $ 0.			
e	Enter the reimbursement (if any) paid by the foundation during the year for political expenditure tax imposed on foundation managers. ▶ $ 0.			
2	Has the foundation engaged in any activities that have not previously been reported to the IRS? *If "Yes," attach a detailed description of the activities.*	2		X
3	Has the foundation made any changes, not previously reported to the IRS, in its governing instrument, articles of incorporation, or bylaws, or other similar instruments? *If "Yes," attach a conformed copy of the changes*	3		X
4a	Did the foundation have unrelated business gross income of $1,000 or more during the year?	4a		X
b	If "Yes," has it filed a tax return on **Form 990-T** for this year? N/A	4b		
5	Was there a liquidation, termination, dissolution, or substantial contraction during the year? *If "Yes," attach the statement required by General Instruction T.*	5		X
6	Are the requirements of section 508(e) (relating to sections 4941 through 4945) satisfied either: • By language in the governing instrument, or • By state legislation that effectively amends the governing instrument so that no mandatory directions that conflict with the state law remain in the governing instrument?	6	X	
7	Did the foundation have at least $5,000 in assets at any time during the year? *If "Yes," complete Part II, col. (c), and Part XV*	7	X	
8a	Enter the states to which the foundation reports or with which it is registered (see instructions) ▶ IL			
b	If the answer is "Yes" to line 7, has the foundation furnished a copy of Form 990-PF to the Attorney General (or designate) of each state as required by *General Instruction G? If "No," attach explanation*	8b	X	
9	Is the foundation claiming status as a private operating foundation within the meaning of section 4942(j)(3) or 4942(j)(5) for calendar year 2013 or the taxable year beginning in 2013 (see instructions for Part XIV)? *If "Yes," complete Part XIV*	9	X	
10	Did any persons become substantial contributors during the tax year? If "Yes," attach a schedule listing their names and addresses	10		X

Part VII-A Statements Regarding Activities *(continued)*

11	At any time during the year, did the foundation, directly or indirectly, own a controlled entity within the meaning of section 512(b)(13)? If "Yes," attach schedule (see instructions)	11		X
12	Did the foundation make a distribution to a donor advised fund over which the foundation or a disqualified person had advisory privileges? If "Yes," attach statement (see instructions)	12		X
13	Did the foundation comply with the public inspection requirements for its annual returns and exemption application?	13	X	

Website address ▶ WWW.ABBVIEPAF.ORG

14 The books are in care of ▶ THE FOUNDATION Telephone no. ▶ 847-938-2906

Located at ▶ D031C AP31-3NW 1 N WAUKEGAN RD, NORTH CHICAGO, IL ZIP+4 ▶ 60064

15 Section 4947(a)(1) nonexempt charitable trusts filing Form 990-PF in lieu of **Form 1041** - Check here ▶ ☐ and enter the amount of tax-exempt interest received or accrued during the year ▶ 15 N/A

			Yes	No
16	At any time during calendar year 2013, did the foundation have an interest in or a signature or other authority over a bank, securities, or other financial account in a foreign country? See the instructions for exceptions and filing requirements for Form TD F 90-22.1. If "Yes," enter the name of the foreign country ▶	16		X

Part VII-B Statements Regarding Activities for Which Form 4720 May Be Required

File Form 4720 if any item is checked in the "Yes" column, unless an exception applies.

			Yes	No
1a	During the year did the foundation (either directly or indirectly):			
	(1) Engage in the sale or exchange, or leasing of property with a disqualified person? ☐ Yes ☒ No			
	(2) Borrow money from, lend money to, or otherwise extend credit to (or accept it from) a disqualified person? ☐ Yes ☒ No			
	(3) Furnish goods, services, or facilities to (or accept them from) a disqualified person? ☐ Yes ☒ No			
	(4) Pay compensation to, or pay or reimburse the expenses of, a disqualified person? ☐ Yes ☒ No			
	(5) Transfer any income or assets to a disqualified person (or make any of either available for the benefit or use of a disqualified person)? ☐ Yes ☒ No			
	(6) Agree to pay money or property to a government official? (**Exception.** Check "No" if the foundation agreed to make a grant to or to employ the official for a period after termination of government service, if terminating within 90 days.) ☐ Yes ☒ No			
b	If any answer is "Yes" to 1a(1)-(6), did **any** of the acts fail to qualify under the exceptions described in Regulations section 53.4941(d)-3 or in a current notice regarding disaster assistance (see instructions)? N/A Organizations relying on a current notice regarding disaster assistance check here ▶ ☐	1b		
c	Did the foundation engage in a prior year in any of the acts described in 1a, other than excepted acts, that were not corrected before the first day of the tax year beginning in 2013?	1c		X
2	Taxes on failure to distribute income (section 4942) (does not apply for years the foundation was a private operating foundation defined in section 4942(j)(3) or 4942(j)(5)):			
a	At the end of tax year 2013, did the foundation have any undistributed income (lines 6d and 6e, Part XIII) for tax year(s) beginning before 2013? ☐ Yes ☒ No If "Yes," list the years ▶ _____, _____, _____, _____			
b	Are there any years listed in 2a for which the foundation is **not** applying the provisions of section 4942(a)(2) (relating to incorrect valuation of assets) to the year's undistributed income? (If applying section 4942(a)(2) to **all** years listed, answer "No" and attach statement - see instructions.) N/A	2b		
c	If the provisions of section 4942(a)(2) are being applied to **any** of the years listed in 2a, list the years here. ▶ _____, _____, _____, _____			
3a	Did the foundation hold more than a 2% direct or indirect interest in any business enterprise at any time during the year? ☐ Yes ☒ No			
b	If "Yes," did it have excess business holdings in 2013 as a result of **(1)** any purchase by the foundation or disqualified persons after May 26, 1969; **(2)** the lapse of the 5-year period (or longer period approved by the Commissioner under section 4943(c)(7)) to dispose of holdings acquired by gift or bequest; or **(3)** the lapse of the 10-, 15-, or 20-year first phase holding period? *(Use Schedule C, Form 4720, to determine if the foundation had excess business holdings in 2013.)* N/A	3b		
4a	Did the foundation invest during the year any amount in a manner that would jeopardize its charitable purposes?	4a		X
b	Did the foundation make any investment in a prior year (but after December 31, 1969) that could jeopardize its charitable purpose that had not been removed from jeopardy before the first day of the tax year beginning in 2013?	4b		X

Part VII-B Statements Regarding Activities for Which Form 4720 May Be Required *(continued)*

5a	During the year did the foundation pay or incur any amount to:			
	(1) Carry on propaganda, or otherwise attempt to influence legislation (section 4945(e))?	☐ Yes ☒ No		
	(2) Influence the outcome of any specific public election (see section 4955); or to carry on, directly or indirectly, any voter registration drive?	☐ Yes ☒ No		
	(3) Provide a grant to an individual for travel, study, or other similar purposes?	☐ Yes ☒ No		
	(4) Provide a grant to an organization other than a charitable, etc., organization described in section 509(a)(1), (2), or (3), or section 4940(d)(2)?	☐ Yes ☒ No		
	(5) Provide for any purpose other than religious, charitable, scientific, literary, or educational purposes, or for the prevention of cruelty to children or animals?	☐ Yes ☒ No		
b	If any answer is "Yes" to 5a(1)-(5), did any of the transactions fail to qualify under the exceptions described in Regulations section 53.4945 or in a current notice regarding disaster assistance (see instructions)? N/A	5b		
	Organizations relying on a current notice regarding disaster assistance check here ▶ ☐			
c	If the answer is "Yes" to question 5a(4), does the foundation claim exemption from the tax because it maintained expenditure responsibility for the grant? N/A ☐ Yes ☐ No			
	If "Yes," attach the statement required by Regulations section 53.4945-5(d).			
6a	Did the foundation, during the year, receive any funds, directly or indirectly, to pay premiums on a personal benefit contract? ☐ Yes ☒ No			
b	Did the foundation, during the year, pay premiums, directly or indirectly, on a personal benefit contract?	6b		X
	If "Yes" to 6b, file Form 8870.			
7a	At any time during the tax year, was the foundation a party to a prohibited tax shelter transaction? ☐ Yes ☒ No			
b	If "Yes," did the foundation receive any proceeds or have any net income attributable to the transaction? N/A	7b		

Part VIII Information About Officers, Directors, Trustees, Foundation Managers, Highly Paid Employees, and Contractors

1 List all officers, directors, trustees, foundation managers and their compensation.

(a) Name and address	(b) Title, and average hours per week devoted to position	(c) Compensation (If not paid, enter -0-)	(d) Contributions to employee benefit plans and deferred compensation	(e) Expense account, other allowances
SEE STATEMENT 2		0.	0.	0.

2 Compensation of five highest-paid employees (other than those included on line 1). If none, enter "NONE."

(a) Name and address of each employee paid more than $50,000	(b) Title, and average hours per week devoted to position	(c) Compensation	(d) Contributions to employee benefit plans and deferred compensation	(e) Expense account, other allowances
NONE				

Total number of other employees paid over $50,000 ▶ 0

Part VIII **Information About Officers, Directors, Trustees, Foundation Managers, Highly Paid Employees, and Contractors** *(continued)*

3 Five highest-paid independent contractors for professional services. If none, enter "NONE."

(a) Name and address of each person paid more than $50,000	(b) Type of service	(c) Compensation
NONE		
Total number of others receiving over $50,000 for professional services ▶		0

Part IX-A **Summary of Direct Charitable Activities**

List the foundation's four largest direct charitable activities during the tax year. Include relevant statistical information such as the number of organizations and other beneficiaries served, conferences convened, research papers produced, etc.	Expenses
1 N/A	
2	
3	
4	

Part IX-B **Summary of Program-Related Investments**

Describe the two largest program-related investments made by the foundation during the tax year on lines 1 and 2.	Amount
1 N/A	
2	
All other program-related investments. See instructions.	
3	
Total. Add lines 1 through 3 ▶	0.

Part X Minimum Investment Return (All domestic foundations must complete this part. Foreign foundations, see instructions.)

1	Fair market value of assets not used (or held for use) directly in carrying out charitable, etc., purposes:		
a	Average monthly fair market value of securities	1a	0.
b	Average of monthly cash balances	1b	2,235,765.
c	Fair market value of all other assets	1c	
d	**Total** (add lines 1a, b, and c)	1d	2,235,765.
e	Reduction claimed for blockage or other factors reported on lines 1a and 1c (attach detailed explanation) — 1e: 0.		
2	Acquisition indebtedness applicable to line 1 assets	2	0.
3	Subtract line 2 from line 1d	3	2,235,765.
4	Cash deemed held for charitable activities. Enter 1 1/2% of line 3 (for greater amount, see instructions)	4	33,536.
5	**Net value of noncharitable-use assets.** Subtract line 4 from line 3. Enter here and on Part V, line 4	5	2,202,229.
6	**Minimum investment return.** Enter 5% of line 5	6	110,111.

Part XI Distributable Amount (see instructions) (Section 4942(j)(3) and (j)(5) private operating foundations and certain foreign organizations check here ▶ [X] and do not complete this part.)

1	Minimum investment return from Part X, line 6		1	
2a	Tax on investment income for 2013 from Part VI, line 5	2a		
b	Income tax for 2013. (This does not include the tax from Part VI.)	2b		
c	Add lines 2a and 2b		2c	
3	Distributable amount before adjustments. Subtract line 2c from line 1		3	
4	Recoveries of amounts treated as qualifying distributions		4	
5	Add lines 3 and 4		5	
6	Deduction from distributable amount (see instructions)		6	
7	**Distributable amount** as adjusted. Subtract line 6 from line 5. Enter here and on Part XIII, line 1		7	

Part XII Qualifying Distributions (see instructions)

1	Amounts paid (including administrative expenses) to accomplish charitable, etc., purposes:		
a	Expenses, contributions, gifts, etc. - total from Part I, column (d), line 26	1a	787,981,527.
b	Program-related investments - total from Part IX-B	1b	0.
2	Amounts paid to acquire assets used (or held for use) directly in carrying out charitable, etc., purposes	2	
3	Amounts set aside for specific charitable projects that satisfy the:		
a	Suitability test (prior IRS approval required)	3a	
b	Cash distribution test (attach the required schedule)	3b	
4	**Qualifying distributions.** Add lines 1a through 3b. Enter here and on Part V, line 8, and Part XIII, line 4	4	787,981,527.
5	Foundations that qualify under section 4940(e) for the reduced rate of tax on net investment income. Enter 1% of Part I, line 27b	5	0.
6	**Adjusted qualifying distributions.** Subtract line 5 from line 4	6	787,981,527.

Note. The amount on line 6 will be used in Part V, column (b), in subsequent years when calculating whether the foundation qualifies for the section 4940(e) reduction of tax in those years.

Part XIII Undistributed Income (see instructions)

N/A

	(a) Corpus	(b) Years prior to 2012	(c) 2012	(d) 2013
1 Distributable amount for 2013 from Part XI, line 7				
2 Undistributed income, if any, as of the end of 2013				
a Enter amount for 2012 only				
b Total for prior years: _____, _____, _____				
3 Excess distributions carryover, if any, to 2013:				
a From 2008				
b From 2009				
c From 2010				
d From 2011				
e From 2012				
f **Total** of lines 3a through e				
4 Qualifying distributions for 2013 from Part XII, line 4: ▶ $				
a Applied to 2012, but not more than line 2a				
b Applied to undistributed income of prior years (Election required - see instructions)				
c Treated as distributions out of corpus (Election required - see instructions)				
d Applied to 2013 distributable amount				
e Remaining amount distributed out of corpus				
5 Excess distributions carryover applied to 2013 (If an amount appears in column (d), the same amount must be shown in column (a).)				
6 **Enter the net total of each column as indicated below:**				
a Corpus. Add lines 3f, 4c, and 4e. Subtract line 5				
b Prior years' undistributed income. Subtract line 4b from line 2b				
c Enter the amount of prior years' undistributed income for which a notice of deficiency has been issued, or on which the section 4942(a) tax has been previously assessed				
d Subtract line 6c from line 6b. Taxable amount - see instructions				
e Undistributed income for 2012. Subtract line 4a from line 2a. Taxable amount - see instr.				
f Undistributed income for 2013. Subtract lines 4d and 5 from line 1. This amount must be distributed in 2014				
7 Amounts treated as distributions out of corpus to satisfy requirements imposed by section 170(b)(1)(F) or 4942(g)(3)				
8 Excess distributions carryover from 2008 not applied on line 5 or line 7				
9 **Excess distributions carryover to 2014.** Subtract lines 7 and 8 from line 6a				
10 Analysis of line 9:				
a Excess from 2009				
b Excess from 2010				
c Excess from 2011				
d Excess from 2012				
e Excess from 2013				

Part XIV Private Operating Foundations (see instructions and Part VII-A, question 9)

1 a If the foundation has received a ruling or determination letter that it is a private operating foundation, and the ruling is effective for 2013, enter the date of the ruling ▶ 10/10/07

b Check box to indicate whether the foundation is a private operating foundation described in section [X] 4942(j)(3) or [ ] 4942(j)(5)

2 a Enter the lesser of the adjusted net income from Part I or the minimum investment return from Part X for each year listed	Tax year (a) 2013	Prior 3 years (b) 2012	(c) 2011	(d) 2010	(e) Total
	0.	0.	0.	0.	0.
b 85% of line 2a	0.	0.	0.	0.	0.
c Qualifying distributions from Part XII, line 4 for each year listed	787,981,527.	651,002,624.	599,264,263.	487,187,374.	2,525,435,788.
d Amounts included in line 2c not used directly for active conduct of exempt activities	0.	0.	0.	0.	0.
e Qualifying distributions made directly for active conduct of exempt activities. Subtract line 2d from line 2c	787,981,527.	651,002,624.	599,264,263.	487,187,374.	2,525,435,788.
3 Complete 3a, b, or c for the alternative test relied upon: a "Assets" alternative test - enter: (1) Value of all assets	53,271,158.	30,799,815.	26,269,677.	21,717,131.	132,057,781.
(2) Value of assets qualifying under section 4942(j)(3)(B)(i)	53,271,158.	30,799,815.	26,269,677.	21,717,131.	132,057,781.
b "Endowment" alternative test - enter 2/3 of minimum investment return shown in Part X, line 6 for each year listed					0.
c "Support" alternative test - enter: (1) Total support other than gross investment income (interest, dividends, rents, payments on securities loans (section 512(a)(5)), or royalties)	802,240,228.	648,120,873.	604,125,175.	492,857,634.	2,547,343,910.
(2) Support from general public and 5 or more exempt organizations as provided in section 4942(j)(3)(B)(iii)				0.	0.
(3) Largest amount of support from an exempt organization				0.	0.
(4) Gross investment income				0.	0.

Part XV Supplementary Information (Complete this part only if the foundation had $5,000 or more in assets at any time during the year-see instructions.)

1 **Information Regarding Foundation Managers:**

a List any managers of the foundation who have contributed more than 2% of the total contributions received by the foundation before the close of any tax year (but only if they have contributed more than $5,000). (See section 507(d)(2).)

NONE

b List any managers of the foundation who own 10% or more of the stock of a corporation (or an equally large portion of the ownership of a partnership or other entity) of which the foundation has a 10% or greater interest.

NONE

2 **Information Regarding Contribution, Grant, Gift, Loan, Scholarship, etc., Programs:**

Check here ▶ [ ] if the foundation only makes contributions to preselected charitable organizations and does not accept unsolicited requests for funds. If the foundation makes gifts, grants, etc. (see instructions) to individuals or organizations under other conditions, complete items 2a, b, c, and d.

a The name, address, and telephone number or e-mail address of the person to whom applications should be addressed:

SEE ATTACHED

b The form in which applications should be submitted and information and materials they should include:

SEE ATTACHED

c Any submission deadlines:

N/A

d Any restrictions or limitations on awards, such as by geographical areas, charitable fields, kinds of institutions, or other factors:

SEE ATTACHED

Part XV Supplementary Information (continued)

3 Grants and Contributions Paid During the Year or Approved for Future Payment

Recipient Name and address (home or business)	If recipient is an individual, show any relationship to any foundation manager or substantial contributor	Foundation status of recipient	Purpose of grant or contribution	Amount
a *Paid during the year*				
OVER 155,000 ELIGIBLE INDIVIDUALS (LIST AVAILABLE UPON REQUEST) N/A N/A	NONE	N/A	Provide various pharmaceutical and medical nutrition products at no charge to eligible individuals	783,366,952.
Total ▶ 3a				783,366,952.
b *Approved for future payment*				
NONE				
Total ▶ 3b				0.

Part XVI-A Analysis of Income-Producing Activities

Enter gross amounts unless otherwise indicated.	Unrelated business income		Excluded by section 512, 513, or 514		(e)
	(a) Business code	(b) Amount	(c) Exclusion code	(d) Amount	Related or exempt function income
1 Program service revenue:					
a					
b					
c					
d					
e					
f					
g Fees and contracts from government agencies					
2 Membership dues and assessments					
3 Interest on savings and temporary cash investments					
4 Dividends and interest from securities					
5 Net rental income or (loss) from real estate:					
a Debt-financed property					
b Not debt-financed property					
6 Net rental income or (loss) from personal property					
7 Other investment income					
8 Gain or (loss) from sales of assets other than inventory					
9 Net income or (loss) from special events					
10 Gross profit or (loss) from sales of inventory					
11 Other revenue:					
a					
b					
c					
d					
e					
12 Subtotal. Add columns (b), (d), and (e)		0.		0.	0.
13 Total. Add line 12, columns (b), (d), and (e)					13 0.

(See worksheet in line 13 instructions to verify calculations.)

Part XVI-B Relationship of Activities to the Accomplishment of Exempt Purposes

Line No. ▼	Explain below how each activity for which income is reported in column (e) of Part XVI-A contributed importantly to the accomplishment of the foundation's exempt purposes (other than by providing funds for such purposes).

Part XVII Information Regarding Transfers To and Transactions and Relationships With Noncharitable Exempt Organizations

			Yes	No
1	Did the organization directly or indirectly engage in any of the following with any other organization described in section 501(c) of the Code (other than section 501(c)(3) organizations) or in section 527, relating to political organizations?			
a	Transfers from the reporting foundation to a noncharitable exempt organization of:			
	(1) Cash	1a(1)		X
	(2) Other assets	1a(2)		X
b	Other transactions:			
	(1) Sales of assets to a noncharitable exempt organization	1b(1)		X
	(2) Purchases of assets from a noncharitable exempt organization	1b(2)		X
	(3) Rental of facilities, equipment, or other assets	1b(3)		X
	(4) Reimbursement arrangements	1b(4)		X
	(5) Loans or loan guarantees	1b(5)		X
	(6) Performance of services or membership or fundraising solicitations	1b(6)		X
c	Sharing of facilities, equipment, mailing lists, other assets, or paid employees	1c		X

d If the answer to any of the above is "Yes," complete the following schedule. Column (b) should always show the fair market value of the goods, other assets, or services given by the reporting foundation. If the foundation received less than fair market value in any transaction or sharing arrangement, show in column (d) the value of the goods, other assets, or services received.

(a) Line no	(b) Amount involved	(c) Name of noncharitable exempt organization	(d) Description of transfers, transactions, and sharing arrangements
		N/A	

2a Is the foundation directly or indirectly affiliated with, or related to, one or more tax-exempt organizations described in section 501(c) of the Code (other than section 501(c)(3)) or in section 527? ☐ Yes ☒ No

b If "Yes," complete the following schedule.

(a) Name of organization	(b) Type of organization	(c) Description of relationship
N/A		

Sign Here

Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete Declaration of preparer (other than taxpayer) is based on all information of which preparer has any knowledge

May the IRS discuss this return with the preparer

▶ X _____ 15

Signature of officer or trustee Date

Paid Preparer Use Only

Print/Type preparer's name	Preparer's signature
KIMBERLY ANDERSON, CPA	KIMBERLY ANDERSON

Firm's name ▶ CLIFTONLARSONALLEN LLP

Firm's address ▶ PO BOX 1347
RACINE, WI 53401-1347

323622
10-10-13

Schedule B (Form 990, 990-EZ, or 990-PF)

Department of the Treasury
Internal Revenue Service

Schedule of Contributors

▶ Attach to Form 990, Form 990-EZ, or Form 990-PF.
▶ Information about Schedule B (Form 990, 990-EZ, or 990-PF) and its instructions is at www.irs.gov/form990 .

OMB No. 1545-0047

2013

Name of the organization	Employer identification number
ABBVIE PATIENT ASSISTANCE FOUNDATION	26-1215559

Organization type (check one):

Filers of:	Section:
Form 990 or 990-EZ	☐ 501(c)( ) (enter number) organization
	☐ 4947(a)(1) nonexempt charitable trust **not** treated as a private foundation
	☐ 527 political organization
Form 990-PF	☒ 501(c)(3) exempt private foundation
	☐ 4947(a)(1) nonexempt charitable trust treated as a private foundation
	☐ 501(c)(3) taxable private foundation

Check if your organization is covered by the **General Rule** or a **Special Rule.**
Note. Only a section 501(c)(7), (8), or (10) organization can check boxes for both the General Rule and a Special Rule. See instructions.

General Rule

☒ For an organization filing Form 990, 990-EZ, or 990-PF that received, during the year, $5,000 or more (in money or property) from any one contributor. Complete Parts I and II.

Special Rules

☐ For a section 501(c)(3) organization filing Form 990 or 990-EZ that met the 33 1/3% support test of the regulations under sections 509(a)(1) and 170(b)(1)(A)(vi) and received from any one contributor, during the year, a contribution of the greater of **(1)** $5,000 or **(2)** 2% of the amount on (i) Form 990, Part VIII, line 1h, or (ii) Form 990-EZ, line 1. Complete Parts I and II.

☐ For a section 501(c)(7), (8), or (10) organization filing Form 990 or 990-EZ that received from any one contributor, during the year, total contributions of more than $1,000 for use *exclusively* for religious, charitable, scientific, literary, or educational purposes, or the prevention of cruelty to children or animals. Complete Parts I, II, and III.

☐ For a section 501(c)(7), (8), or (10) organization filing Form 990 or 990-EZ that received from any one contributor, during the year, contributions for use *exclusively* for religious, charitable, etc., purposes, but these contributions did not total to more than $1,000. If this box is checked, enter here the total contributions that were received during the year for an *exclusively* religious, charitable, etc., purpose. Do not complete any of the parts unless the **General Rule** applies to this organization because it received *nonexclusively* religious, charitable, etc., contributions of $5,000 or more during the year ..... ▶ $ _____

Caution. An organization that is not covered by the General Rule and/or the Special Rules does not file Schedule B (Form 990, 990-EZ, or 990-PF), but it **must** answer "No" on Part IV, line 2, of its Form 990; or check the box on line H of its Form 990-EZ or on its Form 990-PF, Part I, line 2, to certify that it does not meet the filing requirements of Schedule B (Form 990, 990-EZ, or 990-PF).

Name of organization	Employer identification number
ABBVIE PATIENT ASSISTANCE FOUNDATION	26-1215559

Part I **Contributors** (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
1	ABBOTT LABORATORIES 100 ABBOTT PARK ROAD ABBOTT PARK, IL 60064-3500	$ 2,861,748.	Person [X] Payroll [ ] Noncash [X] (Complete Part II for noncash contributions.)
2	ABBOTT LABORATORIES 100 ABBOTT PARK ROAD ABBOTT PARK, IL 60064-3500	$ 299,483.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
3	ABBVIE INC. D031C AP31-3NW, 1 N WAUKEGAN ROAD NORTH CHICAGO, IL 60064	$ 797,902,094.	Person [X] Payroll [ ] Noncash [X] (Complete Part II for noncash contributions.)
4	ABBVIE INC. D031C AP31-3NW, 1 N WAUKEGAN ROAD NORTH CHICAGO, IL 60064	$ 8,990,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
		$	Person [ ] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
		$	Person [ ] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

Name of organization	Employer identification number
ABBVIE PATIENT ASSISTANCE FOUNDATION	26-1215559

Part II **Noncash Property** (see instructions). Use duplicate copies of Part II if additional space is needed.

(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (see instructions)	(d) Date received
1	VARIOUS NUTRITIONAL PRODUCTS	$ 2,861,748.	VARIOUS
3	VARIOUS MEDICATIONS	$ 797,902,094.	VARIOUS
		$	
		$	
		$	
		$	

Name of organization	Employer identification number
ABBVIE PATIENT ASSISTANCE FOUNDATION	26-1215559

Part III *Exclusively* religious, charitable, etc., individual contributions to section 501(c)(7), (8), or (10) organizations that total more than $1,000 for the year. Complete columns **(a)** through **(e)** and the following line entry. For organizations completing Part III, enter the total of *exclusively* religious, charitable, etc., contributions of **$1,000 or less** for the year. (Enter this information once.) ▶ $

Use duplicate copies of Part III if additional space is needed.

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held

(e) Transfer of gift

Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held

(e) Transfer of gift

Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held

(e) Transfer of gift

Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held

(e) Transfer of gift

Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee

OFFICE OF THE SECRETARY OF STATE

JESSE WHITE • Secretary of State

DECEMBER 3, 2012 6579-041-6

C T CORPORATION SYSTEM
600 S SECOND ST
SPRINGFIELD, IL 62704

RE ABBVIE PATIENT ASSISTANCE FOUNDATION

DEAR SIR OR MADAM:

ENCLOSED YOU WILL FIND THE ARTICLES OF AMENDMENT FOR THE ABOVE NAMED CORPORATION.

FEES IN THIS CONNECTION HAVE BEEN RECEIVED AND CREDITED.

SINCERELY,

JESSE WHITE
SECRETARY OF STATE
DEPARTMENT OF BUSINESS SERVICES
CORPORATION DIVISION
TELEPHONE (217) 782-6961

FORM **NFP 110.30** (rev. Dec. 2003)
ARTICLES OF AMENDMENT
General Not For Profit Corporation Act

Jesse White, Secretary of State
Department of Business Services
501 S. Second St., Rm. 350
Springfield, IL 62756
217-782-1832
www.cyberdriveillinois.com

Remit payment in the form of a check or money order payable to Secretary of State.

FILED
DEC 0 3 2012
JESSE WHITE
SECRETARY OF STATE

File # 0579-041-6 Filing Fee: $25 Approved:

———— Submit in duplicate ———— Type or Print clearly in black ink ———— Do not write above this line ————

1. Corporate Name **(See Note 1 on back.)**: Abbott Patient Assistance Foundation

2. Manner of Adoption of Amendment:
The following amendment to the Articles of Incorporation was adopted on May 25, 2012 (Month, Day & Year) in the manner indicated below (check one only):

☐ By affirmative vote of a majority of the directors in office, at a meeting of the board of directors, in accordance with Section 110.15. **(See Note 2 on back.)**

☑ By written consent, signed by all the directors in office, in compliance with Sections 110.15 and 108.45. **(See Note 3 on back.)**

☐ By members at a meeting of members entitled to vote by the affirmative vote of the members having not less than the minimum number of votes necessary to adopt such amendment, as provided by this Act, the Articles of Incorporation or the bylaws, in accordance with Section 110.20. **(See Note 4 on back.)**

☐ By written consent signed by members entitled to vote having not less than the minimum number of votes necessary to adopt such amendment, as provided by this Act, the Articles of Incorporation, or the bylaws, in compliance with Sections 107.10 and 110.20. **(See Note 5 on back.)**

3. Text of Amendment:
(a.) When an amendment effects a name change, insert the new corporate name below. Use 3(b.) below for all other amendments. *Article 1: The Name of the Corporation is:

AbbVie Patient Assistance Foundation
New Name

(b.) All amendments other than name change.
If the amendment affects the corporate purpose, the amended purpose is required to be set forth in its entirety. If there is not sufficient space to add the full text of the amendment, attach additional sheets of this size.

Name change effective date 1/1/2013

Printed by authority of the State of Illinois. July 2007 - 10M - C 130.17

4. The undersigned Corporation has caused these Articles to be signed by a duly authorized officer who affirms, under penalties of perjury, that the facts stated herein are true and correct.

All signatures must be in BLACK INK.

Dated December 3 (Month & Day) 2012 (Year) — Abbott Patient Assistance Foundation (Exact Name of Corporation)

John A. Berry (Any Authorized Officer's Signature)

John A. Berry, Secretary (Name and Title (type or print))

5. If there are no duly authorized officers, the persons designated under Section 101.10(b)(2) must sign below and print name and title.

The undersigned affirms, under penalties of perjury, that the facts stated herein are true.

Dated _____ (Month & Day) , _____ (Year)

Signature	Name and Title (print)
Signature	Name and Title (print)
Signature	Name and Title (print)
Signature	Name and Title (print)

NOTES

1. State the true and exact corporate name as it appears on the records of the Secretary of State BEFORE any amendment herein is reported.
2. Directors may adopt amendments without member approval only when the corporation has no members, or no members entitled to vote pursuant to §110.15.
3. Director approval may be:
   a. by vote at a director's meeting (either annual or special), or
   b. by consent, in writing, without a meeting.
4. All amendments not adopted under Sec. 110.15 require that:
   a. the board of directors adopt a resolution setting forth the proposed amendment, and
   b. the members approve the amendment.

   Member approval may be:
   a by vote at a members meeting (either annual or special), or
   b. by consent, in writing, without a meeting.

   To be adopted, the amendment must receive the affirmative vote or consent of the holders of at least two-thirds of the outstanding members entitled to vote on the amendment (but if class voting applies, also at least a two-thirds vote within each class is required).

   The Articles of Incorporation may supersede the two-thirds vote requirement by specifying any smaller or larger vote requirement not less than a majority of the outstanding votes of such members entitled to vote, and not less than a majority within each class when class voting applies (Sec. 110.20)
5. When member approval is by written consent, all members must be given notice of the proposed amendment at least five days before the consent is signed. If the amendment is adopted, members who have not signed the consent must be promptly notified of the passage of the amendment. (Sec. 107.10 & 110.20)

Printed by authority of the State of Illinois. July 2007 - 10M - C 130.17

abbvie PATIENT ASSISTANCE FOUNDATION

AbbVie Patient Assistance Foundation
Application for Androgel® (testosterone gel) 1.62% and 1.0%

The AbbVie Patient Assistance Foundation provides AbbVie 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 AbbVie 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.
- ☐ Enclose a copy of government issued ID (Driver License, State ID, Military ID, etc)
- ☐ Include prescription on prescriber's Rx paper

Fax or mail the completed application and documentation to:

AbbVie Patient Assistance Foundation
P.O. Box 66550
St. Louis, MO 63166-6550
Phone: 1-800-222-6885 or 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.

abbvie PATIENT ASSISTANCE FOUNDATION

Application For Androgel® (testosterone gel) 1.62% and 1.0%

AbbVie Patient Assistance Foundation • P.O. Box 66550 St. Louis, MO 63166-6550 • Phone: 1-800-222-6885 • FAX: 1-800-276-9901

Please fax this form to 1-800-276-9901 or mail to address above

HEALTHCARE PROVIDER INFORMATION

DEA Number: **Physician Name: (First)** **(Last)**

Address: **City:** **State:** **Zip:**

Email Address: **Office Contact:** **Phone:** **Fax:**

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 only) **XXX-XX-** ☐ **Patient Name: (First)** **(Last)**

Address: **Home Phone:** **Work Phone:**

City: **State:** **Zip:** **Date of Birth:** ____/____/____ **Gender:** ☐ **Male** ☐ **Female**

Number of people in household (include self):		**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.

INSURANCE INFORMATION – Please include a copy of patient's Insurance Card and Prescription Card (front and back)

	Medical Coverage	Prescription Coverage for Androgel	Eligibility Status E=Eligible P=Pending I=Ineligible	Policy Number	Contact and Phone
Medicare	☐ Yes ☐ No	☐ Yes ☐ No			
Medicare Part D	☐ Yes ☐ No	☐ Yes ☐ No			
Medicaid	☐ Yes ☐ No	☐ Yes ☐ No			
Private Insurance	☐ Yes ☐ No	☐ Yes ☐ No			
State Elderly Drug Assistance	☐ Yes ☐ No	☐ Yes ☐ No			
Veterans Assistance	☐ Yes ☐ No	☐ Yes ☐ No			
Disabled: ☐ Yes ☐ No			**Veteran: ☐ Yes ☐ No**		
Other:					

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 AbbVie 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 AbbVie 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:**

REPRESENTATIVE FOR PURPOSES OF THE PROGRAM (If applicable)

I permit the AbbVie 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:

PATIENT CLINICAL INFORMATION

Patient diagnosis (ICD.9 code) _____ **Patient allergies:** ☐ **No Known** _____

Please list the names of other medications the patient is currently taking: ☐ **None** _____

PRESCRIPTION - MEDICATION MUST BE SHIPPED TO THE PATIENT'S HOME

AndroGel® (testosterone gel) • AndroGel® 1.62 % Pump Topical • AndroGel® 1% Topical

- **Use prescribers blank form & submit with application**
- **Enclose a copy of a government issued ID of the patient when ordering the product listed above: Driver License, State ID, Military ID, etc.**

Special Note: **New York Prescribers please submit prescription on an original NY State prescription blank, for all other States, if not faxed, must be on State specific blank if applicable for your State**

Signature of Physician: _____ _____ _____

(Must be MD / DO; no PAC / NP) ☐ **Substitution Allowed** ☐ **Dispense as Written** **Date**

1. Authorization for Release of Health Information By signing this form, I represent to the AbbVie 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 AbbVie 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 AbbVie 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 AbbVie 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 AbbVie Patient Assistance Foundation is not made in exchange for any explicit or implicit agreement or understanding that AbbVie 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.

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

abbvie PATIENT ASSISTANCE FOUNDATION

AbbVie Patient Assistance Foundation Application for Creon® (pancrelipase) Delayed Release Capsules

The AbbVie Patient Assistance Foundation provides AbbVie 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 AbbVie 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.

Fax or mail the completed application and documentation to:

AbbVie Patient Assistance Foundation
P.O. Box 66550
St. Louis, MO 63166-6550
Phone: 1-800-222-6885 or 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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Please fax this form to 1-800-276-9901 or mail to address above

HEALTHCARE PROVIDER INFORMATION

DEA Number: **Physician Name: (First)** **(Last)**

Address: **City:** **State:** **Zip:**

Email Address: **Office Contact:** **Phone:** **Fax:**

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 only) **XXX-XX-** ☐ **Patient Name: (First)** **(Last)**

Address: **Home Phone:** **Work Phone:**

City: **State:** **Zip:** **Date of Birth:** ____/____/____ **Gender:** ☐ **Male** ☐ **Female**

Number of people in household (include self):		**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.

INSURANCE INFORMATION – Please include a copy of patient's Insurance Card and Prescription Card (front and back)

	Medical Coverage	Prescription Coverage for Creon	Eligibility Status E=Eligible P=Pending I=Ineligible	Policy Number	Contact and Phone
Medicare	☐ Yes ☐ No	☐ Yes ☐ No			
Medicare Part D	☐ Yes ☐ No	☐ Yes ☐ No			
Medicaid	☐ Yes ☐ No	☐ Yes ☐ No			
Private Insurance	☐ Yes ☐ No	☐ Yes ☐ No			
State Elderly Drug Assistance	☐ Yes ☐ No	☐ Yes ☐ No			
State Children Health Insurance	☐ Yes ☐ No	☐ Yes ☐ No			
Veterans Assistance	☐ Yes ☐ No	☐ Yes ☐ No			
Disabled: ☐ **Yes** ☐ **No** **Veteran:** ☐ **Yes** ☐ **No**					
Other:					

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 AbbVie 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 AbbVie 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:**

REPRESENTATIVE FOR PURPOSES OF THE PROGRAM (If applicable)

I permit the AbbVie 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:

PATIENT CLINICAL INFORMATION

Patient diagnosis (ICD.9 code) _____ **Patient allergies:** ☐ **No Known** _____

Please list the names of other medications the patient is currently taking: ☐ **None** _____

PRESCRIPTION - MEDICATION

Creon® (pancrelipase) Delayed-Release Capsules	**Instructions**	**Quantity** (Product dispensed in 100 ct stock bottles)	**Refills**
☐ **3,000 Lipase Units** ☐ **6,000 Lipase Units** ☐ **12,000 Lipase Units** ☐ **24,000 Lipase Units**			

Special Note: **New York Prescribers please submit prescription on an original NY State prescription blank, for all other States, if not faxed, must be on State specific blank if applicable for your State**

Signature of Physician: _____ _____ _____

(Must be MD / DO/ PAC / NP) ☐ **Substitution Allowed** ☐ **Dispense as written** **Date**

1. Authorization for Release of Health Information: By signing this form, I represent to the AbbVie 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 AbbVie 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 AbbVie 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 AbbVie 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 AbbVie Patient Assistance Foundation is not made in exchange for any explicit or implicit agreement or understanding that AbbVie 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

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.

abbvie PATIENT ASSISTANCE FOUNDATION

Patient Assistance Application for HUMIRA® (adalimumab)

The AbbVie Patient Assistance Foundation provides AbbVie 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 AbbVie 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. Failure to complete required information will delay the review process.
- ☐ Provide front and back copies of all prescription insurance card(s).
- ☐ Provide proof of income (tax return, W2, pay stub) for all in household.
    - o If there is no household income ($0) due to job loss or other circumstance, you do not need to provide income documents.
- ☐ Physician's signature is required at the bottom of the 1st page.
- ☐ Patient's signature is required at the bottom of the 3rd page.

Fax or mail the completed application and documentation to:

Note: If application is faxed, Prescriber MUST sign and fax it with MD office cover sheet.

AbbVie Patient Assistance Foundation
P.O. Box 789
San Bruno, CA 94066
Fax: 1-866-250-2803
Phone: 1-800-222-6885

Upon receipt of a completed application, the physician and patient will be notified of eligibility. If approved, medication will be shipped to the destination indicated on the application. It is the responsibility of the physician or patient to reorder 3 weeks prior to the patient requiring further medication.

Please note, if approved, medication will be scheduled for shipment to the specified location on the application.

Please contact us at 1-800-222-6885 Monday through Friday for additional assistance.

THIS PAGE TO BE COMPLETED BY PHYSICIAN

abbvie PATIENT ASSISTANCE FOUNDATION

Patient Assistance Application for HUMIRA® (adalimumab)

The AbbVie Patient Assistance Foundation provides HUMIRA at no cost to individuals who meet specific program eligibility criteria

PLEASE COMPLETE ALL SECTIONS, SIGN, AND FAX THIS FORM TO 1-866-250-2803 OR MAIL TO:
ABBVIE PATIENT ASSISTANCE FOUNDATION • P.O. BOX 789 • SAN BRUNO, CA 94066. FOR QUESTIONS PLEASE CALL 1-800-222-6885.

PHYSICIAN INFORMATION

Physician Name: ☐MD ☐ DO ☐ Other.____ ☐ Rheum ☐ Derm ☐ Gastro ☐ Other:____

Office Name: Office Contact Name:

Address: City/State/Zip

Phone: Fax:

State License #: Tax ID#: NPI/Insurance Provider #:

PATIENT HISTORY AND SHIPPING PREFERENCE *(Please circle specific diagnosis code(s))*

Patient's Name: DOB:

☐ Allergies (List): ☐ No known allergies

☐ Rheumatoid Arthritis (714.0)
☐ Psoriatic Arthritis (696.0)
☐ Ankylosing Spondylitis (720.0)
☐ Ulcerative Colitis (556.3, 556.5, 556.6, 556.8, 556.9)
☐ Crohn's Disease (555.0, 555.1, 555.2, 555.9)
☐ Polyarticular Juvenile Idiopathic Arthritis [JIA] (714.30)
☐ Plaque Psoriasis (696.1)
Date of Diagnosis: _____
☐ Other

If this patient is eligible to receive medication through the AbbVie Patient Assistance Foundation, ship to. ☐ Physician Office ☐ Patient
Shipping Address (if different from physician/patient address):

PHYSICIAN'S ORDERS

Rheumatoid Arthritis, Ankylosing Spondylitis, Psoriatic Arthritis, and Polyarticular JIA if ≥30kg(66 lbs)			
☐ HUMIRA Pen 40 mg/0.8mL	40 mg SC inj. every other week	84 day supply	Refills:
☐ HUMIRA Pre-Filled Syringe 40 mg/0.8mL	40 mg SC inj. every other week	84 day supply	Refills:
Polyarticular JIA 15kg(33 lbs) to <30kg(66 lbs) only			
☐ HUMIRA Pre-Filled Syringe 20 mg/0.4mL	20 mg SC inj. every other week	84 day supply	Refills:
Crohn's Disease or Ulcerative Colitis			
STARTING THERAPY			
☐ Crohn's Disease/Ulcerative Colitis Starter Package (HUMIRA Pen 40 mg/0.8mL)	☐ Four 40 mg SC inj. Day 1, Two 40 mg SC inj. Day 15, #6 pens		No Refills
	☐ Two 40 mg SC inj. Day 1, Two 40 mg SC inj. Day 2, Two 40 mg SC inj. Day 15, #6 pens		No Refills
☐ HUMIRA Pre-Filled Syringe 40 mg/0.8mL	☐ Four 40 mg SC inj. Day 1, Two 40 mg SC inj. Day 15, #6 syringes		No Refills
	☐ Two 40 mg SC inj. Day 1, Two 40 mg SC inj. Day 2, Two 40 mg SC inj. Day 15, #6 syringes		No Refills
ONGOING THERAPY			
☐ HUMIRA Pen 40 mg/0.8mL	40 mg SC inj. every other week	84 day supply	Refills:
☐ HUMIRA Pre-Filled Syringe 40 mg/0.8mL	40 mg SC inj. every other week	84 day supply	Refills
Plaque Psoriasis			
STARTING THERAPY			
☐ Psoriasis Starter Package (HUMIRA Pen 40 mg/0.8mL)	Two 40 mg SC inj. for first dose (Day 1), then one 40 mg SC inj. one week after first dose (Day 8), then one 40 mg SC inj. three weeks after first dose (Day 22), #4 pens		No Refills
☐ HUMIRA Pre-Filled Syringe 40 mg/0.8mL	Two 40 mg SC inj. for first dose (Day 1), then one 40 mg SC inj. one week after first dose (Day 8), then one 40 mg SC inj. three weeks after first dose (Day 22), #4 syringes		No Refills
ONGOING THERAPY			
☐ HUMIRA Pen 40 mg/0.8mL	40 mg SC inj. every other week	84 day supply	Refills
☐ HUMIRA Pre-Filled Syringe 40 mg/0.8mL	40 mg SC inj. every other week	84 day supply	Refills:
Other ☐ HUMIRA	SIG:	Qty:	Refills:

Special Note: New York Prescribers please submit prescription on an original NY State prescription blank, for all other States, if not faxed, must be on State specific blank if applicable for your State

PHYSICIAN CERTIFICATION

Physician Signature: ☐ _____
(no stamps) **(Substitution Permitted)** **Date**

Physician Signature: ☐ _____
(no stamps) **(Dispense as Written)** **Date**

By signing this form, I represent to the AbbVie Patient Assistance Foundation (the "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 Foundation and its contracted third parties.

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 Foundation in writing immediately if the status of my State License Number registration changes. If this applicant is eligible for the Foundation's patient assistance program (the "PAP") for HUMIRA, I understand that the Foundation will send the medication to the designated shipping location, which could include my office or the patient's home. The Foundation reserves the right to request additional information if needed and to change or discontinue the PAP at any time, without notice. By signing this form, I certify that I am prescribing the aforementioned medication for an individual participating in the PAP. 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 PAP is not made in exchange for any explicit or implicit agreement or understanding that AbbVie Product will be used, purchased, leased, ordered, prescribed, recommended, or arranged for or provided formulary or other preferential or qualifying status. By signing this form, I authorize the Foundation and its representatives to transmit this prescription form electronically, by facsimile, or by mail to a pharmacy designated by the Foundation for the dispensing of the medication called for herein. I understand that I may not delegate signature authority. I certify that treatment with this medication is medically necessary.

THIS PAGE TO BE COMPLETED BY PATIENT

abbvie PATIENT ASSISTANCE FOUNDATION

Patient Assistance Application for HUMIRA® (adalimumab)

The AbbVie Patient Assistance Foundation provides HUMIRA at no cost to individuals who meet specific program eligibility criteria

PLEASE COMPLETE ALL SECTIONS, SIGN, AND FAX THIS FORM TO 1-866-250-2803 OR MAIL TO:
ABBVIE PATIENT ASSISTANCE FOUNDATION • P.O. BOX 789 • SAN BRUNO, CA 94066. FOR QUESTIONS, PLEASE CALL 1-800-222-6885.

PATIENT INFORMATION

Patient Name:	Sex. ☐ M ☐ F
DOB:	SSN (last four digits ONLY): ___ ___ ___
Address (No P.O. Box)	
City/State/Zip:	
Daytime Phone:	Evening Phone
Treating Physician Name:	
Treating Physician Phone.	Treating Physician Fax:
Primary Care Physician Name:	Primary Care Physician Phone:
Other Medications (List):	

INSURANCE INFORMATION

☐ I have no insurance coverage

☐ I have insurance coverage that does not adequately cover HUMIRA (Please provide details below or attach a copy of the insurance card. Include detailed list of medical expenses for household, including medications, office visits, insurance premiums, medical bills, etc.)

PRIMARY INSURANCE	SECONDARY INSURANCE
Insurance Company:	Insurance Company:
Insurance Co. Phone:	Insurance Co. Phone:
Policy #.	Policy #:
Group #.	Group #:
Policyholder Name:	Policyholder Name:
Relationship to Policyholder:	Relationship to Policyholder:
Policyholder DOB:	Policyholder DOB:

Medicare Questions:

- Are you eligible for Medicare? ☐ Yes ☐ No If No, anticipated date of Medicare eligibility (if within the year)? _____
- Are you enrolled into a Medicare Prescription Drug Plan? ☐ Yes ☐ No ☐ Unsure
- Are you eligible for extra help (financial assistance from Social Security) with medication costs under Medicare Part D? ☐ Yes ☐ No ☐ Unsure
- If Medicare eligible, please provide the value of your assets: $_____

(Assets include checking and savings accounts, CD's, stocks and bonds, savings bonds, mutual funds, IRAs and other investments, cash at home or anywhere else, and the value of your life insurance policies if turned in for cash right now. Do not include your home, vehicles, burial plots, or personal possessions.)

FINANCIAL INFORMATION (Proof of income required)

Current Monthly Household Income: $_____ # in Household (circle): 1 2 3 4 5 6 _____

Source of Income: ☐ Wages ☐SSDI ☐SSI ☐ Unemployment ☐ Pension ☐ Other: _____

Please provide current income documentation (tax return, pay stub, etc) to avoid processing time delay.

- ***If there is no household income ($0) due to job loss or other circumstance, you do not need to provide income documents.***
- ***If income documents do not match current income, please explain:***_____

REPRESENTATIVE INFORMATION

I permit the AbbVie Patient Assistance Foundation to speak with the following person about this application and permit such person(s) to sign any related documents on my behalf for purposes of this Program

Name	Relationship:	Phone Number:
Name:	Relationship:	Phone Number:

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abbvie PATIENT ASSISTANCE FOUNDATION

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Patient Certification and Authorization for Disclosure of Information

I request and authorize the sharing of any information regarding my health, treatment, and coverage that pertains to payment for HUMIRA among my insurance companies, my physicians, AbbVie Inc. or third parties contracted by AbbVie, and the AbbVie Patient Assistance Foundation (the "Foundation") or third parties contracted by the Foundation. 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 (the "PAP") (should I qualify). However, if I do not provide this authorization, my decision will not affect my ability to obtain treatment from my health care providers or decisions about payment, enrollment, or eligibility for benefits made by my insurance companies. I know I may cancel this authorization at any time by writing to the AbbVie Patient Assistance Foundation at P.O. Box 789 San Bruno, CA 94066. If I cancel this Authorization, I can no longer participate in certain aspects of 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 the PAP services to me.

For Eligible Patient Assistance Patients Only:

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 PAP as determined by the Foundation. In the event that I am eligible for the PAP, 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 PAP may be changed or 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 at no cost from the Foundation. I agree that I will notify the Foundation if my insurance or financial situation changes.

Patient's Name:_____ **Signature:**_____ **Date:**_____

Personal Representative Authorization (if Applicable):
Note. If the Patient is unable to sign, is under the age of 18, or has designated signature authority, the Patient's Personal Representative may sign this Form. However, only certain individuals may qualify as the Patient's Personal Representative for purposes of this Authorization. A Patient's Representative must have the requisite knowledge and information regarding the Patient'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 Patient's Personal Representative is a consumer assistance or charitable organization, please list name of entity and purpose of entity under Relationship to Patient.

Patient's Personal Representative's Name:_____ **Signature:**_____

Relationship to Patient:_____ **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 patient's information to the Foundation and its contracted third parties. The Foundation urges all entities disclosing information about the patient to consult with legal counsel prior to relying on this form.

abbvie PATIENT ASSISTANCE FOUNDATION

Application for Kaletra® (lopinavir/ritonavir) and Norvir® (ritonavir)

The AbbVie Patient Assistance Foundation provides AbbVie 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 AbbVie 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.
- ☐ Patient's signature/date is required on the application.
- ☐ Prescriber's signature/date is required on the application.
- ☐ For Norvir Assistance: Financial information section is not required.

Fax or mail the completed application and documentation to:

AbbVie 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 will be notified of program eligibility. If the 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 3 weeks prior to the patient requiring further medication.

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

For alternative shipping options, please contact the AbbVie Patient Assistance Foundation at 1-800-222-6885.

abbvie PATIENT ASSISTANCE FOUNDATION

Application for Kaletra® (lopinavir/ritonavir) and Norvir® (ritonavir)

AbbVie Patient Assistance Foundation • PO Box 270 • Somerville NJ 08876 • Phone: (800) 222-6885 • Fax: (866) 483-1305

PATIENT INFORMATION

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

Patient Address | 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 for prescriptions? ☐ Yes ☐ No Are you covered by Medicaid? ☐Yes ☐No

Are you enrolled in ADAP? ☐Yes ☐No Have you been ☐Denied ☐Waitlisted ☐Pending ☐Not Applied

Total Monthly Income for your entire household $ _____

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 AbbVie 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 AbbVie Patient Assistance Foundation at P.O. Box 270 Somerville, NJ 08876. 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 high quality service, 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

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 AbbVie 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 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 Foundation, 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 to Applicant.

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

Medicine Requested

Product: _____ **Strength:** _____ **Sig:** _____ **Reorders allowed:** up to 1 year

PRESCRIBER INFORMATION

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 AbbVie 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 AbbVie Patient Assistance Foundation and its contracted third parties.**
2. **Physician:** 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 AbbVie 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 AbbVie 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 by the AbbVie Patient Assistance Foundation is not made in exchange for any explicit or implicit agreement or understanding that AbbVie 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 (no stamps): _____ **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.

abbvie PATIENT ASSISTANCE FOUNDATION

Application for Lupron Depot® and Lupron Depot-PED® (leuprolide acetate for depot suspension)

The AbbVie Patient Assistance Foundation provides AbbVie 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 AbbVie 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:

AbbVie 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.

abbvie PATIENT ASSISTANCE FOUNDATION

Application For Lupron Depot® and Lupron Depot-PED® (leuprolide acetate for depot suspension)

AbbVie Patient Assistance Foundation • PO Box 270 • Somerville NJ 08876 • Phone: (800) 222-6885 • Fax: (866) 483-1305

PATIENT INFORMATION

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

Patient Address | 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 for prescriptions? ☐Yes ☐No Do you have private medical insurance? ☐Yes ☐No

Are you covered through 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 AbbVie 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 AbbVie Patient Assistance Foundation at P O Box 270 Somerville, NJ 08876 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 high quality service, 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

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 AbbVie 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. 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 Foundation, 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 to Applicant

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

Medicine Requested

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

PRESCRIBER INFORMATION

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 AbbVie 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 AbbVie Patient Assistance Foundation and its contracted third parties.**
2. **Physician:** 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 AbbVie 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 AbbVie 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 by the AbbVie Patient Assistance Foundation is not made in exchange for any explicit or implicit agreement or understanding that AbbVie 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 (no stamps): _____ **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

abbvie PATIENT ASSISTANCE FOUNDATION

AbbVie Patient Assistance Foundation Application for Marinol® (dronabinol)

The AbbVie Patient Assistance Foundation provides AbbVie 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 AbbVie 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.

Fax or mail the completed application and documentation to:

AbbVie 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.

abbvie PATIENT ASSISTANCE FOUNDATION

Application For Marinol® (dronabinol)

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

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 ☐ Marinol®

The product listed above must be shipped to the patient's address

Patient diagnosis (ICD.9 code):

1. **Authorization for Release of Health Information: By signing this form, I represent to the AbbVie 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 AbbVie 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 AbbVie 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 AbbVie 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 AbbVie Patient Assistance Foundation is not made in exchange for any explicit or implicit agreement or understanding that AbbVie 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.

Social Security / ID No: **Patient Name: (First)** **(Last)**

Address: **Home Phone: ( )** **Work Phone: ( )**

City: **State:** **Zip:**

US Resident: ☐ Yes ☐ No **Date of Birth:** ____/____/____ **Gender:** ☐ Male ☐ Female

Veteran: ☐ Yes ☐ No **Disabled:** ☐ Yes ☐ 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 Monthly 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 AbbVie 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 AbbVie 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:**

abbvie PATIENT ASSISTANCE FOUNDATION

Marinol® Prescription and Order Form

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

Section 1 - Physician and Prescription Information					
Physician Name:	DEA/State License #:		Phone: ( )	Fax: ( )	
Address: (no P.O. Box)	City:		State:	Zip:	
Prescription	**Instructions**	**Quantity**	**Day Supply**		**Refills**
Marinol® ☐ 2.5 mg ☐ 5 mg ☐ 10 mg			☐30 ☐60 ☐90		

Enclose a copy of a government issued ID of the patient when ordering the product listed above:
Driver License, State ID, Military ID, etc.,
The products listed above must be shipped to the patient's address

Physician Signature:

(must be MD / DO no PAC / NP) ☐_____ ___/___/___ ☐_____
(substitution allowed) (date) (dispense as written)

Section 2 - Patient Information			
Patient Name:		SS #, Green Card, VISA:	
Street Address:		Date of Birth:	
City:	State:	Zip:	Phone: ( )

Medication Information

Patient allergies: ☐No Known _____
Please list the names of other medications the patient is currently taking: ☐ 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.

Abbott Medical Nutrition
Patient Assistance Program Application

The Abbott Medical Nutrition Program is a program of the AbbVie Patient Assistance Foundation that provides products at no cost to eligible 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 program's purpose of providing products at no cost to individuals in need.

The Abbott Medical Nutrition Patient Assistance Program is designed to supplement medical nutrition product needs.

Abbott Nutrition Products available through the program do not include all packaging configurations and flavors.

If the product you or your health care professional has requested is not available, you will be provided with product that most closely meets the ingredient composition of the product specified in the initial request.

Prior to submitting an application, we suggest that you contact the program by calling 1-866-801-5657 as program availability is subject to change.

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 copy of Medicaid and/or Social Security denial, if applicable.
- ☐ Provide copy of private insurance denial letter OR the published policy that states nutritional products are not a covered benefit, if applicable.
- ☐ Contact 1-866-801-5657 to confirm program availability for the requested product

Fax or mail the completed application and documentation to:

Abbott Medical Nutrition Patient Assistance Program
PO Box 579
Somerville, NJ 08876

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. Reorder timeframes vary by product. Please contact us to reorder your approved product. It is the responsibility of the prescriber's office or the patient to reorder.

Please contact us at 1-866-801-5657 Mon-Fri 8am-5pm CST for additional assistance.

Abbott Medical Nutrition Patient Assistance Program Application

AbbVie Patient Assistance Foundation • PO Box 579 • Somerville NJ 08876
Phone: (866) 801-5657 • Fax: (866) 734-7353

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 for Nutrition Products? ☐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 Medical 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 medication 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 AbbVie Patient Assistance Foundation at P.O. Box <XXX> Somerville, NJ 08876. 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, AbbVie and the AbbVie Patient Assistance Foundation 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 AbbVie Patient Assistance Foundation 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 Medical 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:** _____

Product Requested (If the product requested is not available, you will be provided with product that most closely meets the ingredient composition of the requested product.)

Product: _____ **Flavor(s):** _____ **Administration** ☐Oral ☐Tube

% Caloric Need to be met with Product _____ Estimated Total Caloric Need of Patient (Daily): _____ Number of servings per day. _____

Product: _____ **Flavor(s):** _____ **Administration** ☐Oral ☐Tube

% Caloric Need to be met with Product _____ Estimated Total Caloric Need of Patient (Daily): _____ Number of servings per day: _____

Primary Diagnosis: _____ **Indications for Use:** _____

Please provide both a primary diagnosis (i.e. HIV/Aids, diabetes, etc.) and the indications for use (i.e. involuntary weight loss, cachexia, malnutrition, etc.) that requires the need for nutrition therapy. Applications for Metabolic products and Elecare require a primary diagnosis only.

PRESCRIBER INFORMATION

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 Medical 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 Medical 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 Medical 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 (no stamps): _____ **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.

abbvie PATIENT ASSISTANCE FOUNDATION

AbbVie Patient Assistance Foundation Application

The AbbVie Patient Assistance Foundation provides AbbVie 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 AbbVie 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:

AbbVie Patient Assistance Foundation
PO Box 270
Somerville, NJ 08876
Fax: 1-866-898-1473
Phone: 1-800-222-6885

Upon receipt of a completed application, the prescriber and the patient will be notified of program eligibility. If the 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 3 weeks prior to the patient requiring further medication.

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

abbvie PATIENT ASSISTANCE FOUNDATION

AbbVie Patient Assistance Foundation Application

AbbVie Patient Assistance Foundation • PO Box 270 • Somerville NJ 08876 • Phone: 1-800-222-6885 • Fax: 1-866-898-1473

PATIENT INFORMATION

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

Patient Address | City | State | Zip

Date of Birth: _____ SSN (Last four digits only): XXX- _____

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 for prescriptions? ☐ Yes ☐ No

Are you covered through 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 AbbVie 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 AbbVie Patient Assistance Foundation at P.O. Box 270 Somerville, NJ 08876. 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 high quality service, 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.

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 AbbVie 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. 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 Foundation, 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 to Applicant.

Patient's Representative _____ **Relationship** _____ **Date:** _____

Medicine Requested

Product: _____ **Strength:** _____ **Sig:** _____ **Reorders allowed:** up to 1 year

Product: _____ **Strength:** _____ **Sig:** _____ **Reorders allowed:** up to 1 year

PRESCRIBER INFORMATION

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

Shipping Address | 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 AbbVie 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 AbbVie Patient Assistance Foundation and its contracted third parties.**
2. **Physician:** 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 AbbVie 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 AbbVie 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 by the AbbVie Patient Assistance Foundation is not made in exchange for any explicit or implicit agreement or understanding that AbbVie 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 (no stamps): _____ **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.

abbvie PATIENT ASSISTANCE FOUNDATION

Patient Assistance Application for Zemplar® (paricalcitol)

The AbbVie Patient Assistance Foundation provides AbbVie 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 AbbVie 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. Failure to complete required information will delay the review process.
- ☐ Provide front and back copies of all prescription insurance card(s).
- ☐ Provide proof of income (tax return, W2, pay stub) for all in household.
  - o If there is no household income ($0) due to job loss or other circumstance, you do not need to provide income documents.
- ☐ Physician's signature is required at the bottom of the 1st page.
- ☐ Patient's signature is required at the bottom of the 3rd page.

Fax or mail the completed application and documentation to:

Note: If application is faxed, Prescriber MUST sign and fax it with MD office cover sheet.

AbbVie Patient Assistance Foundation
P.O. Box 399
San Bruno, CA 94066
Fax: 1-800-361-9942
Phone: 1-800-222-6885

Upon receipt of a completed application, the physician and patient will be notified of eligibility. If approved, medication will be shipped to the destination indicated on the application. It is the responsibility of the physician or patient to reorder 3 weeks prior to the patient requiring further medication.

Please note, if approved, medication will be scheduled for shipment to the specified location on the application.

Please contact us at 1-800-222-6885 Monday through Friday for additional assistance.

THIS PAGE TO BE COMPLETED BY PHYSICIAN

abbvie PATIENT ASSISTANCE FOUNDATION

Patient Assistance Application for Zemplar® (paricalcitol)

The AbbVie Patient Assistance Foundation provides Zemplar at no cost to individuals who meet specific program eligibility criteria

PLEASE COMPLETE ALL SECTIONS, SIGN, AND FAX THIS FORM TO 1-800-361-9942 OR MAIL TO:
ABBVIE PATIENT ASSISTANCE FOUNDATION • P.O. BOX 399 • SAN BRUNO, CA 94066. FOR QUESTIONS PLEASE CALL 1-800-222-6885.

PHYSICIAN INFORMATION

Physician Name:	☐MD ☐DO ☐Other ____	☐ Nephrology ☐ Other _____
Office Name:	Office Contact Name:	
Address:	City/State/Zip:	
Phone:	Fax:	
State License #:	Tax ID#:	NPI/Insurance Provider #:

PATIENT HISTORY AND SHIPPING PREFERENCE

Patient's Name:	DOB:
Allergies (List):	☐ No known allergies
PTH Level:	Date of PTH Level:

If patient is eligible to receive medication through the AbbVie Patient Assistance Foundation, ship to: (No P.O. Boxes)
☐ Patient ☐ Physician Office **NOTE: Injectable products must be shipped to Physician's office**

Shipping Address (if different from patient address):

PRESCRIPTION INFORMATION

ZEMPLAR CAPSULES	ZEMPLAR INJECTION
☐ Secondary Hyperparathyroidism (588.81) and CKD Stage 3 (585.3) ☐ Secondary Hyperparathyroidism (588.81) and CKD Stage 4 (585.4) ☐ Secondary Hyperparathyroidism (588.81) and CKD Stage 5 (585.5) ☐ Other (include code(s)) _____	☐ Secondary Hyperparathyroidism (588.81) and CKD Stage 5 (585.5) ☐ Other (include code(s)) _____
☐ Zemplar Capsules 1mcg *NDC: 00074-4317-30* ☐ Zemplar Capsules 2mcg *NDC: 00074-4314-30* ☐ Zemplar Capsules 4mcg *NDC: 00074-4315-30*	☐ Zemplar Injection 2 mcg/mL, 2mcg/vial *NDC: 00074-4637-01* ☐ Zemplar Injection 5 mcg/mL, 5mcg/vial *NDC: 00074-1658-01*
Route of Administration: Oral Directions for Use: _____	Route of Administration IV Directions for Use: _____
Quantity to be Dispensed: ☐ 90 day supply ☐ Other_____	Refills: ☐ 1 year ☐ Other_____
Quantity to be Dispensed. ☐ 90 day supply ☐ Other_____	Refills: ☐ 1 year ☐ Other_____

Special Note: New York Prescribers please submit prescription on an original NY State prescription blank, for all other States, if not faxed, must be on State specific blank if applicable for your State

PHYSICIAN CERTIFICATION

Physician Signature: ☐ _____
(no stamps) (Substitution Permitted) Date

Physician Signature: ☐ _____
(no stamps) (Dispense as Written) Date

Authorization for Release of Health Information: By signing this form, I represent to the AbbVie Patient Assistance Foundation (the "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 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 AbbVie 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 Foundation's patient assistance program (the "PAP") for Zemplar, I understand that the Foundation will send the medication to the designated shipping location, which could include my office or the patient's home. The Foundation reserves the right to request additional information if needed and to change or discontinue the PAP at any time, without notice. By signing this form, I certify that I am prescribing the aforementioned medication for an individual participating in the PAP. 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 PAP is not made in exchange for any explicit or implicit agreement or understanding that AbbVie Product will be used, purchased, leased, ordered, prescribed, recommended, or arranged for or provided formulary or other preferential or qualifying status. By signing this form, I authorize the Foundation and its representatives to transmit this prescription form electronically, by facsimile, or by mail to a pharmacy designated by the Foundation for the dispensing of the medication called for herein. I understand that I may not delegate signature authority. I certify that treatment with this medication is medically necessary.

THIS PAGE TO BE COMPLETED BY PATIENT

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PATIENT INFORMATION

Patient Name:	Sex: ☐ M ☐ F
DOB:	SSN (last four digits ONLY):___ | | | ___
Address (No P.O. Box):	
City/State/Zip:	
Daytime Phone:	Evening Phone:
Treating Physician Name:	
Treating Physician Phone:	Treating Physician Fax:
Primary Care Physician Name:	Primary Care Physician Phone:
Other Medications (List):	

INSURANCE INFORMATION

☐ I have no insurance coverage
☐ I have insurance coverage that does not cover Zemplar (please provide details below or attach a copy of the insurance card)

PRIMARY INSURANCE	SECONDARY INSURANCE
Insurance Company:	Insurance Company:
Insurance Co. Phone:	Insurance Co. Phone:
Policy #:	Policy #:
Group #:	Group #:
Policyholder Name:	Policyholder Name:
Relationship to Policyholder:	Relationship to Policyholder:
Policyholder DOB:	Policyholder DOB:

Medicare Questions:

- Are you eligible for Medicare? ☐ Yes ☐ No If No, anticipated date of Medicare eligibility (if within the year)? _____
- Are you enrolled into a Medicare Prescription Drug Plan? ☐ Yes ☐ No ☐ Unsure
- Are you eligible for extra help (financial assistance from Social Security) with medication costs under Medicare Part D? ☐ Yes ☐ No ☐ Unsure
- If Medicare eligible, please provide the value of your assets: $_____

(Assets include checking and savings accounts, CD's, stocks and bonds, savings bonds, mutual funds, IRAs and other investments, cash at home or anywhere else, and the value of your life insurance policies if turned in for cash right now. Do not include your home, vehicles, burial plots, or personal possessions.)

FINANCIAL INFORMATION (Proof of income required)

Current Monthly Household Income $:_____ # in Household (circle): 1 2 3 4 5 6 ____

Source of Income: ☐ Wages ☐ SSDI ☐ SSI ☐ Unemployment ☐ Pension ☐ Other: _____

Please provide current income documentation (tax return, pay stub, etc.) to avoid delays in processing time.

- ***If there is no household income ($0) due to job loss or other circumstance, you do not need to provide income documents.***
- ***If income documents do not match current income, please explain:***

REPRESENTATIVE INFORMATION

I permit the AbbVie Patient Assistance Foundation to speak with the following person about this application and permit such person(s) to sign any related documents on my behalf for purposes of this Program:

Name:	Relationship:	Phone Number:
Name:	Relationship:	Phone Number:

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Patient Certification and Authorization for Disclosure of Information

I request and authorize the sharing of any information regarding my health, treatment, and coverage that pertains to payment for Zemplar among my insurance companies, my physicians, AbbVie Inc. or third parties contracted by AbbVie, and the AbbVie Patient Assistance Foundation (the "Foundation") or third parties contracted by the Foundation. 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 (the "PAP") (should I qualify). However, if I do not provide this authorization, my decision will not affect my ability to obtain treatment from my health care providers or decisions about payment, enrollment, or eligibility for benefits made by my insurance companies. I know I may cancel this authorization at any time by writing to the AbbVie Patient Assistance Foundation at P.O. Box 399, San Bruno, CA 94066. If I cancel this Authorization, I can no longer participate in certain aspects of 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.

For Eligible Patient Assistance Patients Only:

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 PAP as determined by the Foundation. In the event that I am eligible for the PAP, 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 PAP may be changed or 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 at no cost from the Foundation. I agree that I will notify the Foundation if my insurance or financial situation changes.

Patient's Name:_____ **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 Patient'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 Personal Representative's Name:_____ **Signature:**_____

Relationship to Patient: _____ **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.

FORM 990-PF OTHER EXPENSES STATEMENT 1

DESCRIPTION	(A) EXPENSES PER BOOKS	(B) NET INVEST-MENT INCOME	(C) ADJUSTED NET INCOME	(D) CHARITABLE PURPOSES
SHIPPING AND DISTRIBUTION	2,985,678.	0.		2,985,678.
ADMINISTRATIVE	26,248.	0.		26,248.
OUTSIDE SERVICES	1,602,649.	0.		1,602,649.
TO FORM 990-PF, PG 1, LN 23	4,614,575.	0.		4,614,575.

FORM 990-PF PART VIII - LIST OF OFFICERS, DIRECTORS TRUSTEES AND FOUNDATION MANAGERS STATEMENT 2

NAME AND ADDRESS	TITLE AND AVRG HRS/WK	COMPEN-SATION	EMPLOYEE BEN PLAN CONTRIB	EXPENSE ACCOUNT
THAD SMITH D-031C AP31-3NW, 1 WAUKEGAN ROAD NORTH CHICAGO, IL 600646197	VICE PRESIDENT 10.00	0.	0.	0.
DENIS TIAN D-031C AP31-3NW, 1 WAUKEGAN ROAD NORTH CHICAGO, IL 600646197	TREASURER 1.00	0.	0.	0.
DALE JOHNSON D-031C AP31-3NW, 1 WAUKEGAN ROAD NORTH CHICAGO, IL 600646197	DIRECTOR 1.00	0.	0.	0.
JOHN PILOTTE D-031C AP31-3NW, 1 WAUKEGAN ROAD NORTH CHICAGO, IL 600646197	PRESIDENT 1.00	0.	0.	0.
KELLY INGOLD D-031C AP31-3NW, 1 WAUKEGAN ROAD NORTH CHICAGO, IL 600646197	DIRECTOR 1.00	0.	0.	0.
KEVIN DOLAN D-031C AP31-3NW, 1 WAUKEGAN ROAD NORTH CHICAGO, IL 600646197	DIRECTOR 1.00	0.	0.	0.
ANGELA SEKSTON D-031C AP31-3NW, 1 WAUKEGAN ROAD NORTH CHICAGO, IL 600646197	DIRECTOR 1.00	0.	0.	0.

KATHLEEN SCHEIDT D-031C AP31-3NW, 1 WAUKEGAN ROAD NORTH CHICAGO, IL 600646197	SECRETARY 1.00	0.	0.	0.
STEVEN SCROGHAM D-031C AP31-3NW, 1 WAUKEGAN ROAD NORTH CHICAGO, IL 600646197	ASSISTANT SECRETARY 1.00	0.	0.	0.
TABETHA SKARBEK D-031C AP31-3NW, 1 WAUKEGAN ROAD NORTH CHICAGO, IL 600646197	ASSISTANT TREASURER 1.00	0.	0.	0.
RUSSELL GARICH D-031C AP31-3NW, 1 WAUKEGAN ROAD NORTH CHICAGO, IL 600646197	DIRECTOR 1.00	0.	0.	0.
DARYL DORCY D-031C AP31-3NW, 1 WAUKEGAN ROAD NORTH CHICAGO, IL 600646197	DIRECTOR 1.00	0.	0.	0.
KEVIN BUCKBEE D-031C AP31-3NW, 1 WAUKEGAN ROAD NORTH CHICAGO, IL 600646197	DIRECTOR 1.00	0.	0.	0.
TOTALS INCLUDED ON 990-PF, PAGE 6, PART VIII		0.	0.	0.