Abbott Nutrition®
PATIENT ASSISTANCE PROGRAM APPLICATION

Abbott Nutrition Patient Assistance Program
610 Crescent Executive Court, Suite 200, Lake Mary, FL 32746

Phone: 866-801-5657 **Fax:** 866-734-7353
Hours: Monday through Friday, 9:00am – 5:00pm ET

APPLICATION CHECKLIST (Application will be delayed if all information is not received)

- ☐ **Prescriber AND Patient signature required**
- ☐ All information in required fields
- ☐ Proof of Income (includes, but not limited to: most recent copies of either 1040 form, W2, Paystub, SSA 1099 from previous year, Unemployment award letter)

PRESCRIBER INFORMATION (required)

Prescriber Name:		Specialty:	
Prescriber Address:	City:	State:	Zip Code:
Facllity Name:		Contact Name:	
Phone #:		Fax #:	
Prescriber NPI# :		Prescriber Tax ID#:	

PATIENT INFORMATION (required)

Patient Name:	Date of Birth:	Caregiver Name:	
Phone#:	US Resident? ☐ Yes ☐ No	Gender ☐ M ☐ F	
Patient Address:	City:	State :	Zip Code:

PATIENT INSURANCE INFORMATION (Attach a copy of insurance cards, if available). CHECK HERE IF UNINSURED ☐

Primary Insurance:	Policy#:	Group #:	
Policy Holder's Name:	Policy Holder's Date of Birth:	Payer Phone #:	
Member ID#:	Group#:	PBM BIN#:	PCN#:
Secondary Insurance:	Policy#:	Group #:	
Policy Holder's Name:	Policy Holder's Date of Birth:	Payer Phone #:	

ADMINISTRATION METHOD AND QUANTITY (required)

◯ Tube or ◯ Oral Estimated Caloric Need of Patient (Daily): _____ % of Caloric Need to be Met by Product: _____%

DIAGNOSIS (required)

ICD 10 Diagnosis Code(s): _____ ICD 10 Description: _____

Please provide both a primary diagnosis code (i.e. Z91.011, K90.0, etc.) & the associated code description (i.e. Allergy to milk products, Celiac disease, etc.) that requires the need for nutrition therapy.

PRODUCT REQUESTED (required)

- ☐ Ensure Original
- ☐ Ensure Plus
- ☐ Glucerna Shake
- ☐ Glucerna 1.0 Cal
- ☐ Glucerna 1.2 Cal
- ☐ Glucerna 1.5 Cal
- ☐ Jevity 1.0 Cal
- ☐ Jevity 1.2 Cal
- ☐ Jevity 1.5 Cal
- ☐ Nepro with Carb Steady
- ☐ Osmolite 1.0 Cal
- ☐ Osmolite 1.2 Cal
- ☐ Osmolite 1.5 Cal
- ☐ PediaSure Peptide 1.0 Cal
- ☐ PediaSure Peptide 1.5 Cal
- ☐ Vital Peptide 1.5 Cal
- ☐ Vital 1.0 Cal
- ☐ Vital 1.5 Cal
- ☐ Vital AF 1.2 Cal
- ☐ Vital High Protein
- ☐ PediaSure Shake
- ☐ PediaSure with Fiber
- ☐ PediaSure 1.5 Cal
- ☐ PediaSure 1.5 Cal w/ Fiber
- ☐ PediaSure Enteral 1.0 Cal
- ☐ PediaSure Enteral 1.0 Cal w/ Fiber
- ☐ PediSure Harvest
- ☐ Pulmocare
- ☐ Suplena
- ☐ Calcilo XD
- ☐ Cyclinex-1
- ☐ Cyclinex-2
- ☐ Glutarex-1
- ☐ Glutarex-2
- ☐ Hominex-1
- ☐ Hominex-2
- ☐ I-Valex-1
- ☐ I-Valex-2
- ☐ Ketonex-1
- ☐ Ketonex-2
- ☐ Phenex-1
- ☐ Phenex-2
- ☐ Pro-Phree
- ☐ Propimex-1
- ☐ Propimex-2
- ☐ ProViMin
- ☐ RCF
- ☐ Tyrex-1
- ☐ Tyrex-2
- ☐ Similac PM 60/40
- ☐ Pivot 1.5 Cal
- ☐ EleCare
- ☐ EleCare Jr.
- ☐ TwoCal
- ☐ Hi Cal
- ☐ Perative
- ☐ Promote
- ☐ Promote with Fiber

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PRESCRIBING CLINICIAN CERTIFICATION AND CONSENT (required)

1. **Authorization for Release of Health Information: By signing this form, I represent to the Abbott Nutrition Patient Assistance Program that I have obtained all necessary Federal and state authorizations and consents from my patient to allow me to release health information to the Abbott Nutrition Patient Assistance Program and its contracted third parties.**
2. **Physician/Care Coordinator Verification:** I verify that the information provided is current, complete and accurate to the best of my knowledge and certify that I am authorized to receive medications at the shipping location identified in this application. I verify that my State License is currently in good standing. I further certify that I will notify the Abbott Nutrition Patient Assistance Program (the "Program") in writing immediately if the status of my State License Number registration changes. If this applicant is eligible for the Program assistance, I understand that the Program will send the nutrition product directly to the patient's home unless I request that it be sent to my office for dispensing to the patient. The Program reserves the right to request additional information if needed and to change or discontinue the assistance at any time, without notice. By signing this form, I certify that I am prescribing the aforementioned medication for an individual participating in the Program. I acknowledge that I shall not seek reimbursement for any medication dispensed hereunder from any government program or third party insurer. I also understand that the applicant's acceptance by the Program is not made in exchange for any explicit or implicit agreement or understanding that Abbott Product will be used, purchased, leased, ordered, prescribed, recommended, or arranged for or provided formulary or other preferential or qualifying status. I understand that I may not delegate signature authority. I certify that treatment with this medication is medically necessary.

Prescribing Clinician Name (print):

Prescribing Clinician Signature (no stamped signatures): 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.

PATIENT CONSENT (certification and authorization to disclose information) (required)

Patient Name: Date of Birth:

Patient's Total Annual Household Income: $ Household Size (including patient):

(Attach the most current copies of income documentation for you and all dependent persons. See list of documents above in the Application Checklist Section.) OR check the box below to see if your income verification can be obtained electronically.

☐ I understand that that I am providing 'written instructions' to Abbott's PAP Administrator under the Fair Credit Reporting Act authorizing Abbott's PAP Administrator to obtain information from my credit profile or other information from Experian Health. I authorize Abbott's PAP Administrator to obtain such information solely to determine if I am financially eligible for the Abbott Nutrition Patient Assistance Program.

I understand that any assistance in the form of product at no cost is contingent upon my ability to meet the eligibility criteria for the Abbott Nutrition Patient Assistance Program ("Program"). In the event that I am eligible for patient assistance, I acknowledge that this assistance is temporary and that I may be asked to reapply at designated intervals by the Program. I also understand that the Program assistance may change or be discontinued at any time without any notice to me. I agree that I will not seek reimbursement for any products dispensed under the Program from any government program or third party insurer. I certify that the information I have provided in this form is accurate and complete. I understand that by completing this form I am not guaranteed eligibility to receive the product from the Program. I agree that I will notify the Program if my insurance or financial situation changes. The Program will use my information for purposes of determining patient assistance eligibility. I understand that I need to give my authorization to take part in the Program (should I qualify). I know I may cancel this authorization at any time by writing to the Abbott Nutrition Patient Assistance Program at 610 Crescent Executive Court, Suite 200, Lake Mary, FL 32746. If I cancel this Authorization, I can no longer participate in the Program. This authorization shall be valid for 10 years from the date of the signature on this form. I authorize the Program to share my information with Abbott for the following purposes: (i) to determine eligibility for the Program, (ii) to account for my withdrawal if I decide to stop participating in the Program, (iii) to administer and maintain high quality service, and (iv) as otherwise required or permitted by law. I agree that the Abbott Nutrition Patient Assistance Program does not have any liability in providing Program services to me.

Patient Name (print): Date of Birth:

Patient 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 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 Representative Name (print): Relationship to Patient:

Patient's Representative Signature: Date: