

Thank you for downloading this patient assistance document from NeedyMeds. We hope this program will help you get the medicine you need.

REMEMBER - Send your completed application to address on the form, NOT to NeedyMeds.

Did you know that NeedyMeds has thousands of other free resources?

Here's a look at more ways we can help you save money on medicine and healthcare costs. Each one can be found under the **"Patient Savings"** tab on our website:

- **Diagnosis-Based Assistance** — NeedyMeds lists thousands of assistance programs for almost any health condition. If you are going through chemo treatment for cancer, there are programs that can help with wig costs and scalp-cooling products. We also list resources for free diabetes testing supplies, caregiver lodging support, and much more.
- **Free, Low Cost, and Sliding Scale Clinics** — This popular collection contains information on 18,000+ free, low cost, and sliding scale medical and dental clinics across the U.S. It's a great resource if you need affordable medical treatment and don't know where to go.
- **Coupons, Rebates & More** — You can use the NeedyMeds website to find nearly 2,000 cost-saving opportunities for both prescription and over-the-counter drugs and medical supplies.
- **Medical Transportation** — Need help getting to the doctor's office or medical facility? You may be eligible for financial assistance if you meet certain requirements.

Finally, I want to tell you about the NeedyMeds Drug Discount Card. Thousands of people use this free, anonymous, and easy-to-use tool to get the best price on their medications. To date, our drug discount card has saved patients over \$244,000,000. Check out the next page to learn more.

Feel free to call our toll-free helpline if you have any questions. You can reach us at 1-800-503-6897 Monday-Friday, 9am-5pm Eastern Time.

Thanks for using NeedyMeds! Please let us know if we can do anything else to help you afford the costs of your healthcare.



Richard J. Sagall, MD
President, NeedyMeds

Clip the card and save

 	NeedyMeds Drug Discount Card www.needymeds.org
DRUG DISCOUNT CARD	
BIN: 020750 RX PCN: NMeds RX GRP: PDFPDF ID: NMNA019309901930	Customer Care 1-888-602-2978
This is a drug discount program, not an insurance plan.	
Pharmacy Help Desk: 1-800-404-1031.	

- Save up to 80% on medications*
- Use at over 65,000 pharmacies nationwide including all major chains
- Share the card with friends and family

- Use the card as often as needed
- Free, no fees or registration
- Never expires

What will receive a discount?

All prescription medications are eligible for savings, including over-the-counter medicines and medical supplies written as a prescription, as well as human-equivalent pet medications with a prescription by a veterinarian.

You can also save up to 40% off durable medical equipment, including canes, crutches, splints, incontinence supplies and more. You can also save on diabetic supplies such as glucose meters, test strips, lancets and diabetic shoes. Visit www.needymeds.org/dme to learn more.

What if I have insurance?

Anyone can use the card, but it can't be combined with state or federal insurance. You can use the card instead of insurance if:

- A drug isn't covered by your insurance
- Your insurance has no drug coverage
- You have a high drug deductible
- You have met a low medicine cap
- The card offers a better price than your copay
- You are in the Medicare Part D donut hole

To obtain a plastic drug discount card, send a self-addressed, stamped envelope to:

NeedyMeds Drug Discount Card
PO Box 219
Gloucester, MA 01931

The card is not valid in combination with insurance plans, including Medicare, Medicaid or any state or federal prescription insurance. The card can be used only if you decide not to use your government-sponsored drug plan for your purchases.

* Average savings of 60%, with potential savings of up to 80% or more (based on 2018 national program savings data). All prescription medications are eligible for savings.

This is a drug discount program, not an insurance plan. Discounts are available exclusively through participating pharmacies. The range of the discounts will vary depending on the type of prescription and the pharmacy chosen. This program does not make payments directly to pharmacies. Users are required to pay for all prescription purchases. Cannot be used in conjunction with insurance. You may call 1-888-602-2978 with questions or concerns or to obtain further information.

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:
Facility Name:		Contact Name:	
Phone #:		Fax #:	
Prescriber NPI# :		Prescriber Tax ID#:	

PATIENT INFORMATION (required)

Patient Name:	Date of Birth:	Caregiver Name:
Phone#:	US Resident? <input type="checkbox"/> Yes <input type="checkbox"/> No	Gender <input type="checkbox"/> M <input type="checkbox"/> 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)

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

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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: