proCeed

Simplified access. Coordinated care.

ProCeed Customer Solutions

Intake Forms and Quick Reference Guide

Gain Access

Streamline access to VIEKIRA PAK for your patients using the enclosed proCeed Customer Solutions intake forms.

viekira pak™

ombitasvir, paritaprevir and ritonavir tablets; dasabuvir tablets

INDICATION[1]

VIEKIRA PAK™, with or without ribavirin (RBV), is indicated for the treatment of adult patients with genotype 1 chronic hepatitis C virus infection, including those with compensated cirrhosis.

Limitation of Use:

VIEKIRA PAK is not recommended for use in patients with decompensated liver disease.

SAFETY CONSIDERATIONS[1]

When VIEKIRA PAK is administered with RBV, the contraindications, warnings and precautions (particularly pregnancy avoidance), and adverse reactions for RBV also apply to this combination regimen. Refer to the RBV prescribing information. VIEKIRA PAK is contraindicated in patients with severe hepatic impairment and in patients with known hypersensitivity to ritonavir. VIEKIRA PAK is contraindicated with certain drugs that are highly dependent on CYP3A for clearance; strong inducers of CYP3A or CYP2C8; and strong inhibitors of CYP2C8. ALT elevations >5x ULN occurred in 1% of all subjects and were significantly more frequent in females using ethinyl estradiol-containing medications, which are contraindicated. Perform hepatic lab testing on all patients. HCV/HIV-1 co-infected patients should also be on a suppressive antiretroviral drug regimen.

Please see Important Safety Information on page 2.
Please see full Prescribing Information provided or visit www.viekirahcp.com.

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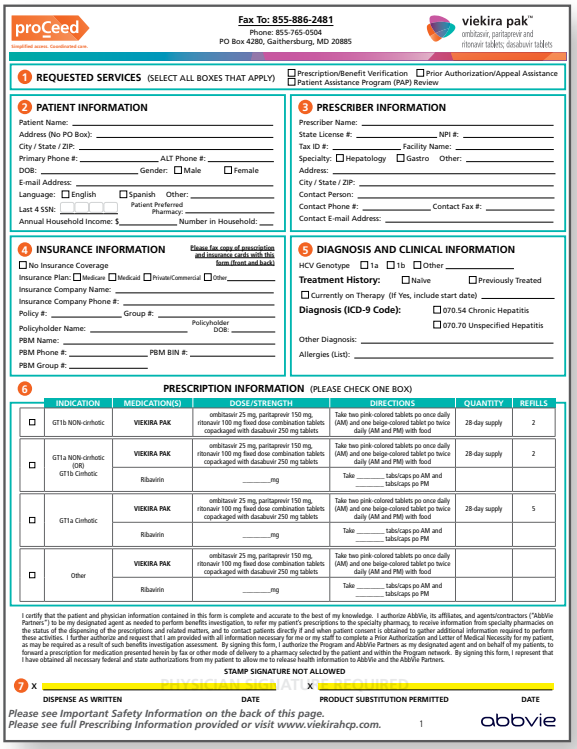
PROCEED INTAKE FORMS QUICK REFERENCE GUIDE

Page 1: Patient intake and prescription form *(completed by provider)*

- Select the requested services
- Provide the intake information
- Complete the prescription
- Sign, date, and fax to 1-855-886-2481
  Physician signature required



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Phone: 855-765-0504
PO Box 4280, Gaithersburg, MD 20885

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1 REQUESTED SERVICES (SELECT ALL BOXES THAT APPLY) ☐ Prescription/Benefit Verification ☐ Prior Authorization/Appeal Assistance ☐ Patient Assistance Program (PAP) Review

2 PATIENT INFORMATION
Patient Name:
Address (No PO Box):
City / State / ZIP:
Primary Phone #: ALT Phone #:
DOB: Gender: ☐ Male ☐ Female
E-mail Address:
Language: ☐ English ☐ Spanish Other:
Last 4 SSN: Patient Preferred Pharmacy:
Annual Household Income: $ Number in Household:

3 PRESCRIBER INFORMATION
Prescriber Name:
State License #: NPI #:
Tax ID #: Facility Name:
Specialty: ☐ Hepatology ☐ Gastro Other:
Address:
City / State / ZIP:
Contact Person:
Contact Phone #: Contact Fax #:
Contact E-mail Address:

4 INSURANCE INFORMATION Please fax copy of prescription and insurance cards with this form (front and back)
☐ No Insurance Coverage
Insurance Plan: ☐ Medicare ☐ Medicaid ☐ Private/Commercial ☐ Other
Insurance Company Name:
Insurance Company Phone #:
Policy #: Group #:
Policyholder Name: Policyholder DOB:
PBM Name:
PBM Phone #: PBM BIN #:
PBM Group #:

5 DIAGNOSIS AND CLINICAL INFORMATION
HCV Genotype ☐ 1a ☐ 1b ☐ Other
Treatment History: ☐ Naive ☐ Previously Treated
☐ Currently on Therapy (If Yes, include start date)
Diagnosis (ICD-9 Code): ☐ 070.54 Chronic Hepatitis ☐ 070.70 Unspecified Hepatitis
Other Diagnosis:
Allergies (List):

6 PRESCRIPTION INFORMATION (PLEASE CHECK ONE BOX)

	INDICATION	MEDICATION(S)	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐	GT1b NON-cirrhotic	VIEKIRA PAK	ombitasvir 25 mg, paritaprevir 150 mg, ritonavir 100 mg fixed dose combination tablets copackaged with dasabuvir 250 mg tablets	Take two pink-colored tablets po once daily (AM) and one beige-colored tablet po twice daily (AM and PM) with food	28-day supply	2
☐	GT1a NON-cirrhotic (OR) GT1b Cirrhotic	VIEKIRA PAK	ombitasvir 25 mg, paritaprevir 150 mg, ritonavir 100 mg fixed dose combination tablets copackaged with dasabuvir 250 mg tablets	Take two pink-colored tablets po once daily (AM) and one beige-colored tablet po twice daily (AM and PM) with food	28-day supply	2
		Ribavirin	_____mg	Take _____ tabs/caps po AM and _____ tabs/caps po PM		
☐	GT1a Cirrhotic	VIEKIRA PAK	ombitasvir 25 mg, paritaprevir 150 mg, ritonavir 100 mg fixed dose combination tablets copackaged with dasabuvir 250 mg tablets	Take two pink-colored tablets po once daily (AM) and one beige-colored tablet po twice daily (AM and PM) with food	28-day supply	5
		Ribavirin	_____mg	Take _____ tabs/caps po AM and _____ tabs/caps po PM		
☐	Other	VIEKIRA PAK	ombitasvir 25 mg, paritaprevir 150 mg, ritonavir 100 mg fixed dose combination tablets copackaged with dasabuvir 250 mg tablets	Take two pink-colored tablets po once daily (AM) and one beige-colored tablet po twice daily (AM and PM) with food		
		Ribavirin	_____mg	Take _____ tabs/caps po AM and _____ tabs/caps po PM		

I certify that the patient and physician information contained in this form is complete and accurate to the best of my knowledge. I authorize AbbVie, its affiliates, and agents/contractors ("AbbVie Partners") to be my designated agent as needed to perform benefits investigation, to refer my patient's prescriptions to the specialty pharmacy, to receive information from specialty pharmacies on the status of the dispensing of the prescriptions and related matters, and to contact patients directly if and when patient consent is obtained to gather additional information required to perform these activities. I further authorize and request that I am provided with all information necessary for me or my staff to complete a Prior Authorization and Letter of Medical Necessity for my patient, as may be required as a result of such benefits investigation assessment. By signing this form, I authorize the Program and AbbVie Partners as my designated agent and on behalf of my patients, to forward a prescription for medication presented herein by fax or other mode of delivery to a pharmacy selected by the patient and within the Program network. By signing this form, I represent that I have obtained all necessary federal and state authorizations from my patient to allow me to release health information to AbbVie and the AbbVie Partners.

STAMP SIGNATURE NOT ALLOWED
7 X PHYSICIAN SIGNATURE REQUIRED X
DISPENSE AS WRITTEN DATE PRODUCT SUBSTITUTION PERMITTED DATE

Please see Important Safety Information on the back of this page.
Please see full Prescribing Information provided or visit www.viekirahcp.com. 1 abbvie

Pages 2-4: Can be faxed or mailed to the indicated PO Box *(completed by the patient)*

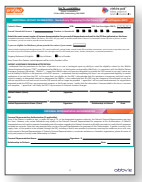
Page 2: HIPAA Authorization

Allows proCeed to advocate on behalf of your patient and coordinate care between healthcare providers (provider, payer, and pharmacy).

Page 3: Patient Support Consent

Allows your patient to access proCeed support services: Co-pay Assistance program, Educational materials, Dedicated proCeed Nurse Connector.

Page 4: Patient Assistance Program Application & Personal Representation Authorization



Allows your patient to be considered for a financial assistance program for uninsured patients. On this form, the patient can designate, if necessary, an individual to sign on his or her behalf.

Please see Important Safety Information on page 2.
Please see full Prescribing Information provided or visit www.viekirahcp.com.

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1 REQUESTED SERVICES (SELECT ALL BOXES THAT APPLY)

☐ Prescription/Benefit Verification ☐ Prior Authorization/Appeal Assistance
☐ Patient Assistance Program (PAP) Review

2 PATIENT INFORMATION

Patient Name: _____
Address (No PO Box): _____
City / State / ZIP: _____
Primary Phone #: _____ ALT Phone #: _____
DOB: _____ Gender: ☐ Male ☐ Female
E-mail Address: _____
Language: ☐ English ☐ Spanish Other: _____
Last 4 SSN: ☐☐☐☐ Patient Preferred Pharmacy: _____
Annual Household Income: $_____ Number in Household: ____

3 PRESCRIBER INFORMATION

Prescriber Name: _____
State License #: _____ NPI #: _____
Tax ID #: _____ Facility Name: _____
Specialty: ☐ Hepatology ☐ Gastro Other: _____
Address: _____
City / State / ZIP: _____
Contact Person: _____
Contact Phone #: _____ Contact Fax #: _____
Contact E-mail Address: _____

4 INSURANCE INFORMATION

Please fax copy of prescription and insurance cards with this form (front and back)

☐ No Insurance Coverage
Insurance Plan: ☐ Medicare ☐ Medicaid ☐ Private/Commercial ☐ Other_____
Insurance Company Name: _____
Insurance Company Phone #: _____
Policy #: _____ Group #: _____
Policyholder Name: _____ Policyholder DOB: _____
PBM Name: _____
PBM Phone #: _____ PBM BIN #: _____
PBM Group #: _____

5 DIAGNOSIS AND CLINICAL INFORMATION

HCV Genotype ☐ 1a ☐ 1b ☐ Other _____
Treatment History: ☐ Naïve ☐ Previously Treated
☐ Currently on Therapy (If Yes, include start date) _____
Diagnosis (ICD-9 Code): ☐ 070.54 Chronic Hepatitis
☐ 070.70 Unspecified Hepatitis
Other Diagnosis: _____
Allergies (List): _____

6 PRESCRIPTION INFORMATION (PLEASE CHECK ONE BOX)

	INDICATION	MEDICATION(S)	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐	GT1b NON-cirrhotic	**VIEKIRA PAK**	ombitasvir 25 mg, paritaprevir 150 mg, ritonavir 100 mg fixed dose combination tablets copackaged with dasabuvir 250 mg tablets	Take two pink-colored tablets po once daily (AM) and one beige-colored tablet po twice daily (AM and PM) with food	28-day supply	2
☐	GT1a NON-cirrhotic (OR) GT1b Cirrhotic	**VIEKIRA PAK**	ombitasvir 25 mg, paritaprevir 150 mg, ritonavir 100 mg fixed dose combination tablets copackaged with dasabuvir 250 mg tablets	Take two pink-colored tablets po once daily (AM) and one beige-colored tablet po twice daily (AM and PM) with food	28-day supply	2
		Ribavirin	_____mg	Take _____ tabs/caps po AM and _____ tabs/caps po PM		
☐	GT1a Cirrhotic	**VIEKIRA PAK**	ombitasvir 25 mg, paritaprevir 150 mg, ritonavir 100 mg fixed dose combination tablets copackaged with dasabuvir 250 mg tablets	Take two pink-colored tablets po once daily (AM) and one beige-colored tablet po twice daily (AM and PM) with food	28-day supply	5
		Ribavirin	_____mg	Take _____ tabs/caps po AM and _____ tabs/caps po PM		
☐	Other	**VIEKIRA PAK**	ombitasvir 25 mg, paritaprevir 150 mg, ritonavir 100 mg fixed dose combination tablets copackaged with dasabuvir 250 mg tablets	Take two pink-colored tablets po once daily (AM) and one beige-colored tablet po twice daily (AM and PM) with food		
		Ribavirin	_____mg	Take _____ tabs/caps po AM and _____ tabs/caps po PM		

I certify that the patient and physician information contained in this form is complete and accurate to the best of my knowledge. I authorize AbbVie, its affiliates, and agents/contractors ("AbbVie Partners") to be my designated agent as needed to perform benefits investigation, to refer my patient's prescriptions to the specialty pharmacy, to receive information from specialty pharmacies on the status of the dispensing of the prescriptions and related matters, and to contact patients directly if and when patient consent is obtained to gather additional information required to perform these activities. I further authorize and request that I am provided with all information necessary for me or my staff to complete a Prior Authorization and Letter of Medical Necessity for my patient, as may be required as a result of such benefits investigation assessment. By signing this form, I authorize the Program and AbbVie Partners as my designated agent and on behalf of my patients, to forward a prescription for medication presented herein by fax or other mode of delivery to a pharmacy selected by the patient and within the Program network. By signing this form, I represent that I have obtained all necessary federal and state authorizations from my patient to allow me to release health information to AbbVie and the AbbVie Partners.

STAMP SIGNATURE NOT ALLOWED

7

X _____ PHYSICIAN SIGNATURE REQUIRED X _____

DISPENSE AS WRITTEN **DATE** **PRODUCT SUBSTITUTION PERMITTED** **DATE**

INDICATION[1]

VIEKIRA PAK™, with or without ribavirin (RBV), is indicated for the treatment of adult patients with genotype 1 chronic hepatitis C virus infection, including those with compensated cirrhosis.

Limitation of Use:

VIEKIRA PAK is not recommended for use in patients with decompensated liver disease.

IMPORTANT SAFETY INFORMATION[1]

Risks Associated with RBV Combination Treatment

If VIEKIRA PAK is administered with RBV, the contraindications, warnings and precautions (particularly pregnancy avoidance), and adverse reactions for RBV also apply to this combination regimen. Refer to the RBV prescribing information.

CONTRAINDICATIONS

VIEKIRA PAK is contraindicated:

- in patients with severe hepatic impairment due to risk of potential toxicity.
- with drugs that are highly dependent on CYP3A for clearance and for which elevated plasma levels are associated with serious and/or life-threatening events; strong inducers of CYP3A or CYP2C8, which may lead to reduced efficacy of VIEKIRA PAK; and strong CYP2C8 inhibitors, which may increase dasabuvir levels and the risk of QT prolongation.
- with the following drugs: alfuzosin HCL; carbamazepine, phenytoin, phenobarbital; gemfibrozil; rifampin; ergotamine, dihydroergotamine, ergonovine, methylergonovine; ethinyl estradiol-containing medicines, such as many oral contraceptives; St. John's wort *(Hypericum perforatum)*; lovastatin, simvastatin; pimozide; efavirenz; sildenafil (when dosed as Revatio* for pulmonary arterial hypertension); triazolam and oral midazolam.
- in patients with known hypersensitivity (e.g., toxic epidermal necrolysis or Stevens-Johnson syndrome) to ritonavir.

WARNINGS AND PRECAUTIONS

Increased Risk of ALT Elevations

- Elevations of ALT to >5x the ULN occurred in 1% of all subjects in clinical trials and were significantly more frequent in females using ethinyl estradiol-containing medications. In female patients, discontinue ethinyl estradiol-containing medications prior to starting therapy and use alternative methods of contraception during therapy (e.g., progestin only or non-hormonal contraception). Use caution when co-administering VIEKIRA PAK with estrogens other than ethinyl estradiol, such as estradiol and conjugated estrogens.
- Perform hepatic lab testing on all patients during the first 4 weeks of treatment and as clinically indicated thereafter. If ALT is elevated above baseline levels, repeat testing and monitor closely. Patients should be instructed to consult their doctor without delay if they have onset of fatigue, weakness, lack of appetite, nausea and vomiting, jaundice, or discolored feces. Consider discontinuing VIEKIRA PAK if ALT levels remain persistently >10x the ULN. Discontinue VIEKIRA PAK if ALT elevation is accompanied by signs or symptoms of liver inflammation or increasing conjugated bilirubin, alkaline phosphatase, or INR.

Risk of Adverse Reactions or Reduced Therapeutic Effect Due to Drug Interactions

- The concomitant use of VIEKIRA PAK and certain other drugs may result in known or potentially significant drug interactions, some of which may lead to loss of therapeutic effect of VIEKIRA PAK and possible development of resistance, or adverse reactions from greater exposures of concomitant drugs or components of VIEKIRA PAK.

HCV/HIV-1 Co-infected Patients: Risk of HIV-1 Protease Inhibitor Drug Resistance

- The ritonavir component of VIEKIRA PAK is an HIV-1 protease inhibitor and can select for HIV-1 protease inhibitor resistance. To reduce this risk, HCV/HIV-1 co-infected patients should also be on a suppressive antiretroviral drug regimen.

ADVERSE REACTIONS

- In subjects receiving VIEKIRA PAK with RBV, the most commonly reported adverse reactions (>10% of subjects) were fatigue, nausea, pruritus, other skin reactions, insomnia, and asthenia. In subjects receiving VIEKIRA PAK without RBV, the most commonly reported adverse reactions (≥5% of subjects) were nausea, pruritus, and insomnia.

Reference: 1. VIEKIRA PAK [package insert]. North Chicago, IL: AbbVie Inc.

*Revatio® is a trademark of its respective owner and not a trademark of AbbVie Inc. The makers of this brand are not affiliated with and do not endorse AbbVie Inc. or its products.

PATIENT HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) AUTHORIZATION

I understand that the purpose of this authorization ("Authorization") is to give my permission for the disclosure and use of my protected health information to the extent it is required under state and federal law. I hereby authorize my healthcare providers, healthcare insurers, and laboratory testing facilities that have provided treatment, payment, or services to me or for me (collectively, "Healthcare Companies") to disclose information about me, my medical condition, and my treatment, insurance coverage and payment information in relation to my use of AbbVie products, (collectively, "Personal Information"), to AbbVie, its affiliates, and agents/contractors ("AbbVie Partners"), in order for AbbVie and AbbVie Partners to use and disclose my Personal Information to: (1) enroll me in and use my Personal Information to provide me with the proCeed programs and related services (for example, financial assistance) ("proCeed Services"); (2) provide me with informational and marketing materials related to the use of my prescribed AbbVie products, clinical trial and market research opportunities, and other services by any means of communication, including by text, e-mail, direct mail, and/or telephone; and (3) de-identify my Personal Information and use or disclose the de-identified data to help improve, develop, and evaluate products, services, materials, programs, and treatment related to my condition or treatment, as well as for health economic outcomes research and market research. I understand that once AbbVie and the AbbVie Partners receive my Personal Information, they may communicate with my Healthcare Companies to provide the proCeed Services. AbbVie and the AbbVie Partners are hereby notified by the Healthcare Companies that they may use the disclosed Personal Information only for the purposes set forth above. I also understand that if my Healthcare Companies use or disclose my Personal Information for marketing purposes, they may receive financial remuneration.

I understand that I am not required to sign this Authorization and that my Healthcare Companies will not condition my treatment, payment, enrollment or eligibility for benefits on whether I sign this Authorization.

I understand that this Authorization is voluntary, and will expire in 10 years or a shorter time period if required by state law, unless I cancel it sooner. I understand that if I do not sign this Authorization, I cannot participate in certain proCeed Services. I may cancel my Authorization by calling 844-277-6233 and by notifying my Healthcare Companies. Once AbbVie receives and processes my cancellation request, AbbVie will not use my Personal Information going forward. I understand that canceling my Authorization will not affect any use of my information that occurred before my request was processed.

I understand that my Personal Information released under this Authorization is subject to re-disclosure by AbbVie and AbbVie Partners and will no longer be protected by HIPAA.

California, Rhode Island, Minnesota and Florida Only: State law prohibits the person receiving my Personal Information from making further disclosure of it, unless another authorization for such disclosure is obtained from me or unless such disclosure is required or permitted by law.

By signing below, I agree to the statements above and that I am currently 18 years of age or older.

X _____	X _____	_____
Patient's Name (Print)	**Signature**	**Date**

OR

X _____	X _____	_____	_____
Patient Representative's Name (Print)	**Signature**	**Relationship to Patient**	**Date**

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PROCEED PATIENT SUPPORT PROGRAM AUTHORIZATION

I hereby consent to participate in AbbVie's proCeed program, which I understand is an AbbVie sponsored coordination of care program designed to provide personalized treatment support. I consent to AbbVie, its affiliates, and agents/contractors ("AbbVie Partners") to use and disclose information that they have been provided for the following purposes: (1) enroll me in and use my personal information to provide me with the proCeed programs and related services, which include reimbursement services, financial assistance, disease management support, nurse support and care coordination ("proCeed Services"); (2) provide me with informational and marketing materials related to the use of my prescribed AbbVie products, clinical trial and market research opportunities, and other services by any means of communication, including by text, e-mail, direct mail, and/or telephone; and (3) de-identify my personal information and use or disclose the de-identified data to help improve, develop, and evaluate products, services, materials, programs, and treatment related to my condition or treatment, as well as for health economic outcomes research and market research. I understand AbbVie and AbbVie Partners will not sell or rent my personal information or otherwise use my personal information for any purpose not authorized above.

I understand that this Consent to Participate is voluntary. However, I understand that if I do not sign this Consent to Participate, I cannot participate in the proCeed program. I may cancel by calling 844-277-6233. Once AbbVie receives and processes my cancellation request, AbbVie will not use my personal information going forward. I understand that cancelling my Consent to Participate will not affect any use of my information that occurred before my request was processed.

By signing below, I agree to the statements above and that I am currently 18 years of age or older.

_____ X _____		_____	
Patient's Name (Print)	**Signature**	**Date**	
OR			
_____ X _____		_____	_____
Patient Representative's Name (Print)	**Signature**	**Relationship to Patient**	**Date**

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ADDITIONAL PATIENT INFORMATION – Needed only if applying for the Patient Assistance Program (PAP)

Patient's Name: _____ DOB: _____ SSN (last four digits ONLY): ☐☐☐☐

Annual Household Income: $ _____ Number in Household: ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 _____

Attach the most current copies of income documentation for you and all dependents and mail to the PO Box indicated on this form.
Acceptable documents include: Federal Tax Return, SSA 1099, W2, pay stubs or benefits award letter. If there is no household income ($0) due to job loss or other circumstance, you do not need to provide income documents.

If you are eligible for Medicare, please provide the value of your assets: _____

(Assets include checking and savings accounts, CDs, 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.)

Shipping Preference (if eligible): ☐ Ship to Patient ☐ Ship to Provider

Note: Puerto Rico Patients: initial shipment will be to the Provider's office.

PATIENT ASSISTANCE PROGRAM ATTESTATION
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 Program ("PAP") as determined by AbbVie Inc. or third parties contracted by AbbVie Inc. in connection with the AbbVie Patient Assistance Program (collectively, "AbbVie"). I agree that AbbVie does not have any obligation to provide the PAP services to me and I waive any and all liability of AbbVie in the provision of the PAP services. I understand that by completing this form I am not guaranteed eligibility to receive medication at no cost from the PAP. 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 as determined by AbbVie. I also understand that the PAP may be changed or discontinued at any time without any notice to me and at such time the PAP services will no longer be provided. I agree that I will not seek reimbursement for any products dispensed under the PAP from any government program or third party insurer. I certify that the information I have provided in this form is accurate and complete. I agree that I will notify the PAP if my insurance or financial situation changes.

_____ **X** _____ _____
Patient's Name (Print) **Signature** **Date**

OR

_____ **X** _____ _____ _____
Patient Representative's Name (Print) **Signature** **Relationship to Patient** **Date**

PERSONAL REPRESENTATIVE AUTHORIZATION

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 PAP, 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.

Personal Representative Name: _____ **Signature: X** _____

Relationship to Patient: _____ **Date:** _____

Please see Important Safety Information on page 2.
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 046-1656308 December 2014

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