THE ABBVIE AND ORASURE PATIENT SUPPORT PROGRAM

PROGRAM DESCRIPTION
AbbVie, OraSure, and your healthcare provider would like to make you aware of a patient support program provided through AbbVie to help newly diagnosed hepatitis C patients understand and better manage their disease (the “Patient Support Program” or “Program”). The Patient Support Program includes support services at no additional charge, and is managed by AbbVie and OraSure.

AbbVie has partnered with OraSure to offer patients a co-payment assistance option as part of the Patient Support Program, and in connection with your purchase and use of the OraQuick® HCV Rapid Antibody Test (the “Co-Payment Assistance Option”). Hepatitis C patients may choose to enroll in the Patient Support Program with or without choosing the Co-Payment Assistance Option.

As part of your enrollment in the Program, AbbVie and OraSure will request certain information from you and your healthcare providers, including date of birth, gender, ethnicity, contact information, OraQuick HCV Rapid Antibody Test results, and insurance information (collectively, “Health Information”).

If you choose to enroll in the Patient Support Program, AbbVie and OraSure will use and disclose your Health Information to:

• Determine your eligibility to participate
• Allow AbbVie’s Hepatitis C Community Educators to contact you about hepatitis C
• Administer the Patient Support Program, which may require AbbVie or OraSure to disclose your Health Information to third parties that AbbVie or OraSure hire to help administer the Patient Support Program
• Contact you by mail, email, or phone with marketing information about AbbVie products or services that relate to hepatitis C that you may wish to order or purchase; or
• Contact you by mail, email, or phone about your participation in the Patient Support Program.

OraSure and AbbVie will use appropriate safeguards to protect your Health Information and will not use or disclose your Health Information (other than as described herein) without your permission. OraSure and AbbVie will provide or transfer your Health Information to a third party only for such third party’s use in relation to the Patient Support Program, including the Co-Payment Assistance Option.

Only patients who have commercial insurance or are uninsured are eligible for the Co-Payment Assistance Option. Participation in the Co-Payment Assistance Option may also be limited or prohibited by law in certain States. The Co-Payment Assistance Option is not available to patients receiving reimbursement under any federal, state or government-funded insurance programs (for example, Medicare, Medicaid, TRICARE, Department of Defense or Veteran’s Affairs programs) or where prohibited by law.

In order to enroll in the Patient Support Program, you must complete and sign both (1) the Authorization for Enrollment in the AbbVie and OraSure Patient Support Program (“Authorization for Enrollment”) and (2) a separate HIPAA Authorization for Use and Disclosure of Health Information (“HIPAA Authorization”). If you do not complete and sign both forms, you will not be eligible to participate in the Patient Support Program, including the Co-payment Assistance Option.

RIGHTS, LIMITATIONS, BENEFIT DISCLOSURE, AND EXPIRATION

Being a member of the Patient Support Program does NOT require you to purchase or use any AbbVie or OraSure product.

Your enrollment in the Program and your HIPAA Authorization are voluntary. Your Health Information, once disclosed by your Provider, in some instances could be legally redisclosed by the recipient without your knowledge, and in such cases may no longer be protected by HIPAA. Your HIPAA Authorization allows AbbVie and OraSure to further disclose your Health Information to third parties only to facilitate the Program.

You may decide not to sign the HIPAA Authorization, which will not affect your ability to obtain care from your Provider, including diagnosis or treatment, eligibility for benefits, or payment for healthcare services from healthcare providers, health plans, and health insurance. However, if you decide not to sign the HIPAA Authorization, you will not be able to participate in the Program.

You have the right to revoke your HIPAA Authorization in writing at any time but your revocation will not change any uses, disclosures, or other actions already taken with your Health Information. In order to revoke, you must do so in writing and send it to your Provider, with copies sent to AbbVie and OraSure at the addresses set forth in the HIPAA Authorization.

You will receive a copy of the HIPAA Authorization from your Provider and you also have a right to obtain a copy of your enrollment authorization by calling AbbVie 1-800-255-5162.

If you are eligible and enroll in the Co-Payment Assistance Option as described in this Program Description, OraSure will pay to your Provider some or all of your co-payment up to a maximum of $5.

Your HIPAA Authorization will expire on the earlier of (i) your Provider’s receipt of your written revocation of the HIPAA Authorization (sent to your Provider with copies sent to AbbVie and OraSure) or (ii) five (5) years from the date of your signature on the HIPAA Authorization, unless a shorter period is prescribed by state law.

To be removed from the Patient Support Program or to request a copy of your enrollment authorization, please contact AbbVie Customer Service at 1-800-255-5162.
AGREEMENT FOR ENROLLMENT IN THE ABBVIE AND ORASURE PATIENT SUPPORT PROGRAM

To enroll in the AbbVie and OraSure Patient Support Program (the “Program”) you must complete and sign this form.

Please fax pages 2, 3, 4 and 5 of this form to 908-809-6217.
- Fill necessary fields with CAPITAL LETTERS
- Always use one box per letter and leave one box space to separate words
- Use dark ink pen or marker

You must also complete and sign a separate HIPAA Authorization for Use and Disclosure of Health Information (“HIPAA Authorization”).

☐ Patient Support Program with Co-Payment Assistance Option  ☐ Patient Support Program Only

I have read the Program Description and the Rights, Limitations, Benefit Disclosure, and Expiration for the AbbVie and OraSure Patient Support Program. By signing below, I hereby voluntarily enroll in the Program and authorize my Provider to disclose my Health Information to AbbVie and OraSure as described in the Program description and in the separate HIPAA Authorization that I have signed.

PATIENT SIGNATURE

Patient Signature: Date:

Patient Name (Last)

Patient Name (First) (Middle initial)

If not the Patient, indicate relationship to Patient:

PROVIDER SIGNATURE

I hereby confirm that Patient has voluntarily enrolled in the Program and has provided me a signed HIPAA Authorization authorizing me to disclose the Patient’s Health Information as set forth in that Authorization, that I have provided Patient with a copy of the HIPAA Authorization and that I will retain a copy in my files.

SIGNATURE

Provider Signature: Date:

Provider Name (Last)

Provider Name (First) (Middle initial)

NPI

Provider Contact Phone

Date of Service (MM/DD/YYYY)

Patient Test Result (fill in one)

Source (fill in one)

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## PATIENT SUPPORT PROGRAM ENROLLMENT

- Fill all fields with CAPITAL LETTERS
- Always use one box per letter and leave one box space to separate words
- Use dark ink pen or marker

### PATIENT INFORMATION

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<th>Field</th>
<th>Information</th>
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<td>Patient DOB (MM/DD/YYYY)</td>
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<td>Gender (fill in one)</td>
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### PROVIDER INFORMATION

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<td>Date of Service (MM/DD/YYYY)</td>
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HIPAA AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

PATIENT INFORMATION

Patient Name (Last)

Patient Name (First) (Middle initial)

I have read the Program Description and the Rights, Limitations, Benefit Disclosure, and Expiration for the AbbVie and OraSure Patient Support Program (the “Program”). By signing below, I hereby authorize my Provider (identified below) to use and/or disclose my Health Information to AbbVie, Inc. (“AbbVie”) and to OraSure Technologies, Inc. (“OraSure”) for purposes of enrolling and participating in the Program.

In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand the following:

• This Authorization covers the use and disclosure of my name, address, contact information, date of birth, gender, ethnicity, insurance information and OraQuick HCV Rapid Antibody Test® results (collectively, “Health Information”).

• My Health Information will be disclosed to AbbVie, Inc., 1 North Waukegan Road, North Chicago, IL 60064, and to OraSure Technologies, Inc., 220 East First Street, Bethlehem, PA 18015.

• My Health Information will be used and disclosed solely for purposes of my enrolling and participating in the Program.

• More specifically, my Health Information will be used and disclosed for the following purposes: (1) to determine my eligibility to participate in the Program, (2) to allow AbbVie’s Hepatitis C Community Educators to contact me about hepatitis C, (3) to administer the Program which may require AbbVie or OraSure to disclose my Health Information to third parties that AbbVie or OraSure hire to help administer the Program, (4) to contact me by mail, email or phone with marketing information about AbbVie products or services that relate to hepatitis C that I may wish to order or purchase, or (5) to contact me by mail, email, or phone about my participation in the Program. In addition, I understand that AbbVie and OraSure may further disclose my Health Information to facilitate the Program.

• My Health Information may be redisclosed by AbbVie or OraSure to third parties without my knowledge as part of the Program, and in such cases my Health Information may no longer be protected by HIPAA.
HIPAA AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION (CONT)

- I have the right to revoke this Authorization in writing at any time by writing to my Provider (identified below) with copies to AbbVie and OraSure at the addresses listed above. My revocation of this authorization will not, however, affect any uses, disclosures, or other actions already taken with my Health Information prior to my revocation.

- My signing of this Authorization is voluntary. My treatment by my Provider, payment for healthcare services, enrollment in a health plan, or eligibility for benefits under a health plan will not be conditioned upon my authorization of this disclosure. However, I understand that if I decide not to sign this Authorization, I will not be able to participate in the Program, including the Co-Payment Assistance Option.

- This Authorization will expire on the earlier of (1) my Provider’s receipt of my written revocation of this Authorization or (2) five years from the date of my signature below (unless a shorter period is prescribed by state law).

PROVIDER INFORMATION

Provider Name (Last)

Provider Name (First) (Middle initial)

Provider Address

Provider City Provider State Provider Zip

I have read and reviewed this Authorization and had any questions about this form answered. In addition, I have been provided a copy of this Authorization.

SIGNATURE

Patient Signature: Date: