Background and History of the Common Patient Assistance Program Application (CPAPA)

HIV patient assistance programs (PAPs) are administered by pharmaceutical companies and provide free antiretroviral (ARV) medicines to low-income people who are uninsured (in some cases, underinsured) and who do not qualify for assistance programs, such as Medicaid, Medicare, or AIDS Drug Assistance Programs (ADAPs). Each individual company has different eligibility criteria for qualifying for assistance through their PAP.

In 2012, the Department of Health and Human Services (DHHS), along with seven pharmaceutical companies, NASTAD (the National Alliance of State & Territorial AIDS Directors), and community stakeholders developed a common patient assistance program application (CPAPA) that can be used by both providers and patients. The CPAPA was updated in January 2019 and is reflected in this document. Before 2012, patients and advocates had to complete different and separate sets of paperwork for each company. The CPAPA form helps simplify this process. The form combines common information collected on each individual company’s form to allow individuals to fill out one, consolidated form. Once the form is completed, case managers or individuals then submit the single form to each individual company, reducing the overall amount of paperwork necessary to apply for a PAP.

You may send feedback about the form or its instructions to commonpapform@NASTAD.org (please do not send questions about eligibility or status of an application).
Instructions for Using the Common Patient Assistance Program Application (CPAPA)

Step 1: Review the “Program Description” and “Form Instructions” provided on page 1 of the CPAPA form.

Step 2: Review the information listed under the second column of page 3 of the CPAPA form for each of the companies you are planning to submit to for enrollment.

A single CPAPA form may be submitted to each individual company, reducing the overall amount of paperwork necessary to apply for a PAP. However, each company may have special requirements such as where the medication can be shipped after enrollment and if a patient advocate may sign the form on the patient’s behalf. Be sure to review this information in each company’s section prior to completing the rest of the form and compile all necessary attachments (see step 8 below).
Step 3: Complete “Patient General Information” section (see page 2).

Fill out the “Patient General Information” portion of the CPAPA form including name, mailing address, phone number, language, gender, date of birth, and information regarding the patient’s household. You may also opt to provide an e-mail address for future communications. Choose who will be the follow-up point of contact: the patient’s provider; a caseworker; the patient; OR other (please specify). If you leave this question blank the PAP will follow-up with the provider by default.

Step 4: Complete the “Coverage Information” section (see page 2).

Mark if the patient is “Enrolled,” “Not Eligible,” “Denied,” “Pending,” “Not Applied,” or “Waitlisted” (ADAP only) for all possible forms of coverage. If the patient is covered by private insurance drug coverage, list the name of the insurer, as some companies may still consider eligibility for their PAP if the patient has insufficient insurance to meet the patient’s needs.
Step 5: Complete the “Physician/Prescriber” section (see page 2).

It is important to ensure this section is complete. All licenses and special ID numbers are required to verify the physician and the original prescription.

**Physician/Prescriber Information**

Name (First):  (Middle):  (Last):
Business/Facility Name:  Phone:  Fax:
Office Contact Name (First):  (M.I.):  (Last):
Mailing Address:  City:  State:  Zip:
Professional Designation/Specialty:  National Provider Identifier:
Tax ID #:  DEA #:  State License #: 

Step 6: Complete the “Alternate Shipping Information” section (see page 2).

**Note:** Some PAPs require that medication be shipped directly to the physician/prescriber. However, **provide the physician/prescriber’s full mailing address in the section above regardless of whether or not the patient enrolls in a PAP that allows shipping to another address.**

**Alternate Shipping Information**

Name (First):  (Middle):  (Last):
Business/Facility Name:  Phone:  Fax:
Shipping Address:  City:  State:  Zip:
Relationship to patient:  Reason for alternate: 

Step 7: Complete the “Advocate Information” section (see page 2).

**Note:** Some PAPs will not accept an application without a patient’s ink signature (even if an advocate signs on their behalf). **Be sure to check each PAPs’ requirements as listed on the second column of page 3.**

**Advocate Information**

Name (First):  (Middle):  (Last):
Business/Facility Name:  Phone:  Fax:
Street Address:  City:  State:  Zip:
Relationship to patient:  

Advocate Signature  Date
Step 8: Compile all necessary attachments (see page 3).

The CPAPA form needs to be submitted to each PAP necessary to complete the prescribed treatment regimen. Each submission must include copies of all necessary attachments; each program has different requirements. Review which attachments are required for each PAP using the information provided in the third column of page 3. Special code numbers are listed. The key is located at the very top of the page. (Example: AbbVie PAP requirements attachment #6 – the original prescription form.)

Step 9: Complete the remaining portion of the form on page 3.

For each PAP to which the CPAPA form will be submitted, mark: the medication(s) needed; how the application will be submitted (by fax, mail, or electronically, depending on the PAP’s requirements); and where the medication should be shipped.

Step 10: Sign application on page 4.

Both the patient (or legal representative) and the physician/prescriber must sign the completed application either electronically or in ink.
Step 11: Send completed application.

Either fax, mail, or electronically submit the individual application and required attachments to the contact information located just under the pharmaceutical company name in column one on page 3. If an original signature is required, you will need to mail the form in addition to initially faxing it.

AbbVie Patient Assistance Foundation
P.O. Box 270, Somerville, NJ 08876 — Phone: 800-222-6885 Fax: 866-483-1305

This publication was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under cooperative agreement #U69HA26846 as part of an award totaling $500,000 with zero percentage financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS or the U.S. Government.