CLEAR FORM

ADVANCING ACCESS®
PATIENT ENROLLMENT FORM

INSTRUCTIONS

Please complete all applicable sections of the Patient Enrollment Form.

Mail or fax the completed Enrollment Form and all required documentation to Gilead's Advancing Access® program at the address or fax number below. Both sets of information are necessary to ensure timely enrollment form review. You may complete an electronic enrollment form online at www.GileadAdvancingAccess.com.

An Advancing Access case specialist will notify the requestor about the patient's coverage and benefits, alternate funding options, and/or qualification for the Patient Assistance Program/ Medication Assistance Program (PAP/MAP), depending on the support requested.

PATIENT CONFIDENTIALITY

Patient confidentiality is of primary importance to us. All patient information will remain confidential. Information may be provided to clinicians, social workers, or family members when required to complete the enrollment process and coordinate patient assistance, and to credit bureaus to determine program eligibility with your consent within this Enrollment Form.

IMPORTANT REMINDER

Please be certain that all applicable pages of the Enrollment Form are completed and include all appropriate documentation when submitting the form. Incomplete forms slow the review process and, in some cases, may require a patient to reapply for the program.

Gilead Sciences, Inc., reserves the right to modify or discontinue the Advancing Access program or terminate assistance at any time. Third-party reimbursement is affected by a range of factors; therefore, Gilead Sciences, Inc., cannot guarantee any coverage or reimbursement.

ADVANCING ACCESS®
PO Box 13185
La Jolla, CA 92039-3185

VISIT:
www.GileadAdvancingAccess.com

PHONE:
1-800-226-2056
(M–F 9 AM–8 PM ET)

FAX:
1-800-216-6857

GET STARTED >

A STEP-BY-STEP GUIDE TO FILLING OUT THE FORM

TO BE COMPLETED BY THE PATIENT OR PATIENT'S REPRESENTATIVE:

- **SECTION 1 (REQUIRED)**
  Check the box next to each support offering you are requesting from Advancing Access.
- **SECTION 2 (REQUIRED)**
  Write the name of the Gilead product you are requesting assistance with from Advancing Access.
- **SECTION 3 (REQUIRED)**
  Complete all fields with the patient's information.
- **SECTION 4 (REQUIRED)**
  Check the appropriate box to indicate if the patient is insured or uninsured.
  - If the patient is insured, fill in the patient's insurance information and fax a copy (front and back) of the patient's insurance card. If the patient has a secondary insurance, check the box to indicate this and fax a copy of the secondary insurance card.
  - If the patient is uninsured, complete Section 5 to apply to the Patient Assistance Program/Medication Assistance Program (PAP/MAP).
- **SECTION 5 (REQUIRED ONLY IF SHIPPING PRESCRIPTION DIRECTLY TO THE PRESCRIBER'S OFFICE, AND/OR APPLYING TO THE PATIENT ASSISTANCE PROGRAM/MEDICATION ASSISTANCE PROGRAM [PAP/MAP])**
  - Provide the patient's annual household income and household size and complete the additional insurance information portion.
  - Attach documentation for all sources of income and proof of residency. Patient photo ID may be required.
  - Check the appropriate box, sign, and date if you would like to have the prescription shipped directly to the prescriber's office/ clinic and/or if you are applying to the PAP/MAP.
- **SECTION 6 (REQUIRED)**
  The patient (or the patient's representative) must sign and date this section.

TO BE COMPLETED BY THE PRESCRIBER:

- **SECTION 7 (REQUIRED)**
  Complete all fields with the prescriber's information.*
- **SECTION 8 (REQUIRED)**
  A healthcare provider must provide the patient's diagnosis and medical information.
- **SECTION 9 (REQUIRED)**
  The prescriber must sign and date this section for reimbursement support and the Patient Assistance Program/Medication Assistance Program (PAP/MAP).
- **SECTION 10 (REQUIRED ONLY IF APPLYING TO THE PAP/MAP AND REQUESTING MAIL ORDER SHIPMENTS)**
  - Provide prescription information.
  - Prescriber must sign and date consent if shipping the prescription to their office/clinic.

*As used in this document, "prescriber" may refer to a licensed pharmacist permitted by law to prescribe or furnish DESCOVY for PrEP® (pre-exposure prophylaxis) or TRUVADA for PrEP® (pre-exposure prophylaxis).

ADVANCING ACCESS®

THIS PAGE TO BE COMPLETED BY **PATIENT** OR **PATIENT'S REPRESENTATIVE**

Enroll via the online portal at
www.GileadAdvancingAccess.com

PATIENT ENROLLMENT FORM

PHONE: **1-800-226-2056** | FAX: **1-800-216-6857**

1. REQUESTED PATIENT SUPPORT REQUIRED

CHECK ALL BOXES THAT APPLY

- ☐ Benefits Investigation
- ☐ Prior Authorization and Appeals Information
- ☐ Co-pay Coupon Program Enrollment
- ☐ Patient Assistance Program (PAP) or Medication Assistance Program (MAP) Eligibility Screening

2. GILEAD MEDICATION PRESCRIBED REQUIRED

Product Name:	If requesting DESCOVY® or TRUVADA®, please indicate for: ☐ Treatment ☐ PrEP/Prevention

3. PATIENT INFORMATION REQUIRED

First Name:	Last Name:	M.I.:	Preferred Name:
Address:	Apt./Unit #:	City:	
State:	ZIP Code:	Phone #: ( ) –	Preferred Language:
Email:		Date of Birth: / /	SSN# (Last 4 digits):
Alternate Contact Name:		Phone #: ( ) –	Relationship:

CONTACT AUTHORIZATION

☐ Yes ☐ No I authorize Advancing Access to leave a detailed message, including the name of my prescription, if I am unavailable when they call.

☐ Yes ☐ No I authorize Advancing Access to send me correspondence via US mail. This includes, but is not limited to, approval/denial letters for the Patient Assistance Program, reminder letters for re-enrollment periods, etc. If I select "No," or do not check either box, I understand that all communication will be via phone.

I authorize Advancing Access to provide me with information on my benefits and other communications that contain reference to the Advancing Access program or the ARx Patient Solutions Pharmacy through the following: ☐ Text ☐ Email ☐ Phone

4. INSURANCE INFORMATION REQUIRED

PLEASE INCLUDE A COPY OF THE FRONT AND BACK OF INSURANCE CARD(S)

☐ Patient is uninsured (ie, no health insurance through any public or private payer) — SEE OPTIONAL "PATIENT FINANCIAL INFORMATION" SECTION 5

☐ Patient is insured (Please fill out all of the applicable insurance information below — 🖇Attach copy [front & back] of all insurance cards, including medical and prescription.)

Primary Insurance:		Is this a Medicare Part D plan? ☐ Yes ☐ No	
Plan Name:		Insurance Phone #: ( ) –	
Subscriber Name:	Policyholder Name:	Policyholder Relationship to Patient:	
Policy #:	Group #:	Rx Bin #:	Rx PCN #:

☐ Check box if patient has secondary insurance coverage and fax a copy of insurance cards, if available.

5. PATIENT FINANCIAL INFORMATION REQUIRED ONLY IF APPLYING FOR THE PATIENT ASSISTANCE PROGRAM/ MEDICATION ASSISTANCE PROGRAM (PAP/MAP)

Current annual household income: $ _____
(Documentation for all sources of income may be required)

Number of people in household supported by current annual income: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ Other: _____

ADDITIONAL INSURANCE INFORMATION

Has the patient applied for ADAP or PrEP DAP? ☐ Yes ☐ No If Yes, date of application: _____	What is the ADAP status of the patient? ☐ Not Applied ☐ Pending ☐ Wait-Listed ☐ Denied (🖇Attach denial letter) ☐ Not Eligible, Reason: _____
Is the patient eligible for Medicaid? ☐ Yes ☐ No If No, state reason *(if denied, 🖇attach a copy of the denial letter)*: _____	Has the patient applied for Medicaid? ☐ Yes ☐ No If Yes, date of application: _____
Is the patient eligible for Medicare? ☐ Yes ☐ No If No, state reason *(if denied, 🖇attach a copy of the denial letter)*: _____	Has the patient applied for Medicare? ☐ Yes ☐ No If Yes, date of application: _____
Is the patient eligible for VA benefits? ☐ Yes ☐ No	If Yes, has the patient tried to obtain the medication through the VA? ☐ Yes ☐ No
Is the patient eligible for an insurance plan offered through a state insurance marketplace (also known as an exchange)? ☐ Yes ☐ No If No, state reason: _____	Has the patient applied for an insurance plan offered through a state insurance marketplace (also known as an exchange)? ☐ Yes ☐ No If Yes, date of application: _____

☐ PATIENT CONSENT

REQUIRED ONLY IF SHIPPING PRESCRIPTION DIRECTLY TO THE PRESCRIBER'S OFFICE/CLINIC

By checking this box, I understand that my prescription will be shipped directly to the prescriber's office address listed on this form (Section 7). I authorize the prescriber listed on this form, as my agent, to receive my prescription on my behalf. My prescriber, as my agent, will receive and then provide me with my prescription medication.

☐ APPLICANT DECLARATIONS AND AUTHORIZATIONS

REQUIRED ONLY IF APPLYING FOR THE PAP/MAP

By checking this box, I certify that all of the information provided in this application, including household income, is complete and accurate. I understand that program assistance will terminate if Advancing Access becomes aware of any false or inaccurate information or if this medication is no longer prescribed for me. I understand that I may only use the free product received through the PAP/MAP for my own use and personal consumption, and that I will not offer the product for sale, resale, barter, or trade. I understand that completing this application does not ensure that I will qualify for patient assistance. If I receive free product through the PAP/MAP, I certify that I will not seek reimbursement or credit for this medication from any insurer, health plan, or government program. If I am a member of a Medicare Part D plan, I will not seek to have this medication, or any cost for items associated with it, counted as part of my out-of-pocket cost for prescription drugs. I understand that the PAP/MAP reserves the right to modify the application form, modify or discontinue this program, or terminate assistance at any time and without notice. I authorize the PAP/MAP and its administrator to forward my prescription to a dispensing pharmacy on my behalf. Advancing Access may require me to submit proof of identity and income documentation to verify my eligibility into the Patient Assistance/Medication Assistance Program (eg, identification card, tax return, W-2, last two pay stubs, etc). **I authorize Gilead and its third-party administrator to use the information provided on this form to obtain a personal credit report about me to verify the information on this form and determine my eligibility for the PAP/MAP.**

X **SIGNATURE OF PATIENT or PATIENT'S AUTHORIZED REPRESENTATIVE UNDER FEDERAL OR STATE LAW** (REQUIRED):	**DATE:** / /
Patient Representative's Name (if signing for the patient):	**Patient Representative's Relationship to Patient:**	**Phone #:** ( ) –

PATIENT NAME: _____ **DATE OF BIRTH:** / /

6. PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION REQUIRED

I understand that I must complete this enrollment form before I can receive assistance through Gilead Sciences, Inc.'s Advancing Access ("Program") and the Patient Assistance Program/Medication Assistance Program ("PAP/MAP"). As part of this process, Gilead and its agents and contractors (collectively, "Gilead") will need to obtain, review, use, and disclose my personal and medical information as described below. I hereby authorize my healthcare providers and health plans to disclose my personal and medical information as described below to Gilead in connection with the Program and/or the PAP/MAP, all in accordance with this authorization, and I authorize Gilead to use and disclose the information in accordance with the authorization.

Information to Be Disclosed: Personal information ("PI"), including information about me (for example, my name, mailing address, financial information, and insurance information), my health information, such as my current and future medical condition (including information about my HIV-related status or treatment with this prescription medication and related medical condition), and all information provided on this enrollment form.

Persons Authorized to Disclose My Information: My healthcare providers, including any pharmacy that fills my prescription medication, and any health plans or programs that provide me with healthcare benefits. I understand that my pharmacy providers may receive remuneration for disclosing my PI pursuant to this authorization.

Persons to Whom My Information May Be Disclosed: Gilead, including the third-party administrator responsible for the administration of the Program and the PAP/MAP.

Purposes for Which the Disclosures Are to Be Made: Disclosures of PI may be made to Gilead so that Gilead may use and disclose the PI for purposes of: 1) completing the enrollment process and verifying my enrollment form, including but not limited to confirming my identity and my use or potential use of this prescription medication and prescribed through my relationship with the prescriber identified in Section 7; 2) establishing my eligibility for benefits from my health plan or other programs; 3) providing financial assistance and reimbursement support, if I am eligible, and providing other applicable support, including but not limited to information on third-party resources that may be able to assist me; 4) communicating with my healthcare providers, including, but not limited to, verifying my enrollment and facilitating the provision of my prescription medication to me; 5) contacting me to evaluate the effectiveness of the Program and/or the PAP/MAP; 6) Gilead's internal business purposes, including quality control; 7) audit and compliance purposes, including but not limited to case reviews and support-enhancing surveys; 8) confirming my receipt of the prescribed Gilead medication through the PAP/MAP based on my communication preferences above; and 9) sending me marketing information, offers, and educational materials related to my medical condition, treatment, and/or my prescription medication, including the customer relationship marketing program (this use of my personal information is OPTIONAL and by checking the box below, I may opt in).

I understand that once my PI has been disclosed hereunder, federal privacy law may no longer restrict its use or disclosure. I understand further that I may refuse to sign this authorization and that if I refuse, my eligibility for health plan benefits or ability to obtain treatment from my healthcare providers will not change, but I will not have access to the support offered by the Program and/or the PAP/MAP. I also understand that I may cancel this authorization at any time by notifying Gilead in writing at Advancing Access, PO Box 13185, La Jolla, CA 92039-3185. If I cancel, Gilead will stop using this authorization to obtain, use, or disclose my PI after the cancellation date, but the cancellation will not affect uses or disclosures of any PI that have already been made pursuant to this authorization before the cancellation date. I am entitled to a copy of this signed authorization, which expires the earlier of two (2) years from the date it is signed by me or other time period required under the laws of the state in which I reside.

☐ **Marketing Communications Opt-in (OPTIONAL):** By checking this box, I agree to receive marketing information, offers, and educational materials related to my medical condition, treatment, and/or my prescription medication, including the customer relationship marketing program. The marketing outreach program is separate from the PAP/MAP. I understand that opting in to the marketing outreach program is not required as a condition of purchasing any goods or receiving a co-pay or other support from Gilead.

X **SIGNATURE OF PATIENT or PATIENT'S AUTHORIZED REPRESENTATIVE UNDER FEDERAL OR STATE LAW** (REQUIRED): **DATE:** / /

Patient Representative's Name (if signing for the patient): **Patient Representative's Relationship to Patient:** **Phone #:** ( ) –

ADVANCING ACCESS® PATIENT ENROLLMENT FORM

PHONE: **1-800-226-2056** | FAX: **1-800-216-6857**

PATIENT NAME: _____ **DATE OF BIRTH:** / /

7. PRESCRIBER INFORMATION REQUIRED

MUST BE COMPLETED BY A HEALTHCARE PROVIDER

Prescriber Name:	Facility Name:		
Address:	City:	State:	ZIP Code:
Office Contact:	Phone #: ( ) –	Fax #: ( ) –	
NPI #:	State License #:	Tax ID #:	

8. DIAGNOSIS/MEDICAL INFORMATION REQUIRED

MUST BE COMPLETED BY A HEALTHCARE PROVIDER

Diagnosis (Please include ICD code):

9. PRESCRIBER CERTIFICATION AND STATEMENT OF MEDICAL NECESSITY REQUIRED

By signing this form, I certify that I am personally prescribing or furnishing Gilead medication for the patient identified in Section 3. I certify that this prescription medication is medically necessary for the patient and that it will be used as directed. I certify that I will be supervising or coordinating the patient's treatments, in accordance with law, and verify that the information provided as part of my patient's application for the Patient Assistance Program/Medication Assistance Program ("PAP/MAP") is complete and accurate to the best of my knowledge. I certify that I have not received and shall not seek reimbursement for any Gilead medication dispensed to the patient through the PAP/MAP from any government program or third-party insurer. If applicable, I certify that medication provided to me by the PAP/MAP for the eligible patient identified in Section 3 will be provided by me to such patient for his or her own use without charge. I certify that I will not otherwise use any such medication or prescribe, provide, furnish, or dispense all or any portion thereof to any other person or patient. I will notify Gilead if all or any portion of the medication provided to me by the PAP/MAP for the patient identified in Section 3 is not prescribed, provided, furnished, or dispensed to that patient, and I will ensure such medication is returned to Gilead or its designated representative, by calling 1-800-226-2056 within 30 days. I certify that I will not sell, resell, offer for sale, trade, or barter medication provided to me under the PAP/MAP.

I consent that Gilead may perform an audit related to: 1) the applicant identified in Section 3, including but not limited to confirming patient identity and verifying medical necessity; and 2) the dispensing of medication provided to the prescriber through the PAP/MAP, including confirming patient receipt of the prescribed Gilead medication and the timely return of any medications received for, but not dispensed to, the patient identified in Section 3, if applicable.

If prescribing DESCOVY for PrEP® or TRUVADA for PrEP®, I certify that the applicant has been tested for HIV infection and found to be HIV negative, and regular HIV testing will be conducted as part of the applicant's care plan. As part of my applicant's eligibility, I agree to periodically verify continued use of Gilead medication and resubmit current prescriptions.

I certify that I have received the appropriate written authorization from the patient, in accordance with the Health Insurance Portability and Accountability Act of 1996, applicable state health information privacy law(s), and any other applicable requirements, in order to release the patient's personal and medical information to Gilead and its agents and contractors for the purposes of assessing the patient's insurance coverage and eligibility for participation in Advancing Access, conducting random audits to verify the information provided on this enrollment form, and for other purposes as outlined in the Patient Authorization For Use and Disclosure of Personal Health Information in Section 6. Gilead is authorized to contact me about the information provided on this form and as needed to facilitate my patient's enrollment and participation in Advancing Access. I understand that Gilead may, if authorized by the patient, contact the patient directly to verify Advancing Access eligibility and updates to insurance coverage, as well as to confirm the receipt of Gilead medication through the PAP/MAP.

SPECIAL NOTE: New York prescribers, please submit prescription on an original NY State prescription blank. For all other states, if not faxed, prescription must be on State specific blank if applicable for your State.

X **PRESCRIBER SIGNATURE** (REQUIRED): **DATE:** / /

10. PRESCRIPTION INFORMATION

REQUIRED IF REQUESTING MAIL ORDER SHIPMENTS

PLEASE FILL OUT THE BELOW PRESCRIPTION FORM WHICH WILL BE SENT TO THE PAP/MAP DISPENSING PHARMACY ONCE YOUR PATIENT IS APPROVED

Rx

Patient First Name:	Last Name:	Date of Birth: / /	
Medication:		Strength:	
Quantity: **30**	Directions for Use:	Refills:	

Delivery Options: ☐ Retail Pharmacy Pick Up ☐ Mail Order Shipments ☐ Pick up initial supply at retail pharmacy (all subsequent fills via mail order)

Ship to: ☐ Patient Address (Section 3) ☐ Prescriber Office Address ☐ Alternate Address

Alternate Ship to Address:	City:	State:	ZIP Code:

HEALTHCARE PROVIDER CONSENT

REQUIRED IF SHIPPING THE PRESCRIPTION TO PRESCRIBER'S OFFICE/CLINIC

I understand that completing this enrollment form does not guarantee that assistance will be provided to my patient. My patient has given consent for me to receive their Gilead medication on their behalf. I will receive and secure my patient's medication at my office until it's provided to my patient, when applicable. I will comply with and abide by my State Practitioner Dispensing Laws for authorized prescribers, when applicable. Any medications supplied by Gilead as a result of this enrollment form are for the use of the patient named on this form only and shall not be sold, traded, bartered, transferred, returned for credit, or submitted to any third party (such as Medicare, Medicaid, or other benefit provider) for reimbursement. The medicine will be provided only to this eligible and enrolled patient at no charge of any kind. The information provided on this enrollment form is subject to random audits and verification. Gilead may change or cancel this program at any time; Gilead also reserves the right to terminate my patient's enrollment at any time. If medicine is not provided to my patient within 30 days of receipt, medicine must be returned to the ARx Patient Solutions Pharmacy. Healthcare facility may be subject to audits by Gilead and its third-party audit firm.

X **PRESCRIBER SIGNATURE** (REQUIRED): **DATE:** / /

FAX COMPLETED FORM TO ADVANCING ACCESS AT 1-800-216-6857

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