INSTRUCTIONS

Complete all applicable sections of the Enrollment Form.

- **Section 1 (required)**: Check the box next to each support offering you are requesting from Advancing Access®.
- **Section 2 (required)**: Write the name and dosage 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 9 to apply to the Patient Assistance Program/Medication Assistance Program (PAP/MAP).
- **Section 5 (required)**: Complete all fields with the prescriber's information.
- **Section 6**: A healthcare provider must provide the patient's diagnosis and medical information.
- **Section 7 (required)**: The prescriber must sign and date this section for reimbursement support and the Patient Assistance Program/Medication Assistance Program (PAP/MAP).
- **Section 8 (required)**: The patient (or the patient's representative) must sign and date this section.
- **Section 9 (required only if 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.
  - — The patient must sign and date this section if applying to the PAP/MAP.
  - — Attach documentation for all sources of income. If there is no household income, indicate how the patient/household is being supported.

Mail or fax the completed Enrollment Form and all required documentation to the 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 https://advancingaccessconsent.iassist.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 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 below.

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.

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ADVANCING ACCESS®

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:	mg:
If requesting TRUVADA®, please indicate for: ☐ Treatment ☐ PrEP/Prevention	

3. PATIENT INFORMATION (REQUIRED)

First Name:	Last Name:	M.I.:	Preferred Language:
Address:	Apt./Unit #	City:	
State:	Zip Code:	Phone #:	SSN# (Last 4 digits):
Email:		DOB:	
Alternate Contact Name:		Phone #:	Relationship:

CONTACT AUTHORIZATION

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

4. INSURANCE INFORMATION (REQUIRED)

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

☐ Patient is insured (Please fill out all of the applicable insurance information below. Attach copy—front and back—of patient card.)		☐ Patient is uninsured (ie, no health insurance through any public or private payer) SEE OPTIONAL "PATIENT FINANCIAL INFORMATION" SECTION 9 BELOW	
Primary Insurance:		Is this a Medicare Part D plan? ☐ Yes ☐ No	
Plan name:		Insurance Phone Number:	
Subscriber Name:	Policy Holder Name:	Policy Holder 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. PRESCRIBER INFORMATION (REQUIRED)

Prescriber Name:		Facility Name:	
Address:		City:	
State:	Zip Code:	Office Contact:	
Phone #:		Fax #:	NPI #:
Tax ID #:		State License #:	

6. DIAGNOSIS/MEDICAL INFORMATION

MUST BE COMPLETED BY HEALTHCARE PROVIDER

Diagnosis (Please include ICD code):_____

7. PRESCRIBER CERTIFICATION AND STATEMENT OF MEDICAL NECESSITY

By signing this form, I certify that I am prescribing 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 the patient's treatments and verify that the information provided is complete and accurate to the best of my knowledge. I agree that I shall not seek reimbursement for any Gilead medication dispensed to the patient through the Patient Assistance Program/Medication Assistance Program ("PAP/MAP") from any government program or third-party insurer.

If prescribing 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: 1) verifying the patient's insurance coverage and eligibility for benefits; 2) seeking prior authorization if needed on the patient's behalf; 3) providing financial assistance, support, and referral support as needed; 4) facilitating the provision of the patient's prescription medication to the patient; 5) contacting the patient with educational materials about the patient's prescription medication or to evaluate the effectiveness of the Advancing Access Program and/or the PAP/MAP; and 6) for Gilead's internal business purposes.

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

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PATIENT NAME: _____ DATE OF BIRTH: _____

8. 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 health information ("PHI"), including information about me (for example, my name, mailing address, financial information, and insurance information), my past, 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 healthcare benefits. I understand that my pharmacy providers may receive remuneration for disclosing my PHI pursuant to this authorization.

Persons to Which 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 PHI may be made to Gilead so that Gilead may use and disclose the PHI for purposes of: 1) completing the enrollment process and verifying my enrollment form; 2) establishing my eligibility for benefits from my health plan or other programs; 3) providing financial assistance, support, and referral support, and communicating with my healthcare providers, including, but not limited to, facilitating the provision of my prescription medication to me; 4) contacting me to evaluate the effectiveness of the Program and/or the PAP/MAP; 5) for Gilead's internal business purposes, including quality control and support enhancing surveys; and 6) to send me marketing information, offers, and educational materials related to my 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 under the signatures below, I may opt in).

I understand that once my PHI 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 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 PHI after the cancellation date, but the cancellation will not affect uses or disclosures of any PHI 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.

☐ 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.	
SIGNATURE of PATIENT or PATIENT'S REPRESENTATIVE (REQUIRED):	**DATE:**
Patient Representative's Name (if signing for the patient):	
Patient Representative's Relationship to Patient:	

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

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PATIENT NAME: _____ DATE OF BIRTH: _____

9. PATIENT FINANCIAL INFORMATION REQUIRED ONLY IF APPLYING FOR THE PATIENT ASSISTANCE PROGRAM/MEDICATION ASSISTANCE PROGRAM (PAP/MAP)			
Current Annual Household Income: $			
Number of People in Household supported by above income	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ Other:		
Please submit current documentation for all sources of income (eg, tax return, W2, last 2 pay stubs, etc.). If there is no household income, indicate how the patient/household is being supported:			
ADDITIONAL INSURANCE INFORMATION			
Social Security Number:			
Has the patient applied for ADAP?	☐ Yes ☐ No	If Yes, date of application:	
Has the patient applied for Medicaid?	☐ Yes ☐ No	If Yes, date of application:	
Is the patient eligible for Medicaid?	☐ Yes ☐ No	If No, state reason:	
Is the patient eligible for VA benefits?	☐ Yes ☐ No	If Yes, has the patient tried to obtain the medication through the VA?	☐ Yes ☐ No
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:	
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:	

APPLICANT DECLARATIONS AND AUTHORIZATIONS (REQUIRED ONLY IF APPLYING FOR THE PAP/MAP)

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 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. **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.**

SIGNATURE OF PATIENT/PATIENT REPRESENTATIVE: (REQUIRED ONLY IF APPLYING FOR PAP/MAP)	**DATE:**

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

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