Patient Enrollment Form

ViiVConnect™ is an assistance program that provides access to ViiV Healthcare medicines to eligible patients. Completion of this form can assist with information on coverage and access. There are 3 ways to enroll a patient: **(1)** complete a hard copy and fax to 1-844-208-7676, **(2)** through the online portal at www.viivconnect.com, or **(3)** call 1-844-588-3288 to enroll with a live Access Coordinator.

ViiVConnect™

SERVICES REQUESTED

CHECK ALL THAT APPLY

- ❑ Benefit Verification
- ❑ Co-pay Program
- ❑ Claims Assistance
- ❑ Patient Assistance Program (PAP)*
- ❑ Prior Authorization Assistance
- ❑ General Inquiry

VIIV HEALTHCARE MEDICATION PRESCRIBED (REQUIRED)

Product Name: Dosage (mg):

APPLICANT INFORMATION (REQUIRED)*

First/MI/Last Name: Street:

Preferred Phone: ( ) City: State: ZIP:

DOB: / / # of people, including applicant, living in the household:

Gender: ❑ Male ❑ Female # of people dependent on household income:

Social Security Number (SSN)†: – – Total Gross Annual Income:

I authorize my healthcare providers and others who may be helping me apply to this program to share information about me with ViiVConnect and the companies that ViiVConnect uses to administer the program. I authorize ViiVConnect and its Administrators to obtain a consumer report on me. My consumer report, and the information derived from public and other sources, will be used to estimate my income as part of the process to decide if I am eligible to receive free medication from ViiVConnect. Upon request, ViiVConnect will provide me the name and address of the consumer reporting agency that provides the consumer report. I understand that the information I provide will be used to determine my eligibility for ViiVConnect, to administer the program or to comply with any requests for disclosures required by law. This authorization will extend for as long as I participate in ViiVConnect and for a period of seven years thereafter. I understand ViiVConnect and its Administrators may request additional documents and information at any time, even if I am already enrolled, so that they can decide if the information on this form is complete and true.

ViiVConnect may attempt to reach you directly by phone. If you are not available: Select "Yes" if you authorize ViiVConnect to leave a toll-free callback number only. Select "No" if you do not want ViiVConnect to leave a callback number. ❑ Yes ❑ No

SHIPPING ADDRESS (Only complete this section if medicine is being shipped somewhere other than the mailing address above)

Addressee or Business Name:

Street: City: State: ZIP:

Specify addressee's relationship to the applicant: ❑ Self ❑ Patient Representative (must complete Patient Representative information on page 2) ❑ Other (specify relationship):

ALLERGY AND HEALTH INFORMATION (REQUIRED)

List any known drug allergies: ❑ Check box if none

List any known health conditions: ❑ Check box if none

PRESCRIPTION COVERAGE (REQUIRED)

1. Is the applicant eligible for any state or federal prescription drug coverage plan such as Medicaid? ❑ Yes ❑ No

2. Is the applicant eligible for Puerto Rico's Government Healthcare Program, Mi Salud? ❑ Yes ❑ No

3. Does the applicant have any private prescription drug coverage (including employer-sponsored plans, private group plans, etc)? ❑ Yes ❑ No

- If "yes," please indicate why assistance is needed:

4. Does the applicant have prescription drug coverage through a health insurance marketplace plan/exchange? ❑ Yes ❑ No

5. What is the ADAP status of the applicant? ❑ Denied ❑ Wait-listed ❑ Pending ❑ Not Applied/Not Eligible

6. Is the applicant enrolled in a Medicare Part D prescription drug plan? ❑ Yes ❑ No

7. If "yes" to question 6, has the applicant spent $600 or more on prescription expenses since January 1st of the current calendar year? ❑ Yes ❑ No

- If "yes," please scan an explanation of benefits or pharmacy receipt(s) indicating the applicant paid a total of $600 for prescriptions in the current calendar year

INSURANCE INFORMATION (Include scanned copies of the front and back of ALL insurance cards, including medical and prescription)

PRIMARY Insurance Name: Policyholder Name:

Phone: ( ) Policyholder DOB: / /

Policy ID #: Group #: Policyholder Relationship to Patient:

Subscriber Name: Policyholder Phone: ( )

PRESCRIBER INFORMATION (REQUIRED)

Prescriber's First/Last Name: Office Contact Name:

Practice Name: Street:

Phone: ( ) Fax: ( ) City: State: ZIP:

Prescriber Tax ID: Prescriber NPI #:

Prescriber State License #: Group NPI #:

Patient Diagnosis and ICD-9/ICD-10 Code:

*Prescription must accompany completed form.

†The sole purpose of the SSN is to determine income eligibility without the need to provide documentation. If you do not have an SSN or you are unable to provide it, please note that income documentation may be required to review program eligibility.

ViiV Healthcare

Form continued on the following page.

PATIENT AUTHORIZATION AND RELEASE TO COLLECT, USE, AND DISCLOSE MEDICAL INFORMATION

I certify that the information provided herein is true and correct. I understand that the collection, use, and disclosure of my health information are protected under law. Information contained in this Enrollment Form, such as my name, address, insurance, prescription, and medical information, is "protected health information." By signing below, I agree to the collection, use, and disclosure of my protected health information as described below. **I understand that my healthcare providers will not base any medical treatment decisions on my agreement to sign this Patient Authorization and Release.** I understand that once information about me is released based on this authorization, federal privacy laws may not prevent the entities described below from further disclosing my information. However, I understand that such entities have agreed to use or disclose information received only for the purposes described in this authorization or as required by law. I understand that ViiV Healthcare does not charge a fee for participation in this Program. There may be a co-payment for each prescription filled at a retail pharmacy. If my advocate charges a fee for enrollment or refills of my medicine, this money is not paid by or to ViiV Healthcare. I certify that any product that I receive from the Program is for my own use and will not be sold, bartered or given to any other person. I certify that the information provided in this application is complete and accurate to the best of my knowledge and agree to notify ViiV Healthcare of any change in my insurance eligibility or financial status. I understand that this authorization will remain in effect for two (2) years or until my coverage, coding, reimbursement, or other inquiry has been resolved, whichever is longer. I also understand that I have the right to revoke this authorization at any time by calling 1-844-588-3288 or mailing a signed, written statement of my revocation to ViiVConnect, PO Box 220100, Charlotte, NC 28222-0100, but that such a revocation would end my eligibility to participate in the programs as described. Revoking this authorization will prohibit disclosures after the date written revocation is received, except to the extent that action has been taken in reliance on this authorization. This means that after you revoke this authorization, your information may be disclosed among ViiV Healthcare and the company or companies that help ViiV Healthcare administer the programs to maintain records of your participation, but it will not be otherwise disclosed or used.

Enrollment in ViiVConnect for reimbursement support and patient assistance: The patient, or the patient's authorized representative, MUST sign this form to receive reimbursement support and assistance from ViiVConnect.
Before signing, you, the patient, should review, understand, and agree to the terms of this authorization and release. If an authorized representative signs for the patient, please indicate relationship to the patient. By signing below, I authorize ViiVConnect, as well as its agents and assignees and any other companies that ViiV Healthcare uses to administer reimbursement services for ViiV Healthcare products, to do the following:

1. Request and receive from my doctor, healthcare provider, health insurer, or pharmacist information necessary to investigate and resolve my insurance coverage, coding, reimbursement inquiry, or review my eligibility for patient assistance programs and co-pay assistance.
2. Collect, use, and disclose to each other any information that I provide to ViiVConnect for the purpose of investigating and resolving my insurance coverage, coding, or reimbursement inquiry.
3. Disclose to my treating physician, healthcare provider, or pharmacist information I provided to ViiVConnect when necessary to resolve my insurance coverage, coding, or reimbursement inquiry. By signing below, I also authorize my insurer, doctor, healthcare provider, and pharmacist to release information about my prescribed medications and medical condition requested by ViiVConnect.
4. Contact my insurer, other potential funding sources, social workers, patient advocacy organizations, and/or patient assistance programs on my behalf to determine if I am eligible for health insurance coverage or other funds and disclose to them information about my prescribed medications and medical condition that has been provided by me or my physician, healthcare provider, or pharmacist.
5. Disclose any information obtained from the sources listed above to third parties if required by law.
6. Obtain a consumer report on me. My consumer report, and the information derived from public and other sources, will be used to estimate my income as part of the process to decide if I am eligible to receive free medication from ViiV Healthcare. Upon request, ViiVConnect will provide me the name and address of the consumer reporting agency that provides the consumer report.
7. Request additional documents and information at any time, even if I am already enrolled so that they can decide if the information on this form is complete and true.

Patient Name (print):
Note: Medicare Part D patients cannot enroll by phone.

Patient Signature:

Date: / /

Patient Representative Name* (if other than patient) who can obtain information on patient's behalf (print):

Patient Representative Signature (if other than patient); stamped signature not accepted:

Date: / / **Relationship to Patient:**

By my signature, I certify to the best of my knowledge, the information on this application is correct and complete. I have no knowledge of any intent to sell, barter, or give this product to any person other than the Applicant for whom it has been prescribed. To the best of my knowledge, the Applicant has no medical/prescription insurance benefits for the indicated pharmaceutical(s), including Medicaid or other public programs other than as indicated, and the Applicant has insufficient financial resources to pay for the prescribed therapy. My signature above also serves as attestation that the Applicant has authorized me to act on his/her behalf.

Complete, sign, and electronically submit all pages of this form and applicable corresponding documents, including a copy of the prescription,† through the portal or fax to **1-844-208-7676 (toll-free)**.
For assistance with any questions, please call **1-844-588-3288 (toll-free),** Monday through Friday, 8AM to 8PM ET.

*Not required if Applicant is self-enrolling; only complete this section if the patient representative enrolls the Applicant and wants to be the contact person and receive program correspondence for the Applicant.
†Please note that faxed prescriptions are only valid if faxed directly from a physician's office and accompanied by a fax cover sheet.

ViiV Healthcare