COMMON PATIENT ASSISTANCE PROGRAM APPLICATION (HIV)

Program Description

The purpose of this enrollment tool is to collect information that numerous pharmaceutical companies and foundations providing the donated products of pharmaceutical companies require for enrollment in various HIV patient assistance programs (PAPs). These PAPs provide medicines at little or no cost to eligible patients. To facilitate enrollment in multiple PAPs, this tool consolidates all of the necessary information in one place. In each instance in which the tool refers to "PAPs" it means all of the PAPs for which the applicant may be eligible. **Each PAP will determine a patient's eligibility for assistance based on their individual program requirements.**

Further, each PAP requires its own application and that, once completed, can be printed out multiple times and submitted to individual PAPs with the required attachments.

Important Information

1. PAPs cannot process incomplete applications.
2. Make sure all required information and accompanying documents are complete and signed before they are submitted to each PAP.
3. Page 2, Patient General Information, line 5: indicate the correct contact for additional follow-up. If none is selected, the default is the provider.
4. Page 2, Coverage Information: respond for each category of coverage.
5. Page 2, Alternate Shipping Information: this address is used if the PAP will ship to a location other than the physician/prescriber. Note that not all PAPs will ship to an alternate address.
6. Page 2, Advocate Information: indicate if an advocate is applying on behalf of a patient, and be sure to include a signature. If no advocate is involved, leave this section blank.
7. Page 3, IMPORTANT: check the "Required Attachments" carefully. Differen attachments may be required by differen PAPs. Especially note whether an original prescription form is required.
8. Page 4, IMPORTANT: signatures from the patient (or the patient's legal representative) and the provider are ALWAYS required.
9. IMPORTANT: send completed, signed, Common PAP Applications to the corresponding addresses listed for EACH COMPANY from which medication is sought.
10. Complete the form using either blue/black pen or via computer, responding to all required questions.

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.

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Patient General Information

Name (First): _____ (Middle): _____ (Last): _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Ok to call? ◯ Yes ◯ No E-mail (optional): _____

Language: ◯ English ◯ Spanish ◯ Other: _____ Gender: ◯ M ◯ F Date of birth: _____

U.S. Resident? ◯ Yes ◯ No

Number in Household: ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 Current Annual Household Income: $ _____

Follow-Up point of contact: ◯ Provider (*default*) ◯ Caseworker ◯ Patient ◯ Other: _____

Coverage Information *(check all that apply)*

AIDS Drug Assistance Program:	◯ Enrolled	◯ Denied	◯ Pending	◯ Not Applied	◯ Not Eligible	◯ Waitlisted
Medicaid:	◯ Enrolled	◯ Denied	◯ Pending	◯ Not Applied	◯ Not Eligible	
Medicare:	◯ Enrolled	◯ Denied	◯ Pending	◯ Not Applied	◯ Not Eligible	
Medicare Part D:	◯ Enrolled	◯ Denied	◯ Pending	◯ Not Applied	◯ Not Eligible	
Private Insurance Drug Coverage:	◯ Enrolled	◯ Not Enrolled				
If enrolled, Insurer Name: _____						
Veterans Administration Health Benefits	◯ Enrolled	◯ Not Eligible				

Other: _____

Physician/Prescriber Information

Name (First): _____ (Middle): _____ (Last): _____

Business/Facility Name: _____ Phone: _____ Fax: _____

Offi Contact Name (First): _____ (M.I.): _____ (Last): _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Professional Designation/Specialty: _____ National Provider Identifier _____

Tax ID #: _____ DEA #: _____ State License #: _____

Alternate Shipping Information *(some PAPs require medication to be shipped to physician/prescriber while others will ship to the patient's alternate shipping address of choice)*

Name (First): _____ (Middle): _____ (Last): _____

Business/Facility Name: _____ Phone: _____ Fax: _____

Shipping Address: _____ City: _____ State: _____ Zip: _____

Relationship to patient: _____ Reason for alternate: _____

Advocate Information *(if applying on behalf of patient)*

Name (First): _____ (Middle): _____ (Last): _____

Business/Facility Name: _____ Phone: _____ Fax: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Relationship to patient: _____

_____ _____

Advocate Signature Date

Please send general feedback and questions on the Common Patient Assistant Program Application form to commonPAPform@nastad.org. For any questions about eligibility and status of a submitted application, please contact the corresponding company

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IMPORTANT: Send completed, signed, Common PAP Applications to the corresponding addresses listed for EACH COMPANY from which medication is sought.

AbbVie Patient Assistance Foundation P.O. Box 270, Somerville, NJ 08876 — Phone: 800-222-6885 Fax: 866-483-1305 ☐ Kaletra® (lopinavir/ritonavir) ☐ Norvir® (ritonavir)	*If there is a need for an urgent delivery of medication, the health care provider should call the program directly to discuss options. **Original "ink" signature required to complete enrollment. No stamped signatures are accepted.	App. submitted via ○ Fax ○ Mail ○ Ship to Physician Attachment Req.: 6; If insured but cannot affor treatment: 4 & 5
Boehringer Ingelheim Cares Foundation Inc. Patient Assistance Program c/o Express Scripts SDS, Inc. P.O. Box 66745, St. Louis, MO 63166 — Phone: 800-556-8317 Fax: 866-851-2827 ☐ Aptivus® (tipranavir) ☐ Viramune XR® (nevirapine)	*Once an application is received, the patient can expect to receive medicine within 48 hours. **Original "ink" signature required to complete enrollment. No stamped signatures are accepted.	App. submitted via ○ Fax ○ Mail ○ Ship to Physician Attachment Req.: 2; 5 if Part D enrollee
Bristol-Myers Squibb: BMS3assist Program P.O. Box 221430, Charlotte, NC 28222-1430 — Phone: 888-281-8981 Fax: 888-281-8985 ☐ Evotaz® (atazanavir/cobicistat) ☐ Reyataz® (atazanavir sulfate) ☐ Sustiva® (efavirenz)	*Original "ink" signature required to complete enrollment. No stamped signatures are accepted.	App. submitted via ○ Fax ○ Mail Applications submitted via fax MUST be from a physician's offi with a cover note. Attachment Req.: 1, 2 or 3; 4, 5 & 6
Gilead Advancing Access: Reimbursement Solutions for Patients in Need P.O. Box 13185, La Jolla, CA 92039 — Phone: 800-226-2056 Fax: 800-216-6857 ☐ Atripla® (efavirenz/emtricitabine/tenofovir disoproxil fumarate) ☐ Biktarvy® (bictegravir/emtricitabine/tenofovir alafenamide) ☐ Complera® (emtricitabine/rilpivirine/tenofovir disoproxil fumarate) ☐ Descovy® (Emtricitabine, Tenofovir Alafenamide) ☐ Emtriva® (emtricitabine) ☐ Emtriva Oral Solution® (emtricitabine oral solution) ☐ Genvoya® (elvitegravir, cobicistat, emtricitabine, and tenofovir alafenamide) ☐ Odefsey® (emtricitabine/rilpivirine/tenofovir alafenamide) ☐ Stribild™ (elvitegravir/cobicistat/emtricitabine/tenofovir disoproxil fumarate) ☐ Truvada® (emtricitabine and tenofovir disoproxil fumarate) ☐ Tybost® (cobicistat)	*Immediate access is available for all products. Patients that are pre-screened and determined to be eligible for the program may receive a voucher for the immediate pick-up of a 30-day supply at the pharmacy of their choice. **Original "ink" signature required to complete enrollment. No stamped signatures are accepted.	App. submitted via ○ Fax ○ Mail Attachment Req.: 1, 2 or 3; 4 & 5
Johnson & Johnson Patient Assistance Foundation, Inc. P.O. Box 42796, Cincinnati, OH 45242 — Phone: 800-652-6227 Fax: 888-526-5168 ☐ Edurant® (rilpivirine) ☐ Is the patient currently taking? ☐ Intelence® (etravirine) ☐ Is the patient currently taking? ☐ Prezista® (darunavirc) ☐ Is the patient currently taking? ☐ Prezcobix® (darunavir/cobicistat) ☐ Is the patient currently taking? ☐ Symtuza™ (darunavir/cobicistat/ emtricitabine/tenofovir alafenamide) ☐ Is the patient currently taking?	*Immediate access is available through the use of pharmacy card. At the request of the physician, a pharmacy card number will be provided to the patient ONLY, immediately upon eligibility/approval. He/she can then go to the pharmacy with a valid prescription to pick up their medicine. **Original "ink" signature required to complete enrollment. No stamped signatures are accepted.	App. submitted via ○ Fax ○ Mail ○ Pharmacy Card Attachment Req: 2, 4, 5 (if Part D enrollee) & 6
Merck Patient Assistance P.O. Box 690, Horsham, PA 19044-9926 — Phone: 800-727-5400 Fax: 915-849-1037 ☐ Crixivan® (indinavir sulfate) ☐ Delstrigo™ (doravirine/lamivudine/tenofovir disoproxil fumarate) ☐ Isentress® HD (raltegravir) ☐ Isentress® (raltegravir) ☐ Pifeltro™ (doravirine)	*Once a completed application is received, eligible patients can expect to receive medicine within 24 hours. **Merck requires both original "ink" signed enrollment tool and "ink" signed doctor prescription. No copies or stamps are accepted. If the tool is started by fax, the patient must follow up by mailing in the original enrollment process and prescription. ***This Program does not accept an advocate signature on behalf of the patient.	Enrollment form submitted via: ○ Fax ○ Mail ○ Ship to Provider ○ Ship to Patient Attachment Req.: 6 & 7 *Faxed applications still require a follow up hard copy with signature to be mailed.
THERA Patient Support™ P.O. Box 390, Somerville, NJ 08876 — Phone: 833-238-4372 Fax: 855-836-3069 ☐ Trogarzo™ (ibalizumab-uiyk) Prescription type: ☐ New ☐ Continuing Therapy ☐ Restart	*PAP enrollment requires submission of Trogarzo Enrollment Form (available at www.trogarzo.com) with completed CPAPA. Attachments and original "ink" signature required to complete enrollment.	App. submitted via ○ Fax ○ Mail Attachment Req.: 1, 2, or 3; 6, 7, 8 & 9
ViiV Healthcare Patient Assistance Program P.O. Box 220100, Charlotte, NC 28222-0100 — Website: http://www.viivconnect.com Phone: 1-844-588-3288 (toll-free number) Fax: 1-844-208-7676 ☐ COMBIVIR® (lamivudine/zidovudine) ☐ EPIVIR® (lamivudine) ☐ EPZICOM® (abacavir sulfate and lamivudine) ☐ JULUCA® (dolutegravir/rilpivirine) ☐ LEXIVA® (fosamprenavir calcium) ☐ RESCRIPTOR® (delavirdine mesylate) ☐ RETROVIR® (zidovudine) ☐ SELZENTRY® (maraviroc) ☐ TIVICAY® (dolutegravir) ☐ TRIUMEQ® (abacavir/dolutegravir /lamivudine) ☐ TRIZIVIR® (abacavir sulfate, lamivudine, and zidovudine) ☐ VIRACEPT® (nelfinavi mesylate) ☐ ZIAGEN® (abacavir sulfate)	*In order for the patient or Patient Representative to receive ViiV Healthcare medication by mail, ViiVConnect must receive a completed and signed enrollment form and signed prescription. Medicare Part D PAP applicants must also send proof of Part D enrollment and proof of spend for $600 or more on out-of-pocket prescription expenses during the current calendar year. NOTE: Faxed prescriptions are only valid if faxed directly from a physician's offi and accompanied by a fax cover sheet. **Patients who need same-day retail pharmacy access to a ViiV prescription must be enrolled by a Patient Representative phone call to ViiVConnect. A Patient Representative may also help patients apply to ViiVConnect through the ViiVConnect Provider Portal, by fax or by mail if the patient does not require same-day access to their prescription.	App. submitted via ○ Fax ○ Mail ○ Phone ○ ViiVConnect Portal ○ Pharmacy Pick-Up Required attachments: 4, 5, 6 and 7. Income documentation such as tax forms are not required to confir eligibility, as the program completes an online validation of the patient's income. The program will reach out when circumstances require proof of income documentation.

ATTACHMENTS: *(requirements vary by program)* 1. Copy of recent paystub 2. Copy of first page of most recent Federal income tax return 3. Copy of social security check or awards letter 4. Copy of both sides of insurance card (if Part D or insured) 5. Copy of drug receipts (if Part D or insured) 6. Original prescription form 7. Allergy & Health Information: list of any known drug allergies and current medications 8. Site of care specifications for initial and subsequent dosing (e.g., name and location of infusion center, prescribing physician office, home infusion), including authorization for ancillary supplies, as needed (e.g., needles, syringes, etc.) 9. Medication history (complete antiretroviral list along with concomitant medication history

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IMPORTANT: This application is not complete unless both the authorization and the certification are signed by the appropriate individuals.

Patient Authorization

By my signature, I authorize each Program and their agents to do the following:

1. Use any information that I provide in my application for the purpose of enrolling in or to administer the PAPs;
2. Contact my doctor, healthcare provider, or pharmacist about my application for the PAPs, and disclose to them information contained in my application, in order to help me receive Programs' products under the PAPs and ensure that PAPs' guidelines are being met;
3. Request information from my insurer, doctor, healthcare provider, or pharmacist about the prescribed medications I receive or will receive under the PAPs and about my medical condition. This information will be used only to determine my eligibility for the PAPs and to administer the PAPs. By signing below, I also authorize my insurer, doctor, healthcare provider, or pharmacist to release information about my prescribed medications and medical condition that is requested by Programs or their agents;
4. Contact my insurer, other potential funding sources, including the Centers for Medicare and Medicaid Services, social workers or patient advocacy organizations on my behalf in order to determine if I am eligible for health insurance coverage or other funds, and disclose to them information contained in my PAP applications or information about my prescribed medications and medical condition that has been provided by my physician, healthcare provider or pharmacist; and
5. Disclose any information obtained from the sources listed above to third parties required by law.

By my signature, I am signifying that I understand the following:

1. Once medical information about me has been disclosed in reliance upon this Authorization, the information may no longer be protected by federal privacy laws and may be further disclosed; however, Programs agree to protect my information by using and disclosing it only for the purposes described above or as required by law.
2. Programs and their agents will only ask for the information that is needed to process my application, renew my application or provide me with help throughout my Program participation. Each Program will only have access to the information needed for that Program and will not have access to information required for enrollment in any other PAP.
3. This Authorization will remain in effect for as long as I participate in the Program and a period of 5 years after my participation in the Program ends, and that I am entitled to request a copy of this signed Authorization.
4. I have the right to revoke this authorization at any time by mailing a signed written statement of my revocation to the address(es) used on page 1. Such a revocation would end my eligibility to participate in the PAPs. 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 my authorization.
5. Any assistance in the form of product at no cost is contingent upon my ability to meet the eligibility criteria for the Program.
6. The program assistance may change or be discontinued at any time without any notice to me.
7. I agree that the Program does not have any liability in providing PAP services to me.
8. I agree to be bound by the terms and conditions of the Program for which I am deemed eligible and enrolled.

Finally, I understand I may refuse to sign this authorization and that if I refuse, my eligibility for health plan benefit and treatment by my doctor will not change, but I will not have access to the services available through this program.

If I receive any free product from Programs, I certify that I will not seek reimbursement from any public or private prescription drug plan for the use of such product.

I certify that the information in this application is complete and accurate to the best of my knowledge and agree to notify PAPs of any change in my insurance eligibility or financia status within 30 days by providing that information to the address(es) used on page 1.

_____ _____

Signature (Patient or Legal Representative) Date

Physician/Prescriber Certification

By my signature, I certify:

1. To the best of my knowledge, the information on this patient is correct and complete and consistent with applicable privacy laws and regulations, and I understand that Program and/or their agents are relying on this representation.
2. I have no knowledge of any intent to sell, barter or give this product to any person other than the patient for whom it has been prescribed.
3. No reimbursement of the cost of product will be accepted by me from public or private sources, including patients, for any treatments where product will be provided free-of-charge by Program.
4. The medication(s) covered by the PAPs are medically indicated for this patient and that I will be supervising the patient's treatment.
5. I agree to periodically verify continued use of Programs' medication and resubmit current prescriptions.
6. My State license is currently in good standing, I am not prohibited from participating in Federally-funded health care programs, nor am I on the List of Excluded Individuals/Entities maintained by the HHS Offi of Inspector General.

I authorize the Program to forward this prescription to a dispensing pharmacy on behalf of myself and my patient, or to send the medication directly to the patient, or to send the medication to my offi for dispensing to my patient in accordance with individual program requirements.

_____ _____

Signature Date