Common Patient Assistance Program Application (CPAPA) Companion Document

January 2019

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.

COMMON PATIENT ASSISTANCE PROGRAM APPLICATION (HIV) Tool 1/4

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.**

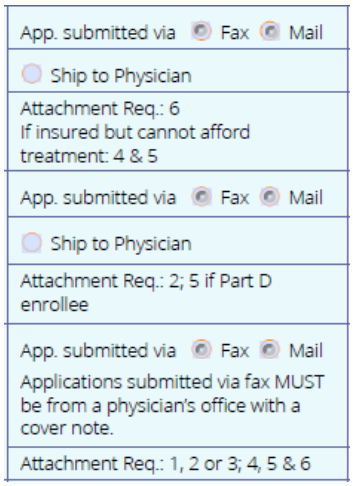
Further, each PAP requires its own application and that, once completed, can be printed out multiple times and submitted to individual PAPs with the required attachments.

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.

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).



App. submitted via Fax Mail

Ship to Physician

Attachment Req.: 6
If insured but cannot afford treatment: 4 & 5

App. submitted via Fax Mail

Ship to Physician

Attachment Req.: 2; 5 if Part D enrollee

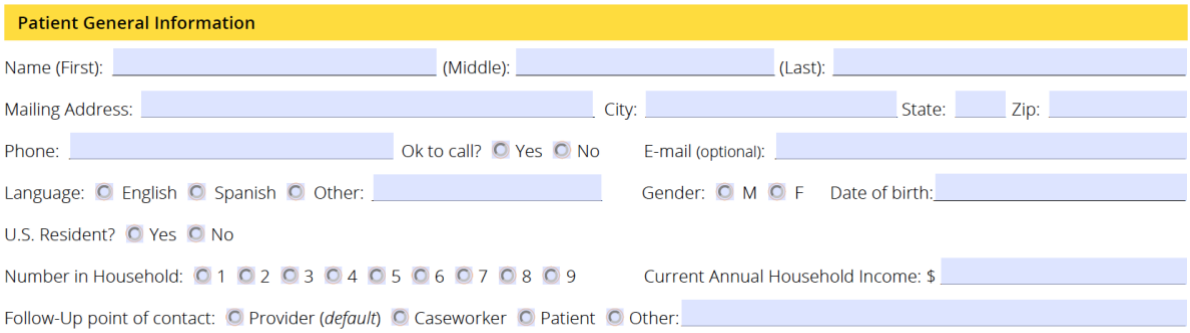
App. submitted via Fax Mail

Applications submitted via fax MUST be from a physician's office with a cover note.

Attachment Req.: 1, 2 or 3; 4, 5 & 6

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.



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: _____

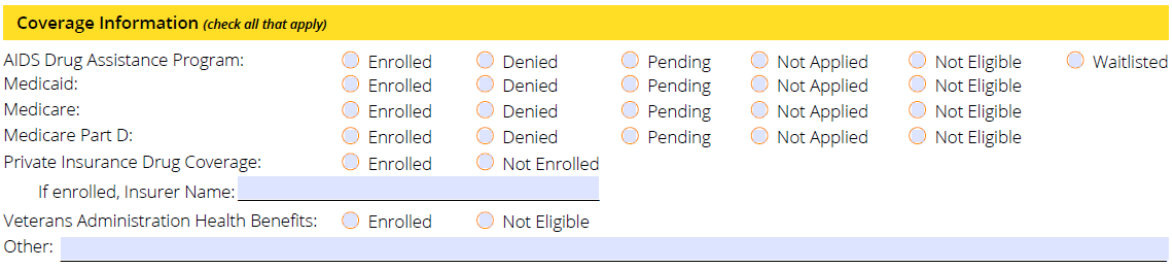
U.S. Resident? ○ Yes ○ No

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: _____

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.



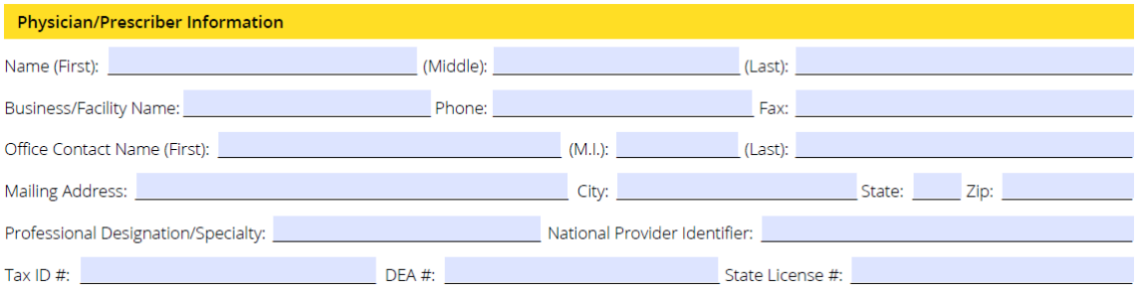
Coverage Information *(check all that apply)*

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: _____

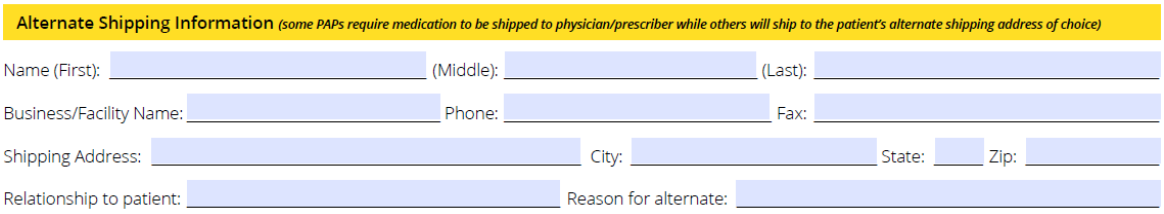
Step 5: Complete the "Physician/Prescriber" section (see page 2).

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.



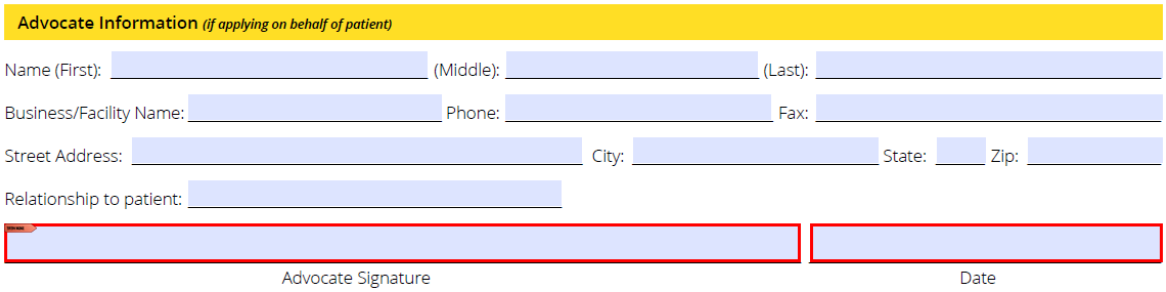
Step 6: Complete the "Alternate Shipping Information" section (see page 2).

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**.



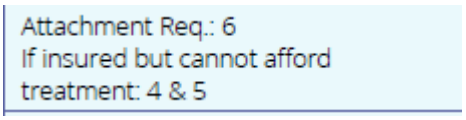
Step 7: Complete the "Advocate Information" section (see page 2).

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**.



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.

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 except Hepsera. 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

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.

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 financial status within 30 days by providing that information to the address(es) used on page 1.

Signature (Patient or Legal Representative) | Date

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

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