



Advancing Access™

Reimbursement Solutions for Patients in Need

Call 1-800-226-2056 to begin enrollment

Medication Requested (For Vistide Only, Attach Prescriptions to Form)

- Truvada® (emtricitabine and tenofovir disoproxil fumarate)
- Viread® (tenofovir disoproxil fumarate)
- Emtriva® (emtricitabine)
- Emtriva Oral Solution® (emtricitabine oral solution)
- Hepsera® (adefovir dipivoxil)
- Vistide® (cidofovir injection)
- Complera™ (emtricitabine/rilpivirine/tenofovir disoproxil fumarate)

ICD-9 Code for Primary Diagnosis:

ICD-9 Code for Secondary Diagnosis (if applicable):

1. PATIENT INFORMATION (please print)

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

Address:

City: _____ State: _____ ZIP Code: _____ Phone #: _____

Patient's other HIV/HBV Meds:

Social Security #: _____ Birth Date: _____ Gender: M F US Resident: YES NO

Patient Language: English Spanish Other: _____

Total Household Income (Attach Proof of Income for each Source Listed)

Salary/Wages: \$ _____	Social Security Disability: \$ _____	Rental Income: \$ _____	Pension/Retirement: \$ _____
Social Security Retirement: \$ _____	Unemployment: \$ _____	Workers Compensation: \$ _____	Other: \$ _____
Supplemental Security Income: \$ _____	Alimony/Child Support: \$ _____	Veterans Benefits: \$ _____	TOTAL: \$ _____

Household Size (number of persons who contribute to or are dependent on patient's household income): _____

Insurance Information (Y = Yes, N = No, P = Pending or Wait Listed) <Payer Type>

Insurer/Payer/Program	Rx Benefits (Circle)	Medical Benefits	Insurer/Payer/Program	Rx Benefits (Circle)	Medical Benefits	Insurer/Payer/Program	Rx Benefits (Circle)	Medical Benefits
Medicare Part D	Y N	Y N	Medicaid:	Y N P	Y N P	AIDS Drug Assistance Program Is applicant eligible? Y <input type="checkbox"/> N <input type="checkbox"/> If Y, Date of Application: _____ If N, state reason: _____	Y N P	Y N P
Private Insurance	Y N	Y N	Other: _____ List Insurer if Y	Y N P	Y N P			

Primary Insurance Company: _____ Policy ID#: _____ Group#: _____

Contact Name: _____ Phone #: _____

Subscriber Name: _____ Date of Birth: _____

<p>Secondary Insurance: Does applicant have additional coverage? <input type="checkbox"/> Y or <input type="checkbox"/> N If YES, provide name, telephone and policy numbers: _____ _____</p>	<p>Has applicant applied to Medicaid or Medicare Part D? YES <input type="checkbox"/> NO <input type="checkbox"/> If YES, date of application: _____</p> <p>Is applicant eligible? YES <input type="checkbox"/> NO <input type="checkbox"/> If NO, state reason: _____</p>
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APPLICANT DECLARATION



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I verify that the information provided on this application is complete and accurate. I understand that the Advancing Access Program may request documentation to verify financial or insurance information and that any assistance in the form of free medication is contingent upon meeting the program eligibility criteria. I also understand that Gilead Sciences, LLC reserves the right at any time and without notice, to modify the application form; modify or discontinue this program and its eligibility criteria; or terminate assistance.

I authorize the Advancing Access Program to obtain information from my prescribing physician, insurance company, and other sources as deemed necessary to ensure the accuracy and completeness of this application.

I authorize my healthcare providers and health plans to disclose personal and medical information about me, including information about my HIV status, to Gilead and its agents and contractors ("Gilead") and I authorize Gilead to use, share and disclose this information to: 1) establish my benefit eligibility; 2) provide support services, including facilitating the provision of Truvada®, Viread®, Emtriva®, Emtriva Oral Solution®, Hepsera®, Vistide® Or Complera™ to me; and to contact me to evaluate therapy and the effectiveness of the program.

I understand that once my health information has been disclosed to Gilead, privacy laws may no longer restrict its use or disclosure; however, Gilead agrees to protect my information by using and disclosing it only for the purposes described above or as required by law. I further understand I may refuse to sign this authorization and that if I refuse, my eligibility for health plan benefits and treatment by my doctor will not change, but I will not have access to the services available through this program. I may cancel this authorization at any time by notifying Gilead in writing and submitting it by fax to 1-800-216-6857 or by calling 1-800-226-2056. If I cancel, Gilead will stop using or disclosing my information for the purposes listed above, except as required by law or as necessary for the orderly termination of my participation in this program. I am entitled to a copy of this signed authorization, which expires 10 years from the date it is signed by me.

Patient's Signature: _____ **Date:** _____

2. PRESCRIBER INFORMATION (please print)

Name:		Title:	
Facility Name:			
Street Address:			
City:	State:	ZIP Code:	
Phone #:	Fax #:		
State License #	DEA#:	NP/PA #:	

3. PATIENT ADVOCATE INFORMATION (if Different from Prescriber)

Name:		Title:	
Facility Name:			
Street Address:		City:	State:
ZIP Code:	Phone#:	Fax#:	

State License Type and Number (if applicable):

A Patient Advocate may be a healthcare worker involved in the patient's care – a physician, nurse, physician assistant, social worker or case manager. Friends or family members cannot act, as Patient Advocates. Patient Advocates are responsible for completing the patient Enrollment Form and working with the patient at specific intervals in the enrollment process.

4. STATEMENT OF MEDICAL NECESSITY

Statement of Medical Necessity for Financially Needy Patients. To the best of my knowledge, this patient has no coverage (including Medicaid or other public programs) for TRUVADA, VIREAD, EMTRIVA, EMTRIVA ORAL SOLUTION, HEPSERA, VISTIDE or COMPLERA. I certify that the medication(s) listed above are medically indicated for this patient and that I will be supervising the patient's treatment. As part of my patient's eligibility, I agree to periodically verify continued use of Gilead medication and resubmit current prescriptions.

Signature _____ **Date** _____

Prescriber Patient Advocate

Applications are considered complete only if they include all of the following:

- Front and Back Pages of Enrollment Form
 - Patient as well as Prescriber or Patient Advocate Signatures
 - Documentation of Income Sources and Residency
- Copy of Prescription (For Vistide Medication Only)

When complete, FAX application and documentation to: **1-800-216-6857**

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 PO Box 13185
 La Jolla, CA 92039-3185
 TEL: 1-800-226-2056 FAX: 1-800-216-6857