GILEAD
Advancing Therapeutics. Improving Lives.

Truvada® for Pre-Exposure Prophylaxis (PrEP) Medication Assistance Program*

Application to be used for TRUVADA for PrEP only

Fax 1-855-330-5478 to begin enrollment

1 Applicant Information

Applicant Name: PLEASE PRINT CLEARLY _____ Applicant Language: ENGLISH ☐ SPANISH ☐ OTHER ☐

Address: _____

City: _____ State: _____ Zip: _____ Phone #: (____) _____

Social Security #:	Date of Birth: MM DD YYYY	Gender:	Resides in U.S/U.S. territories:
___ ___ ___ – ___ ___ – ___ ___ ___	_____ /_____ / _____	M ☐ F ☐	YES ☐ NO ☐

Primary Contact: _____ Relationship: _____ Phone Number: _____

Applicant Financial Information

Current Annual Household Income: $ _____ Number in Household (circle one): **1 2 3 4 5 6** _____

Please include current documentation for all sources of income (eg, tax return, W2, last 2 pay stubs, etc).

☐ **Applicant is insured** (Please fill out all the applicable insurance information below. Attach copy (front and back) of applicant insurance card.)

☐ **Applicant is uninsured** (No health insurance through any public or private payer.) Complete **"Additional Insurance Information"** below.

Primary Payer Name: _____ Is this a Medicare Part D plan? ☐ YES ☐ NO

Plan Name _____ Payer Phone Number: _____

Subscriber Name: _____ Policy #: _____ Group #: _____

☐ **Check box if applicant has secondary insurance coverage and fax insurance cards, if available.**

Additional Insurance Information	**YES**	**NO**	
Has the applicant applied for Medicare Part D?	☐	☐	If Yes, date of application: _____ If No, provide reason: _____
Has the applicant applied for Medicaid?	☐	☐	If Yes, date of application: _____

Void where prohibited by law. Applicants who are enrolled in Medicaid or have coverage for prescription drugs under any other public program or have such coverage from any other third party payer, are ineligible for the TRUVADA for PrEP Medication Assistance Program.

* TRUVADA is indicated, in combination with safer sex practices, for pre-exposure prophylaxis to reduce the risk of sexually acquired HIV-1 in adults at high risk.

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For more information, visit www.Truvada.com

For inquiries, call TRUVADA for PrEP at 1-855-330-5479

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2 Prescriber Information

Prescriber Name: _____ Title: _____

Facility Name: _____ Facility Specialty: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Office Contact: _____ Office Phone #: (_____) _____ Office Fax #: (_____) _____

NPI #: _____ Tax ID #: _____

3 Statement of Medical Necessity

Statement of Medical Necessity for Financially Needy Applicants. To the best of my knowledge, this applicant has no coverage (including Medicaid or other public programs) for TRUVADA. I certify that the medication(s) listed above are medically indicated for this applicant and that I will be supervising the applicant's treatment. I certify that I am prescribing TRUVADA for PrEP as part of a risk reduction strategy for HIV prevention for this applicant. 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.

SIGN HERE **Prescriber Signature:** _____ **Date:** _____

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

- Front and Back Pages of Enrollment Form
- Applicant as well as Prescriber Signatures and Dates
- Documentation of Income Sources and Residency
- Copy of Prescription

When complete, **FAX** application and documentation to: **1-855-330-5478**

Gilead Sciences, Inc.
Medication Assistance Program
P.O. Box 13185
La Jolla, CA 92039-3185
TEL: 1-855-330-5479 | FAX: 1-855-330-5478

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INDIVIDUAL HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) AUTHORIZATION *(REQUIRED)*

INDIVIDUAL AUTHORIZATION FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

I verify that the information provided on this application is complete and accurate. I understand that the Truvada Medication Assistance 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, Inc. and its agents and subcontractors (together, "Gilead") reserve 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. By my signature I understand the following about Gilead with respect to this Authorization.

1. TRUVADA for PrEP Medication Assistance Program. As sponsor of the TRUVADA for PrEP ("Program"), Gilead will need to obtain, review, use and disclose my personal health information to provide me with assistance.
2. My Information. My personal health information includes information that I provide on my application for the Program and information about my treatment and prescriptions, or about payment for my treatment or prescriptions, from my doctors, my pharmacies, other health care providers, and my health plans or insurance companies, including information about my treatment (collectively, "My Information").
3. Purposes. Gilead may use, and disclose to third parties, My Information for the following specific purposes: completing, ensuring the accuracy of and verifying my application; verification that I meet the eligibility requirements for the Program; administration of the Program and provision of its benefits to me; providing support services, including facilitating the provision of TRUVADA, to me; contacting me by mail, telephone or email to evaluate the therapy and the effectiveness of the Program; contacting my doctors, pharmacies, other health care providers, health plans and insurance companies to request My Information or disclose My Information to them; coordination of benefits; reimbursement support; investigating my insurance coverage or other reimbursement sources; analyzing issues related to my participation in the Program or receipt of Program services; or as otherwise required by law (together, the "Purposes").

By my signature I also <u>authorize</u> the following disclosures of My Information:

1. Who is Authorized to Disclose My Information. My doctors, pharmacies, any other health care providers, health plan(s) and insurance companies are authorized to disclose My Information, including information about my treatment, in accordance with this Authorization.
2. To Whom May My Information be Disclosed. I authorize My Information to be disclosed to Gilead (as Gilead is defined above).
3. For What Purposes May My Information be Disclosed. I authorize the disclosure of My Information for the Purposes (as those Purposes are defined above).

By my signature I also <u>understand and agree</u> that the following applies to this Authorization:

1. My Information that I authorize to be disclosed hereunder may be re-disclosed and no longer protected by federal or state privacy laws.
2. This Authorization is voluntary and I may refuse to sign this Authorization. Refusal to sign will not affect my ability to obtain treatment but I will not be able to participate in the Programs.
3. I can cancel this Authorization at any time by notifying Gilead in writing and submitting it by fax to 1-855-330-5478 or by calling 1-855-330-5479 however, the cancellation will not apply to any of My Information already used or disclosed pursuant to this Authorization prior to receipt of my cancellation.
4. This Authorization will expire one (1) year after the date it is signed, below, or, if I participate in the Program, one (1) year after the last date I receive any product or service through the Program.
5. I have read this Authorization or have had it explained to me. I understand that I am entitled to receive a copy of this Authorization once it has been signed.

APPLICANT SIGN HERE

Applicant Signature:_____ **Date:** _____

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TRUVADA for Pre-Exposure Prophylaxis (PrEP) Medication Assistance Program

Please FAX completed prescription and application to 1-855-330-5478

PRESCRIPTION FORM FOR TRUVADA
(200 mg emtricitabine / 300 mg tenofovir disoproxil fumarate)

Physician should complete the prescription for TRUVADA. If you would like to submit an original prescription, please make sure it includes the required information listed below.

Applicant Name: PLEASE PRINT CLEARLY _____ Birth Date: MM _____ / DD _____ / YYYY _____

Applicant Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: (_____) _____ Allergies: _____ None ☐

MEDICATION	DIRECTIONS	QUANTITY	REFILLS
TRUVADA	1 tablet by mouth QD	30	2

Upon receipt of a completed application, the prescriber will be notified of program eligibility. If the applicant is eligible for assistance, a one month supply of medication will be shipped to the prescriber's office.

For prescription questions or refill requests call 1-855-330-5479.

Prescriber Name: _____

Prescriber Address: _____ NPI#: _____

City: _____ State: _____ Zip Code: _____

Prescriber Phone#: (_____) _____

SIGN HERE **Prescriber's Signature:** _____ **Date:** _____

ADDITIONAL INFORMATION

Current medications being taken by applicant: _____

_____

_____

Please FAX the completed prescription and application to 1-855-330-5478

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