Common Patient Assistance Program Application (CPAPA) Companion Document

June 2016

Background and History of the Common Patient Assistance Program Application (CPAPA)

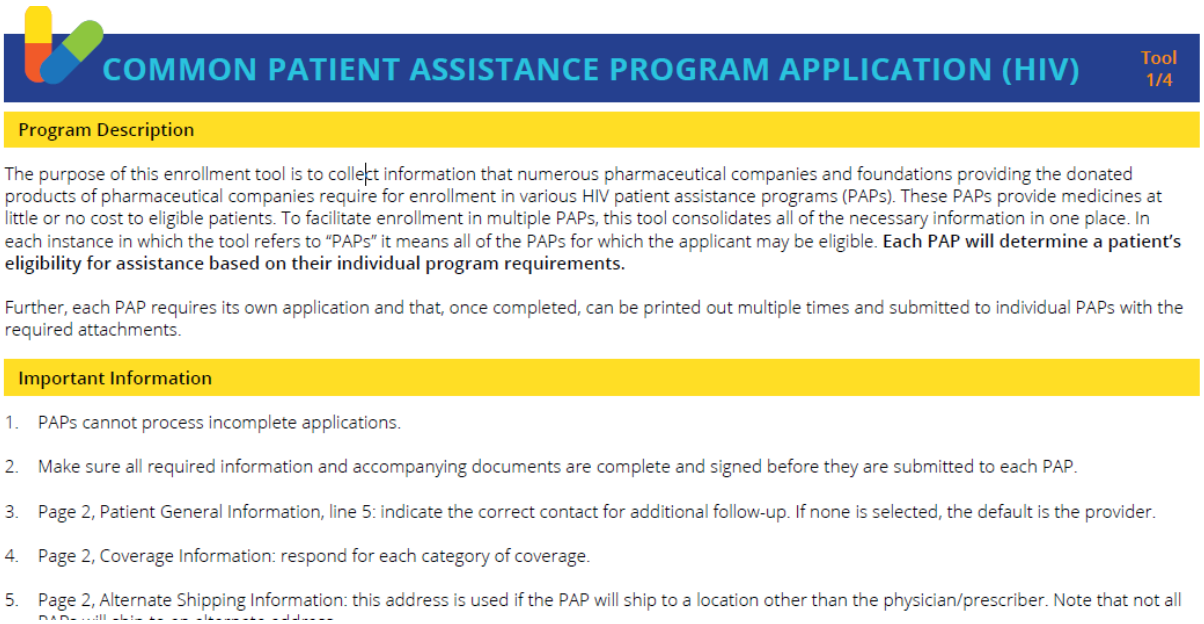
HIV patient assistance programs (PAPs) are administered by pharmaceutical companies and provide free antiretroviral (ARV) medicines to low-income people who are uninsured (in some cases, underinsured) and who do not qualify for assistance programs, such as Medicaid, Medicare, or AIDS Drug Assistance 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 May 2016 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.**

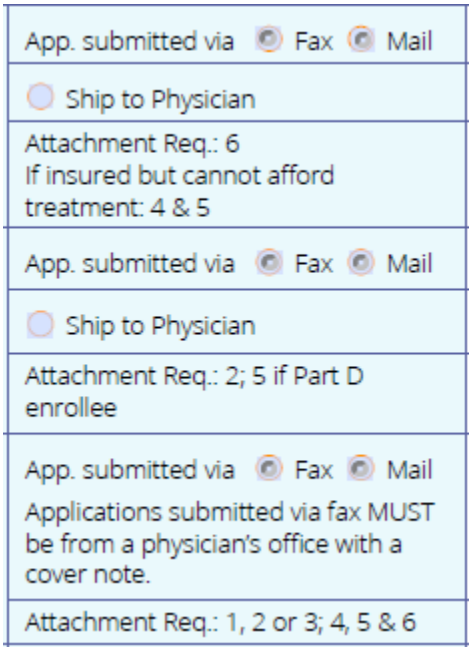
Further, each PAP requires its own application and that, once completed, can be printed out multiple times and submitted to individual PAPs with the required attachments.

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.
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

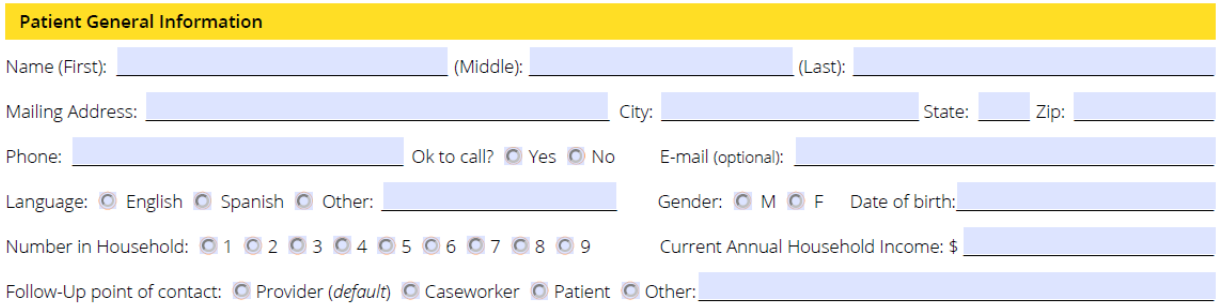
Step 2: Review the information listed under the second column of page 3 of the CPAPA form for each of the companies you are planning to submit to for enrollment.

A single CPAPA form must 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).



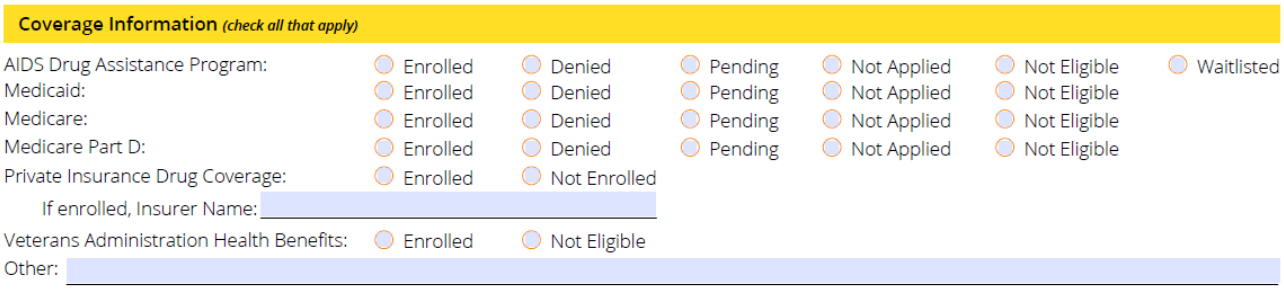
Step 3: Complete "Patient General Information" section (see page 2).

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.



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.



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.

Physician/Prescriber Information

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

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

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

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

Professional Designation/Specialty: _____ National Provider Identifier: _____

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

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**.

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: _____

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**.

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

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

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

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

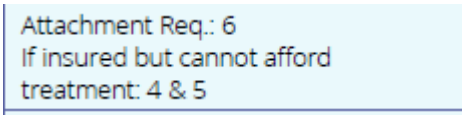
Relationship to patient: _____

_____ _____

Advocate Signature Date

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 attachements; 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. #6 is the original prescription form.)



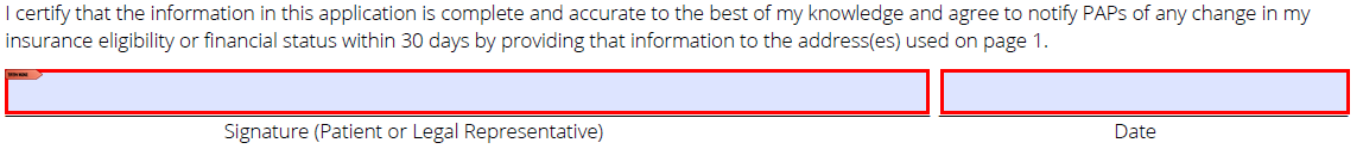
Step 9: Complete the remaining portion of the form on page 3.

For each PAP to which the CPAPA form will be submitted, mark: the medication(s) needed; how the application will be submitted (either by fax or mail, depending on the PAP's requirements); and where the medication should be shipped.

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 afford treatment: 4 & 5
Boehringer Ingelheim Cares Foundation Inc. Patient Assistance Program c/o Express Scripts SDS, Inc. P.O. Box 66565, St. Louis, MO 63166 — Phone: 800-556-8317 Fax: 800-639-9118 ☐ 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 Access Virology Patient Assistance Program P.O. Box 221430 Charlotte, NC 28222 Phone: 888-281-8981 Fax: 888-281-8985 ☐ 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 office with a cover note. Attachment Req.: 1, 2 or 3; 4, 5 & 6
Bristol-Myers Squibb & Gilead Sciences, LLC Atripla Patient Assistance Program P.O. Box 13185, La Jolla, CA 92039 — Phone: 866-290-4767 Fax: 866-290-4487 ☐ Atripla® (efavirenz/emtricitabine/tenofovir disoproxil fumarate)	*Patients that are pre-screened and determined to be eligible for the program may receive a voucher for the immediate pickup 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

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.



Step 11: Send completed application.

Either fax or mail 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

NASTAD is funded under HRSA Cooperative Agreement U69HA26846 to provide States with technical assistance on Part B program and ADAP program administration. Part B grantees and ADAPs may also obtain technical assistance through their HRSA project officer.