CLEAR FORM

SUPPORT PATH®

PATIENT ENROLLMENT FORM

INSTRUCTIONS

Please complete all applicable sections of the Patient Enrollment Form.

Mail or fax the completed Enrollment Form and all required documentation to Gilead's Support Path program at the address or fax number below. Both sets of information are necessary to ensure timely enrollment form review. You may complete an electronic enrollment form online at www.MySupportPath.com.

A Support Path Program Navigator will notify the requestor about the patient's coverage and benefits, alternate funding options, and/or qualification for the Patient Assistance Program (PAP), depending on the support requested.

PATIENT CONFIDENTIALITY

Patient confidentiality is of primary importance to us. All patient information will remain confidential. Information may be provided to clinicians, social workers, or other permitted caregivers when required to complete the enrollment process and coordinate patient assistance, and to credit bureaus to determine program eligibility with your consent within this Enrollment Form.

IMPORTANT REMINDER

Please be certain that all applicable pages of the Enrollment Form are completed and include all appropriate documentation when submitting the form. Incomplete forms slow the review process and, in some cases, may require a patient to reapply for the program.

Gilead Sciences, Inc., and its affiliated companies reserve the right to modify or discontinue the Support Path program or terminate assistance at any time. Third-party reimbursement is affected by a range of factors; therefore, Gilead Sciences, Inc., and its affiliated companies cannot guarantee any coverage or reimbursement.

SUPPORT PATH

PO Box 13185
La Jolla, CA 92039-3185

VISIT:
www.MySupportPath.com

PHONE:
1-855-769-7284

FAX:
1-855-298-8700

GET STARTED >

A STEP-BY-STEP GUIDE TO FILLING OUT THE FORM

TO BE COMPLETED BY THE PATIENT OR PATIENT'S REPRESENTATIVE:

- **SECTION 1 (REQUIRED)**
  Check the box next to each support offering you are requesting from Support Path.
- **SECTION 2 (REQUIRED)**
  Write the name of the Gilead or Asegua product you are requesting assistance with from Support Path.
- **SECTION 3 (REQUIRED)**
  Complete all fields with the patient's information.
- **SECTION 4 (REQUIRED)**
  Check the appropriate box to indicate if the patient is insured or uninsured.
  - If the patient is insured, fill in the patient's insurance information and fax a copy (front and back) of the patient's insurance card. If the patient has a secondary insurance, check the box to indicate this and fax a copy of the secondary insurance card.
  - If the patient is uninsured, complete the "Additional Insurance Information" portion.
- **SECTION 5 (REQUIRED ONLY IF APPLYING TO THE PATIENT ASSISTANCE PROGRAM [PAP])**
  - Provide the patient's annual household income and household size.
  - Attach documentation for all sources of income and proof of residency. Patient photo ID may be required.
  - Sign, date, and provide your phone number, if applicable, if you are applying to the PAP.
- **SECTION 6 (REQUIRED)**
  The patient (or the patient's representative) must sign and date this section.

PATIENTS WHO MEET THE ELIGIBILITY CRITERIA FOR THE PAP WILL BE PREQUALIFIED FOR THE PROGRAM.

- The program will notify the patient and the prescriber of the prequalified status.
- The prescriber's notification will also include a prescription form.
- The prescriber will have up to 30 days from the prequalified date to submit the completed prescription form to the dispensing pharmacy specified on the form.
- Once the dispensing pharmacy receives the completed prescription form, the patient will be enrolled in the PAP and will receive product free of charge from the pharmacy by mail. A toll-free telephone number is included on the enrollment letter upon approval if additional assistance is needed.

TO BE COMPLETED BY THE PRESCRIBER:

- **SECTION 7 (REQUIRED)**
  Complete all fields with the prescriber's information.
- **SECTION 8 (REQUIRED)**
  A healthcare provider must provide the patient's diagnosis and medical information.
- **SECTION 9 (REQUIRED)**
  The prescriber must sign and date this section.

SUPPORT path

Enroll via the online portal at **www.MySupportPath.com**

PATIENT ENROLLMENT FORM

PHONE: **1-855-769-7284** FAX: **1-855-298-8700**

1. REQUESTED PATIENT SUPPORT REQUIRED

CHECK ALL BOXES THAT APPLY

- ☐ Benefits Investigation
- ☐ Prior Authorization and Appeals Information
- ☐ Co-pay Coupon Program Enrollment
- ☐ Patient Assistance Program (PAP) Eligibility Screening

2. GILEAD OR ASEGUA MEDICATION PRESCRIBED REQUIRED

☐ Brand ☐ Authorized Generic | Product Name: | Strength and Form: ☐ Pediatric

3. PATIENT INFORMATION REQUIRED

First Name:	Last Name:	M.I.:	Preferred Name:
Address:	Apt./Unit #:	City:	
State:	ZIP Code:	Phone #: ( ) –	Preferred Language:
Email:	Date of Birth: / /	Gender: ☐ M ☐ F	SSN# (Last 4 digits):	Resides in U.S./U.S. Territories: ☐ Yes ☐ No
Alternate Contact Name:	Phone #: ( ) –	Relationship:	

CONTACT AUTHORIZATION

☐ Yes ☐ No I authorize Support Path to leave a detailed message, including the name of my prescription, if I am unavailable when they call.

☐ Yes ☐ No I authorize Support Path to send me correspondence via US mail. This includes, but is not limited to, approval/denial letters for the Patient Assistance Program (PAP), reminder letters for re-enrollment periods, etc. If I select "No," or do not check either box, I understand that all communication will be via phone.

I authorize Support Path to provide me with information on my benefits and other communications that contain reference to the Support Path program through the following: ☐ Text: ( ) – *my preferred mobile #* ☐ Email ☐ Phone

4. INSURANCE INFORMATION REQUIRED

PLEASE INCLUDE A COPY OF THE FRONT AND BACK OF INSURANCE CARD(S)

☐ Patient is uninsured (ie, no health insurance through any public or private payer) **Complete "Additional Insurance information" below**

☐ Patient is insured (Please fill out all of the applicable insurance information below — Attach copy [front & back] of all insurance cards, including medical and prescription.)

Primary Insurance:	Is this a Medicare Part D plan? ☐ Yes ☐ No
Plan Name:	Insurance Phone #: ( ) –

Preferred Specialty Pharmacy:

Subscriber Name:	Policyholder Name:	Policyholder Relationship to Patient:

Policy #:	Group #:	Rx Bin #:	Rx PCN #:

☐ Check box if patient has secondary insurance coverage and fax a copy of insurance cards, if available.

ADDITIONAL INSURANCE INFORMATION *REQUIRED ONLY IF APPLYING FOR THE PATIENT ASSISTANCE PROGRAM (PAP)*

Is the patient eligible for Medicaid? ☐ Yes ☐ No If No, state reason *(if denied, attach a copy of the denial letter)*:	Has the patient applied for Medicaid? ☐ Yes ☐ No If Yes, date of application:
Is the patient eligible for Medicare? ☐ Yes ☐ No If No, state reason *(if denied, attach a copy of the denial letter)*:	Has the patient applied for Medicare? ☐ Yes ☐ No If Yes, date of application:
Is the patient eligible for VA benefits? ☐ Yes ☐ No	If Yes, has the patient tried to obtain the medication through the VA? ☐ Yes ☐ No
Is the patient eligible for an insurance plan offered through a state insurance marketplace (also known as an exchange)? ☐ Yes ☐ No If No, state reason:	Has the patient applied for an insurance plan offered through a state insurance marketplace (also known as an exchange)? ☐ Yes ☐ No If Yes, date of application:

5. PATIENT FINANCIAL INFORMATION

REQUIRED ONLY IF APPLYING FOR THE PATIENT ASSISTANCE PROGRAM (PAP)

Current annual household income: $ _____ | Number of people in household supported by current annual income: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ Other: _____

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

If there is no household income, indicate how the patient/household is being supported:

APPLICANT DECLARATIONS AND AUTHORIZATIONS

REQUIRED ONLY IF APPLYING FOR THE PATIENT ASSISTANCE PROGRAM (PAP)

I certify that all of the information provided in this application, including household income, is complete and accurate. I understand that program assistance will terminate if Support Path becomes aware of any false or inaccurate information or if this medication is no longer prescribed for me. I understand that I may only use the free product received through the PAP for my own use and personal consumption, and that I will not offer the product for sale, resale, barter, or trade. I understand that completing this application does not ensure that I will qualify for patient assistance. If I receive free product through the PAP, I certify that I will not seek reimbursement or credit for this medication from any insurer, health plan, or government program. If I am a member of a Medicare Part D plan, I will not seek to have this medication, or any cost for items associated with it, counted as part of my out-of-pocket cost for prescription drugs. I understand that the PAP reserves the right to modify the application form, modify or discontinue this program, or terminate assistance at any time and without notice. I authorize the PAP and its administrator to forward my prescription to a dispensing pharmacy on my behalf. Support Path may require me to submit proof of identity and income documentation to verify my eligibility into the Patient Assistance Program (eg, identification card, tax return, W-2, last two pay stubs, etc). **I authorize Gilead, its affiliates, and its third-party administrator to use the information provided on this form to obtain a personal credit report about me to verify the information on this form and determine my eligibility for the PAP.**

X **SIGNATURE OF PATIENT or AUTHORIZED PATIENT REPRESENTATIVE UNDER FEDERAL OR STATE LAW** (REQUIRED ONLY IF APPLYING FOR PAP):	**DATE:** / /
Patient Representative's Name (if signing for the patient — PLEASE PRINT):	**Phone #:** ( ) –
Patient Representative's Relationship to Patient:	

SUPPORT PATH® PATIENT ENROLLMENT FORM PHONE: **1-855-769-7284** FAX: **1-855-298-8700**

PATIENT NAME: _____ **DATE OF BIRTH:** ___/___/___

6. PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PERSONAL MEDICAL INFORMATION REQUIRED

I understand that I must complete this enrollment form before I can receive assistance through Gilead Sciences, Inc.'s Support Path Program ("Program") and the Patient Assistance Program ("PAP"). As part of this process, Gilead and its affiliates and its agents and contractors (collectively, "Gilead") will need to obtain, review, use, and disclose my personal and medical information as described below. I hereby authorize my healthcare providers and health plans to disclose my personal and medical information as described below to Gilead in connection with the Program and/or the PAP, all in accordance with this authorization, and I authorize Gilead to use and disclose the information in accordance with the authorization.

Information to Be Disclosed: Personal information ("PI"), including information about me (for example, my name, mailing address, financial information, and insurance information), my medical information, such as my current and future medical condition (including information about my liver disease-related status or treatment with this prescription medication and related medical condition), and all information provided on this enrollment form.

Persons Authorized to Disclose My Information: My healthcare providers, including any pharmacy that fills my prescription medication, and any health plans or programs that provide me with healthcare benefits. I understand that my pharmacy providers may receive remuneration for disclosing my PI pursuant to this authorization.

Persons to Whom My Information May Be Disclosed: Gilead, including the third-party administrator responsible for the administration of the Program and the PAP.

Purposes for Which the Disclosures Are to Be Made: Disclosures of PI may be made to Gilead so that Gilead may use and disclose the PI for purposes of: 1) completing the enrollment process and verifying my enrollment form, including but not limited to confirming my identity and my use or potential use of this prescription medication and prescribed through my relationship with the prescriber identified in Section 7; 2) establishing my eligibility for benefits from my health plan or other programs; 3) providing financial assistance and reimbursement support, if I am eligible, and providing other applicable support, including but not limited to information on third-party resources that may be able to assist me; 4) communicating with my healthcare providers, including, but not limited to, verifying my enrollment and facilitating the provision of my prescription medication to me; 5) contacting me to evaluate the effectiveness of the Program and/or the PAP; 6) Gilead's internal business purposes, including quality control; 7) audit and compliance purposes, including but not limited to case reviews and support-enhancing surveys; 8) confirming my receipt of the prescribed Gilead medication through the PAP based on my communication preferences in Section 3; and 9) sending me marketing information, offers, and educational materials related to my medical condition, treatment, and/or my prescription medication, including the customer relationship marketing program (this use of my personal information is OPTIONAL and by checking the box below, I may opt in).

I understand that once my PI has been disclosed hereunder, federal privacy law may no longer restrict its use or disclosure. I understand further that I may refuse to sign this authorization and that if I refuse, my eligibility for health plan benefits or ability to obtain treatment from my healthcare providers will not change, but I will not have access to the support offered by the Program and/or the PAP. I also understand that I may cancel this authorization at any time by notifying Gilead in writing at Support Path, PO Box 13185, La Jolla, CA 92039-3185. If I cancel, Gilead will stop using this authorization to obtain, use, or disclose my PI after the cancellation date, but the cancellation will not affect uses or disclosures of any PI that have already been made pursuant to this authorization before the cancellation date. I am entitled to a copy of this signed authorization, which expires the earlier of two (2) years from the date it is signed by me or other time period required under the laws of the state in which I reside.

☐ **Marketing Communications Opt-in (OPTIONAL):** By checking this box, I agree to receive marketing information, offers, and educational materials related to my medical condition, treatment, and/or my prescription medication, as provided under purpose number 9 above. The marketing outreach program is separate from the PAP/Program. I understand that opting in to the marketing outreach program is not required as a condition of purchasing any goods or receiving co-pay or other support from Gilead.

X **SIGNATURE OF PATIENT or AUTHORIZED PATIENT REPRESENTATIVE UNDER FEDERAL OR STATE LAW** (REQUIRED)**:**	**DATE:** ___/___/___
Patient Representative's Name (if signing for the patient — PLEASE PRINT)**:**	**Phone #:** (___) ___-___
Patient Representative's Relationship to Patient:	

SUPPORT PATH® PATIENT ENROLLMENT FORM

PHONE: **1-855-769-7284** FAX: **1-855-298-8700**

PATIENT NAME: _____ **DATE OF BIRTH:** ___/___/___

7. PRESCRIBER INFORMATION REQUIRED

MUST BE COMPLETED BY A HEALTHCARE PROVIDER

Prescriber Name:	Facility Name:		
Address:	City:	State:	ZIP Code:
Office Contact:	Phone #: ( ) –	Fax #: ( ) –	
NPI #:	State License #:	Tax ID #:	

8. DIAGNOSIS/MEDICAL INFORMATION REQUIRED

MUST BE COMPLETED BY A HEALTHCARE PROVIDER

To ensure a timely response, be sure to include details for both **ICD-10 code and **F Score** below.*

Diagnosis:

ICD-10 code*:	**F Score* (Fibrosis Score):**	☐ Other:

HCV Genotype (optional): ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ Other: ☐ HCV/HIV-1 Co-infection

Patient is (select one of the following options and indicate below if patient is ready to start therapy)**:** ☐ Treatment Naïve ☐ Previously Treated ☐ Currently on Therapy

If previously treated or currently on HCV therapy, what medications?:

Is patient ready to start therapy? ☐ Yes ☐ No	Actual or anticipated start date:	Therapy Duration:

9. PRESCRIBER CERTIFICATION AND STATEMENT OF MEDICAL NECESSITY REQUIRED

MUST BE COMPLETED BY A HEALTHCARE PROVIDER

By signing this form, I certify that I am personally prescribing and may furnish Gilead medication for the patient identified in Section 3. I certify that this prescription medication is medically necessary for the patient and that it will be used as directed. I certify that I will be supervising or coordinating the patient's treatments, in accordance with law, and verify that the information provided as part of my patient's application for the Patient Assistance Program ("PAP") is complete and accurate to the best of my knowledge. I certify that I have not received and shall not seek reimbursement for any Gilead medication dispensed to the patient through the PAP from any government program or third-party insurer. If applicable, I certify that medication provided to me by the PAP for the eligible patient identified in Section 3 will be provided by me to such patient for his or her own use without charge. I certify that I will not otherwise use any such medication or prescribe, provide, furnish, or dispense all or any portion thereof for the use of any other person or patient. I will notify Gilead if all or any portion of the medication provided to me by the PAP for the patient identified in Section 3 is not prescribed, provided, furnished, or dispensed to that patient, and I will ensure such medication is returned to Gilead or its designated representative, by calling 1-855-769-7284 within 30 days. I certify that I will not sell, resell, offer for sale, trade, or barter medication provided to me under the PAP.

I consent that Gilead may perform an audit related to: 1) the applicant identified in Section 3, including but not limited to confirming patient identity and verifying medical necessity; and 2) the dispensing of medication provided to the prescriber through the PAP, including confirming patient receipt of the prescribed Gilead medication and the timely return of any medications received for, but not dispensed to, the patient identified in Section 3, if applicable.

I certify that I have received the appropriate written authorization from the patient, in accordance with the Health Insurance Portability and Accountability Act of 1996, applicable state health information privacy law(s), and any other applicable requirements, in order to release the patient's personal and medical information to Gilead and its affiliates and its agents and contractors for the purposes of assessing the patient's insurance coverage and eligibility for participation in Support Path, conducting random audits to verify the information provided on this enrollment form, and for other purposes as outlined in the Patient Authorization For Use and Disclosure of Personal Medical Information in Section 6. Gilead is authorized to contact me about the information provided on this form and as needed to facilitate my patient's enrollment and participation in Support Path. I understand that Gilead may, if authorized by the patient, contact the patient directly to verify Support Path eligibility and updates to insurance coverage, as well as to confirm the receipt of Gilead medication through the PAP.

SPECIAL NOTE: New York prescribers, please submit prescription on an original NY State prescription blank. For all other states, if not faxed, prescription must be on State-specific form, if applicable for your State.

X **PRESCRIBER SIGNATURE** (REQUIRED)**:**	**DATE:** ___/___/___

FAX COMPLETED FORM TO SUPPORT PATH AT 1-855-298-8700

<< RETURN TO INSTRUCTIONS PAGE