ViiV Healthcare Patient Assistance Program • PO Box 52037 • Phoenix, AZ 85072
Phone #: 1.877.7ViiVHC (1.877.784.4842) • Fax #: 1.877.784.4004 • www.ViiVHealthcareForYou.com

ViiV Healthcare Patient Assistance Program provides ViiV Healthcare medicines to both Medicare Part D enrollees as well as those without prescription drug coverage. To apply, send a completed application and required documentation to the address above or fax them to 1.877.784.4004. Healthcare advocates may phone enroll patients who need same day access to ViiV Healthcare medicines unless the patient is enrolled in a Medicare Part D plan. Medicare Part D patients may not enroll by phone. Call 1.877.7ViiVHC or visit www.ViiVHealthcareForYou.com for additional information. This patient assistance program does not constitute health insurance.

APPLICANT INFORMATION Required

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

Mailing Address: _____

City: _____ State: _____ ZIP Code: _____ Phone Number: (_____) _____ - _____

☐ Number of people, including applicant, who live in the household? ☐ Number of people dependent on household income?

Social Security #: ☐☐☐-☐☐-☐☐☐☐ Birth Date: _____ / _____ / _____ (MM / DD / YYYY) Gender: M ☐ F ☐

Total Gross Annual Income: _____

If the applicant filed income tax or was listed as a dependent on someone else's income tax for the most recently filed tax year, attach a copy of page one of the tax form (acceptable tax forms are 1040, 1040A, 1040EZ or 1040X only). If no tax form was filed or if the tax form does not represent current income, attach proof of income from all sources for the most recent 30-day period for the applicant and all members of the household.

PRESCRIPTION COVERAGE Required

1. Is the applicant eligible for any state or federal prescription drug coverage plan such as Medicaid? YES ☐ NO ☐
2. Is the applicant eligible for Puerto Rico's Government Healthcare Program, Mi Salud? YES ☐ NO ☐
3. Does the applicant have any private prescription drug coverage (including employer sponsored plans, private group plans, etc.)? YES ☐ NO ☐
   - ♦ If yes, please indicate why assistance is needed: _____
4. Does the applicant have prescription drug coverage through a Health Insurance Marketplace Plan/Exchange? YES ☐ NO ☐
5. What is your ADAP status? Denied ☐ Waitlisted ☐ Pending ☐ Not Applied /Not Eligible ☐
6. Is the applicant enrolled in a Medicare Part D prescription drug plan? YES ☐ NO ☐
7. If yes to question 6, has the applicant spent $600 or more on prescription expenses since January 1st of the current calendar year? YES ☐ NO ☐
   - ♦ If yes, please provide an EOB or pharmacy receipt(s) indicating the patient paid a total of $600 for prescriptions in the current calendar year.

SHIPPING ADDRESS Only complete this section if medicine is being shipped somewhere other than the Mailing Address above.

Addressee or Business Name: _____

Street Address: _____

City: _____ State: _____ ZIP Code: _____

Specify addressee's relationship to the applicant:

Self ☐ Advocate ☐ (must complete Advocate Information below) Other (specify relationship) ☐ _____

ADVOCATE INFORMATION Optional: Required if enrolling by phone. Not required if patient is self enrolling.

Only complete this section if the advocate enrolls the applicant and wants to be the contact person and receive program correspondence for this applicant.

Advocate ID Number: _____ (Register by calling 1.877.7ViiVHC [1.877.784.4842].)

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

Facility Name: _____

Street Address: _____ City: _____ State: _____ ZIP Code: _____

Phone number: (_____) _____ - _____ Fax number: (_____) _____ - _____

ALLERGY AND HEALTH INFORMATION Optional

List any known drug allergies: _____ Check box if none ☐

List any known health conditions: _____ Check box if none ☐

REQUIRED SIGNATURE ON PAGE 2

THIS VOUCHER BECOMES VALID FOR USE AT A RETAIL PHARMACY AFTER PHONE ENROLLMENT IS COMPLETED.

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www.ViiVHealthcareForYou.com

PATIENT VOUCHER

Patient Name: _____

Patient ID#: _____

This Patient Voucher is for use by patients without prescription drug coverage and serves two purposes: [1] it is your program identification, and [2] it will help your pharmacy process your prescription claim correctly.

Medicare Part D patients may not use the voucher.

PHARMACY PROCESSING INFORMATION
Processor - McK
RxBIN - 610500 **RxGRP** - H3160003
Pharmacy Questions - Call 1.877.7ViiVHC between 9:00am – 7:00pm Eastern Time

HOW TO FILL YOUR INITIAL PRESCRIPTION THROUGH THE VIIV HEALTHCARE PATIENT ASSISTANCE PROGRAM

- After your advocate successfully enrolls you by phone, take this voucher and your ViiV Healthcare prescription(s) to a local retail pharmacy.
- You may obtain up to a 30-day supply per drug.
- Do not attempt to obtain refills at your local pharmacy after 30 days unless directed to by your advocate.
- Contact your advocate if you have any questions.

AUTHORIZED INDIVIDUALS Optional

For the patient: if you would like to give permission to ViiV Healthcare for other individuals (i.e. adult child, parent, friend) to conduct business on your behalf, please print their names here. Please note: these individuals are in addition to a legal guardian or registered advocate who may already be included on this application:

First Name	Last Name	Relationship to patient

APPLICANT AUTHORIZATION TO RELEASE AND DISCLOSE MEDICAL INFORMATION Required

By my signature I authorize ViiV Healthcare, as well as McKesson Specialty Arizona Inc. (MSAZ) and any other companies that ViiV Healthcare uses to administer the ViiV Healthcare Patient Assistance Program (the "Program"), to do the following:

1) Use any information that I provide in my application for the Program for the purpose of helping me receive ViiV Healthcare products under the Program or to administer the Program;
2) Receive and keep records of all prescriptions for the medications I receive under the Program, which will be used to administer the Program;
3) Contact my doctor, healthcare provider, or pharmacist about my application for the Program, and disclose to them information contained in my application, in order to help me receive ViiV Healthcare products under the Program and ensure that Program guidelines are being met;
4) Request information from my insurer, doctor, healthcare provider, or pharmacist about the prescribed medications I receive or will receive under the Program and about my medical condition. This information will be used only to determine my eligibility for the Program and to administer the Program. By signing below, I also authorize my insurer, doctor, healthcare provider, or pharmacist to release information about my prescribed medications and medical condition that is requested by ViiV Healthcare, MSAZ or any company that ViiV Healthcare uses to run the Program;
5) Contact my insurer, other potential funding sources, including the Centers for Medicare and Medicaid Services, social workers or patient advocacy organizations on my behalf in order to determine if I am eligible for health insurance coverage or other funds, and disclose to them information contained in my Program application or information about my prescribed medications and medical condition that has been provided by my physician, healthcare provider, or pharmacist;
6) Disclose any information obtained from the sources listed above to third parties if required by law.

I understand that ViiV Healthcare does not charge a fee for participation in this Program. There may be a co-payment for each prescription filled at a retail pharmacy. If my advocate charges a fee for enrollment or refills of my medicine, this money is not paid by or to ViiV Healthcare.

I understand that this Authorization to Release and Disclose Medical Information will remain in effect for as long as I participate in the Program and for a period of 3 years after my participation in the Program ends.

I understand that my healthcare providers will not condition my medical treatment on my agreement to sign this Authorization to Release and Disclose Medical Information. I also understand that I have the right to revoke this authorization at any time by calling 1.877.7ViiVHC and mailing a signed written statement of my revocation to the Program. Such a revocation would end my eligibility to participate in the Program. Revoking this authorization will prohibit disclosures after the date written revocation is received, except to the extent that action has been taken in reliance on my authorization.

I understand that once medical information about me has been disclosed in reliance upon this Authorization, the information may no longer be protected by federal privacy laws and may be further disclosed.

I certify that the product that I receive from the Program is for my own use and will not be sold, bartered or given to any other person. I certify that the information provided in this application is complete and accurate to the best of my knowledge and agree to notify ViiV Healthcare of any change in my insurance eligibility or financial status.

_____ _____

Patient or Legal Guardian Signature ***Date***

ADVOCATE CERTIFICATION Optional: Required if enrolling by phone. Not required if patient is self enrolling.

By my signature, I certify to the best of my knowledge, the information on this application is correct and complete. I have no knowledge of any intent to sell, barter or give this product to any person other than the Applicant for whom it has been prescribed. To the best of my knowledge, the Applicant has no medical/prescription insurance benefits for the indicated pharmaceutical(s), including Medicaid or other public programs other than as indicated, and the Applicant has insufficient financial resources to pay for the prescribed therapy.

_____ _____

Advocate Signature *(Original signature required. Stamped signature not accepted.)* ***Date***

REMEMBER TO:

- ❒ **Complete the entire form.** An incomplete application will delay processing. Call 1.877.7ViiVHC (1.877.784.4842) or visit www.ViiVHealthcareForYou.com with any questions about how to complete this form.
- ❒ Optional: Healthcare advocates may phone to enroll patients who do not have prescription drug coverage and who need same day access to their medicines. Medicare Part D patients may not enroll by phone.
- ❒ **Mail or fax the following:**
  - ♦ **Completed and signed application.**
  - ♦ **Proof of income.** Either a copy of page one of your income tax form for the most recently filed tax year or proof of income from all sources, for all household members, for the most recent 30-day period.
  - ♦ **Signed prescription.** Signed original prescription(s) for ViiV Healthcare medication written for a 90-day supply with refills if medically appropriate.
    NOTE: Faxed prescriptions are only valid if they are faxed directly from a physician's office and accompanied by a fax cover sheet. Faxed prescriptions received from any other location will not be accepted and will delay medication shipment.
  - ♦ **Medicare Part D applicants must also send:**
    - **Proof of $600 spend.** This can be a printout from the pharmacy that lists the $600 spend for prescriptions for the current calendar year or the most recent Medicare Part D Plan Explanation of Benefits Statement including the first page that includes the patient's name.
    - **A copy of the Medicare Part D prescription drug card.**
  - ♦ **As a reminder, submitted prescriptions and/or enrollment documentation cannot be returned.**
- ❒ Keep a copy of the application and all documents for your records. Please print applicant's name and date of birth on all documents.