

Call 1-800-226-2056 to begin enrollment.

Medication Requested (For Vistide Only, Attach Prescription 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)

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

PLEASE PRINT

1	Patient Information	Name (First): _____ (Last) _____ (Middle Initial) _____	
Address: _____			
City: _____		State: _____	ZIP Code: _____ Phone #: (_____) _____
Patient's other HIV/HBV Meds: _____			
Social Security #: <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> - <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> - <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>		Birth Date: _____ / _____ / _____ <small>MM DD YYYY</small>	Gender: M <input type="checkbox"/> F <input type="checkbox"/>
Patient Language: English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____		U.S. Resident: YES <input type="checkbox"/> NO <input type="checkbox"/>	

Total Annual 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)

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	Y N	AIDS Drug Assistance Program If Y, Date of Application: _____ Is applicant eligible? Y <input type="checkbox"/> N <input type="checkbox"/>	Y N	Y N
Private Insurance	Y N	Y N	Other _____ <small>List Insurer if Y</small>	Y N	Y N	If N, state reason: _____		
						No Insurance Check if Applicable <input type="checkbox"/>		

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

Contact Name: _____ Phone #: (_____) _____

Subscriber Name: _____ Date of Birth: _____

<p>Secondary Insurance: Does applicant have additional coverage? YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>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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Void where prohibited by law. Patients 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 Advancing Access Patient Assistance Program.

<< Complete Page Two on Reverse >>

Applicant Declaration

I verify that the information provided in this application is complete and accurate. I understand that Advancing Access 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 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 Advancing Access 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® and Vistide® 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 the program. I am entitled to a copy of this signed authorization, which expires 10 years from the date it is signed by me.

Patient Signature _____ Date _____

2 Prescriber Information

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 or VISTIDE. 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**

Advancing Access™
Reimbursement Solutions
for Patients in Need

P.O. Box 13185
La Jolla, CA 92039-3185
TEL 1-800-226-2056 FAX 1-800-216-6857