CLEAR FORM

CAYSTON ACCESS PROGRAM®

PATIENT ENROLLMENT FORM

PHONE: **1-877-7CAYSTON** (1-877-722-9786) FAX: **1-877-550-1705**

1. REQUESTED PATIENT SUPPORT

CHECK ALL BOXES THAT APPLY

☐ Benefit Investigation and Pharmacy Triage ☐ CAP Enrollment (Benefit Investigation/Pharmacy Triage not included) ☐ Patient Assistance Program (PAP)

2. PHARMACY PREFERENCE

☐ Accredo ☐ CVS Specialty Pharmacy ☐ IV Solutions, a Maxor company ☐ Pharmaceutical Specialties LLC, a Maxor company

☐ AllianceRx Walgreens Prime ☐ Foundation Care, an AcariaHealth Solution ☐ Kroger Specialty Pharmacy

3. PATIENT INFORMATION

First Name:		Last Name:	M.I.:
Address: *(Note: A physical address will be required to ship the medication)*		Apt./Suite #:	City:
State:	Zip Code:	Date of Birth: / /	Gender: ☐ M ☐ F
Primary Contact:		Relationship:	
Home Phone #: ( ) –	Work Phone #: ( ) –	Cell Phone #: ( ) –	Email:
Preferred Phone #: ☐ Home ☐ Work ☐ Cell		Preferred Language: ☐ English ☐ Other:	
Alternate Contact/Caregiver/Parent:			Contact Phone #: ( ) –

4. INSURANCE INFORMATION (IF YOU ARE ATTACHING COPIES, YOU DO NOT NEED TO COMPLETE THE INSURANCE INFORMATION BELOW)

☐ Check here if you are attaching a copy (front and back) of the patient's insurance card(s).

☐ Yes ☐ No Is the patient prescription paid for in whole or part by a government-funded program such as Medicare, Medicaid, or a Medicare Part D plan, TRICARE, VA or DoD?

☐ Yes ☐ No Do you have a Prescription Drug Card?	Prescription Drug Insurer Name:		Phone #: ( ) –
Card Holder Name:			
ID #:	Group #:	BIN #:	PCN #:
Primary Insurance:			Phone #: ( ) –
Card Holder Name:		ID #:	Group #:
Secondary Insurance:			Phone #: ( ) –
Card Holder Name:		ID #:	Group #:

5. PRESCRIBER INFORMATION

Prescriber First Name:		Prescriber Last Name:	
Facility Name:		Office Contact Name:	
Address:		City:	State: Zip Code:
Office Phone #: ( ) –	Ext: Office Fax #: ( ) –		Email:
Tax ID #:	NPI #:	Medicaid ID #:	State License #:

6. DIAGNOSIS AND CLINICAL INFORMATION (THIS IS FOR INSURANCE PURPOSES ONLY, NOT TO SUGGEST APPROVED USES OR INDICATIONS)

☐ Cystic Fibrosis (E84.9)	☐ Cystic Fibrosis with Pulmonary Manifestations (E84.0)	☐ *Pseudomonas aeruginosa* (B96.5)	☐ Other (Include ICD-10 Code):
FEV_1 Percent Predicted: ☐ <25% ☐ ≥25% - ≤75% ☐ >75%		Other medications:	

7. PRESCRIPTION INFORMATION AND STATEMENT OF MEDICAL NECESSITY

ALTERA® NEBULIZER SYSTEM *(Includes Controller, 1 additional Altera Handset, Nebulizer Connection Cord, AC Power Supply, 4 AA Batteries)* Dispense: ☐ 1 Altera Nebulizer System

Is the patient new to CAYSTON (aztreonam for inhalation solution) treatment: ☐ Yes ☐ No Rx Type: ☐ CAYSTON 75mg per vial, 28-Day Kit *(Note: Altera handset to be included in each shipment)*

Qty: ☐ #84 vials Refills: SIG: ☐ Inhale 75mg (1 vial) via Altera nebulizer three times daily 28 days on 28 days off ☐ Other:

Special Instructions:
(**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 blank if applicable for your State.)

Drug Allergies:
☐ No Known Drug Allergies

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 agents and contractors for the purposes of: 1) verifying the patient's insurance coverage and eligibility for benefits; 2) seeking prior authorization if needed on the patient's behalf; 3) providing financial assistance, support, and referral support as needed; 4) facilitating the provision of the patient's prescription medication to the patient; 5) contacting the patient with educational materials about the patient's prescription medication or to evaluate the effectiveness of the Cayston Access Program and/or the PAP; and 6) for Gilead's internal business purposes.

X **PRESCRIBER SIGNATURE** (REQUIRED): (NO STAMPS ALLOWED — DISPENSE AS WRITTEN) **DATE** (REQUIRED): / /

To view your patient shipment history, refills and reimbursement alerts, register online at www.allyhcpportal.com

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This will help avoid delays at the pharmacy PATIENT NAME: DATE OF BIRTH: / /

8. PATIENT AUTHORIZATION AND CONSENT (READ AND SIGN) — REQUIRED

As further described below, I hereby authorize my providers and health plans to share my personal and medical information as described below with Gilead Sciences, Inc., the manufacturer of CAYSTON® (aztreonam for inhalation solution, 75 mg) ("CAYSTON"), and its contractors for limited purposes, all in accordance with this authorization.

Persons Authorized to Disclose My Information: My healthcare providers, including any pharmacy that fills my prescription for CAYSTON and other drugs or devices, and any Gilead health plans or programs that provide me healthcare benefits.

Information to Be Disclosed: Personal information about me (for example, my name, mailing address, and insurance information) and my medical information (including information about my cystic fibrosis status) (together all such information is called my "health information" in this authorization). I understand that my pharmacy providers may receive remuneration for disclosing my personal and medical information pursuant to this authorization.

Persons to Which My Health Information May Be Disclosed: Gilead, including the third party administrator responsible for the administration of the Cayston Access Program® and the PAP (collectively referred to in this authorization as "Gilead").

Use of Information and Purposes for Which the Disclosures Are To Be Made: 1) establish my eligibility for benefits from my health plan or other programs; 2) provide financial assistance, access reimbursement, and referral support, and communicating with my healthcare providers, including, but not limited to, facilitating the provision of CAYSTON and the Altera® Nebulizer System to me in certain limited situations; 3) to contact me to evaluate therapy, the effectiveness of the program and to conduct market research; 4) for Gilead's internal business purposes, including quality control, and support enhancing surveys; 5) to ensure the accuracy and completeness of my application for assistance; and 6) to send me marketing information, offers, and educational materials related to cystic fibrosis and/or CAYSTON, including the customer relationship marketing program (upon my consent, below).

I understand that once my health information has been disclosed to Gilead, federal privacy laws may no longer restrict its use or disclosure; however, Gilead intends to protect my health information by using and disclosing it for the purposes described above and as required by law. I further understand that I may refuse to sign this authorization and that if I refuse, my eligibility for health plan benefits and treatment by my healthcare providers will not change, but I will not have access to the support available through this program. I may cancel this authorization at any time by notifying Gilead in writing and submitting it by fax to 1-877-550-1705 or at the Cayston Access Program address below. If I cancel, Gilead will stop using this authorization to access my health information after that cancellation date, but the cancellation will not affect any health information that has already been disclosed in reliance on this authorization before that cancellation date. I authorize the Cayston Access Program to leave a message, including the prescription name if I am unavailable. I am entitled to a copy of this signed authorization, which expires at the earlier of 10 (ten) years or other time period required under the state in which I reside, from the date it is signed by me.

☐ I consent to receive text messages by or on behalf of Gilead at the telephone number(s) that I provide. I understand that my consent is not required as a condition of purchasing any goods or receiving support from Gilead. Message and data rates may apply. (OPTIONAL)

☐ I consent to receive marketing information, offers and educational materials related to cystic fibrosis and/or CAYSTON, including the customer relationship marketing program. I understand that my consent is not required as a condition of purchasing any goods or receiving support from Gilead. (OPTIONAL)

PATIENT NAME (REQUIRED)**:**	**DATE OF BIRTH:** / /
Patient Email:	Cell Phone #: ( ) –
Prescriber Name:	Prescriber Phone #: ( ) –
X **SIGNATURE** (REQUIRED): *(Signature of Patient or Authorized Patient Representative)*	**DATE** (REQUIRED)**:** / /
Authorized Patient Representative Name *(if signing for the patient)*:	
Authorized Patient Representative Relationship to Patient:	

FAX COMPLETED FORM TO CAYSTON ACCESS PROGRAM AT 1-877-550-1705

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9. PATIENT FINANCIAL INFORMATION

(REQUIRED ONLY IF REQUESTING ELIGIBILITY SCREENING FOR THE CAYSTON (aztreonam for inhalation solution) PATIENT ASSISTANCE PROGRAM ("CAYSTON PAP"))

Current Household Income: $	Cell Phone #: ( ) –
Number of People in Household supported by above income: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ Other:	
Please include current documentation for all sources of income (e.g., most recent tax return, W-2, last 2 pay stubs, 1099, SSI award letter etc.). If patient household income is $0, indicate how the patient is being supported:	

ADDITIONAL INFORMATION

Are you a U.S. Resident? ☐ Yes ☐ No	
Social Security Number: – –	
Has the patient applied for Medicaid? ☐ Yes ☐ No	If Yes, date of application: / /
Is the patient eligible for Medicaid? ☐ Yes ☐ No	If No, state reason:
Is the patient eligible for VA benefits? ☐ Yes ☐ No	If Yes, has the patient tried to obtain the medication through the VA? ☐ Yes ☐ No
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: / /
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:

APPLICANT DECLARATIONS AND AUTHORIZATIONS (REQUIRED ONLY IF REQUESTING ELIGIBILITY SCREENING FOR THE CAYSTON PATIENT ASSISTANCE PROGRAM (CAYSTON 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 CAYSTON PAP if the program becomes aware of any fraud or if this medication is no longer prescribed for me. 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 prescription 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 prescription or any cost associated with it counted as part of my out-of-pocket cost for prescription drugs. I understand that the CAYSTON 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 CAYSTON PAP and its administrator to forward this prescription to a dispensing pharmacy on my behalf.

I authorize Gilead 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.

Patient/Authorized Patient Representative Signature *(required only if requesting eligibility screening for the Patient Assistance Program (PAP))*:

X **SIGNATURE:**	**DATE:** / /
Authorized Patient Representative Name *(if signing for the patient)*:	
Authorized Patient Representative Relationship to Patient:	

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Cayston Access Program, 6931 Arlington Road, Suite 308, Bethesda, Maryland 20814
(Monday-Friday 8AM - 8PM EST)

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