ViiVConnect **ViiVCONNECT.COM · PHONE: 1-844-588-3288 · FAX: 1-844-208-7676**

ViiVConnect provides comprehensive information on access and coverage to help Patients get their prescribed ViiV Healthcare medications.

ViiVConnect Services Requested:
Check all that apply

- ☐ Benefits Verification
  - ☐ Check here for Benefits Verification ONLY
- ☐ Patient Assistance Program (PAP) Application

ORAL MEDICATIONS ENROLLMENT FORM

This enrollment form to be used for ViiV Healthcare oral medications ONLY.

THE FOLLOWING INFORMATION SHOULD BE FILLED OUT BY THE PATIENT

1 Patient Information

ALL FIELDS REQUIRED

First Name | M.I. | Last Name | Preferred Name | D.O.B. (mm/dd/yyyy)

Street Address | Apt/Bldg/Fl | City | State | ZIP Code | Sex: ☐ M ☐ F | Gender Identity

Phone # | Email

☐ Request Spanish Language Materials

PATIENT AUTHORIZATION AND RELEASE

SIGNATURE REQUIRED ON NEXT PAGE

I understand that I must complete and sign this Enrollment Form to participate in ViiVConnect. I also understand that ViiV Healthcare or its agent ("ViiV") may receive and disclose my personal information for services provided to me.

Information that will be used and disclosed: My personal information, such as my name, address, date of birth, insurance information, financial information, medications, prescriptions, medical information, and any other information contained in this Enrollment Form.

Persons and entities authorized to use and disclose my personal information: I authorize my doctor, health plan, healthcare providers, pharmacy and other people I authorize to act on my behalf ("Care Team") to disclose my personal information to ViiV, and I authorize ViiV to collect, use, and disclose my personal information for the purposes identified below.

Purposes for the use and disclosure of my personal information: My personal information will be used by and shared with the persons and entities described in this authorization to:

1. Process my Enrollment Form and collect any additional information necessary to enroll in ViiVConnect as well as verify any information I have provided for enrollment purposes.
2. Identify my health plan benefits and eligibility for health plan coverage and help resolve my insurance coverage, coding, or reimbursement issues.
3. Research alternative insurance coverage options and refer me and my Care Team to other advocacy organizations, health plans, patient support, or patient assistance programs that may be able to help me with access to my medications.
4. Communicate with my Care Team and other healthcare providers and pharmacies about my prescriptions, treatment and medical condition(s).
5. Communicate with me by phone, voicemail, text, mail, and email utilizing my contact information included on this form to provide me information about my health plan benefits, financial assistance services, and ViiV Healthcare medications. I consent to receive autodialed calls and text messages from and on behalf of ViiVConnect at the phone number I have provided. Message frequency may vary. Message and data rates may apply. I may opt out at any time by texting STOP or by contacting ViiVConnect. I understand communications may mention ViiVConnect and medications by name.
6. Provide financial assistance and support services based on ViiV's determination of my eligibility.

Form continued on the following page

Patient Authorization and Release continued from previous page

7. Improve or develop ViiVConnect services and for other internal administrative and business purposes, including analytics.
8. Disclose any of my personal information to third parties if required by law.

I understand that my Care Team will not base any medical treatment decisions on my agreement to sign this Patient Authorization and Release. I also understand that my agreement to sign this Patient Authorization and Release and enroll in ViiVConnect is not required for my valid prescription to be filled. I understand that once my personal information is collected, used, and/or disclosed based on this executed authorization, state and federal privacy laws may not prevent the persons or organizations described above from further disclosing my information.

I understand that I have a right to receive a copy of this signed authorization which will remain in effect for two (2) years, unless a shorter time period is mandated by state law. I also understand that I have the right to revoke this authorization at any time by calling 1-844-588-3288 or mailing a signed, written statement of my revocation to ViiVConnect, PO Box 5490, Louisville, KY 40255, but that such a revocation would end my eligibility to participate in the programs as described. Upon receipt and processing of written revocation of this authorization, further disclosures of your personal information will be prohibited. However, certain information may still be collected, used, and disclosed for administrative purposes by ViiV and any other companies that ViiV uses to collect, use, and disclose such information. For additional information on how ViiV handles your information, please see our privacy notice at **https://privacy.viivhealthcare.com/en-us/**

Authorization for the Sale of My Information to ViiV: I authorize my Care Team (including my healthcare providers, health plans, health insurers, and pharmacies) to disclose my personal information for the purposes described in this authorization and I further authorize my Care Team to accept payment from ViiV in exchange for providing my information.

Please read the Patient Authorization and Release, then sign below. REQUIRED

If the Patient is under 18 years of age, provide Caregiver information and signature.

Patient Name (Please print)	**Patient Signature**	**Date**

Caregiver Name (Please print)	**Caregiver Signature**	**Relationship to Patient**	**Date**

PATIENT COMMUNICATION PERMISSIONS

I do not wish to receive communication via the following (check all that apply): ☐ Phone ☐ Voicemail ☐ Text ☐ Mail ☐ Email

Communication permissions can be updated at any time by calling ViiVConnect.

MARKETING AUTHORIZATION AND RELEASE Optional

I request and authorize ViiV or companies working for or with ViiV to contact me for marketing purposes, including providing me with information about my medication, refill reminders, surveys, and other information and alerts that ViiV believes may be of interest to me (and some of which may be sent directly to my phone). ViiV will not sell or transfer your name, address, or email address to any other party for their marketing use. For additional information regarding how ViiV Healthcare handles your information, please see our privacy notice at **https://viivhealthcare.com/en-us/privacy-notice/**.

Patient or Caregiver Name (Please print)	**Patient or Caregiver Signature**	**Date**

Patient Representative Certification Optional

Complete this only if you are enrolling a Patient and want to be the contact person and receive correspondence on behalf of the Patient.

I attest that I am associated with a healthcare provider office and that the Patient has authorized me to act on their behalf.

Patient Representative Name (Please print)	**Signature** (Stamped signature not accepted)	**ID #**	**Phone #**	**Date**

Form continued on the following page

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ORAL MEDICATIONS ENROLLMENT FORM

2 Insurance Information – Insured Patients

Please attach copies of front and back of all insurance cards, including medical and prescription.

Primary Insurance Name

Policyholder Name

Primary Insurance Phone #

Policyholder Phone #

Policy ID #

Group #

Policyholder DOB

Subscriber Name

Policyholder Relationship to Patient

Patient has secondary insurance: ☐ Yes ☐ No If "yes," indicate insurance name

1 If insurance information is not completed in full, ViiVConnect will reach out to you directly to obtain additional information.

3 ViiV Healthcare Medication Prescribed

ALL FIELDS REQUIRED

This enrollment form to be used for ViiV Healthcare oral medications ONLY.

Please note a prescription must be sent.

Product Name

Dosage (mg)

REQUIRED **Diagnosis Code:** ICD-9/ICD-10 Code

Ship oral medications to: ☐ Prescriber's Office ☐ Patient's Home Address ☐ Other *(Please complete below)* ▼

▸ Street Address

City

State

ZIP Code

4 Prescriber Information

REQUIRED

Office contact information is optional

First Name

Last Name

Practice Name

Phone #

Fax #

Street Address

City

State

ZIP Code

Office Contact Name

Office Contact Phone #

Office Contact Fax #

Prescriber Tax ID

Prescriber State License #

Prescriber Email Address

Prescriber NPI

Group NPI

Site Tax ID

PTAN/UPIN #

Form continued on the following page

ViiVConnect provides comprehensive information on access and coverage to help Patients get their prescribed ViiV Healthcare medications.

ORAL MEDICATIONS ENROLLMENT FORM

5 Patient Assistance Program (PAP) Optional

1 **Complete only if applying for medication at no cost for eligible Patients. Prescription must accompany form.***

# of People Living in Household Who Contribute to, or are Dependent on, Patient's Household Income _____ Total Household Income _____

1. Is the Patient eligible for any state or federal prescription drug coverage plan, such as Medicaid or Puerto Rico's Government Healthcare Program, Mi Salud? ☐ Yes ☐ No

2. Does the Patient have any private prescription drug coverage (including employer-sponsored plans, private group plans, Marketplace plans/exchanges, etc)? ☐ Yes ☐ No

- *If "yes," please indicate why assistance is needed.* _____

3. What is the Patient's ADAP status? ☐ Active ☐ Denied ☐ Wait-listed ☐ Pending ☐ Not Applied/Not Eligible

4. Is the Patient enrolled in a Medicare plan, including Part A, Part B, Part D, or Advantage plans? ☐ Yes ☐ No

- *If "yes," eligibility requires documentation indicating the Patient paid at least $600 on prescription drugs in the current calendar year and including the Member Benefit ID# (MBI).*

MBI# _____

5. Is the patient enrolled in an Alternate Funding Program? ☐ Yes ☐ No

- *If "yes," patients enrolled in an Alternate Funding Program are not eligible for ViiV PAP assistance.*

I authorize ViiV to obtain a consumer report on me. My consumer report and information derived from public and other sources will be used to estimate my income as part of the process to decide if I am eligible to receive free medication through the ViiV Patient Assistance Program. I understand that upon request, ViiV will provide me the name and address of the consumer reporting agency that provided the consumer report.

**Visit ViiVConnect.com or call 1-844-588-3288 for information on Patient eligibility for PAP.*

View Checklist and Submission Instructions on Next Page

Form continued on the following page

ORAL MEDICATIONS ENROLLMENT FORM

Checklist

Before you submit this form, please ensure you've completed all necessary steps:

☐ **1. Have you completely filled out the insurance information, including copies of the insurance cards?**

If not, please complete the insurance information on page 3 and attach all necessary documents.

☐ **2. Have you filled out all of the Prescriber Information section?**

If not, please complete sections 3 and 4 on page 3.

☐ **3. Has your Patient or their Patient Representative signed the form?**

If not, please have your Patient or their Patient Representative sign the form on page 2.

Two Ways to Submit This Form

Complete, sign, and electronically submit all pages of this form and applicable corresponding documents (including the prescription) by following one of the methods below:

Upload the form to the ViiVConnect Provider Portal at ViiVConnectPortal.com

Fax the form to 1-844-208-7676 (toll-free)

For assistance, please call 1-844-588-3288 (toll-free), Monday through Friday, 8 AM to 11 PM (ET).