ZYDELIG® AccessConnect® Enrollment Form

Monday – Friday, 8 AM to 5 PM ET Phone: 1-844-622-2377 Fax: 1-855-553-8672 **ZYDELIGAccessConnect.com** **CLEAR FORM**

ZYDELIG AccessConnect is a central resource with tools designed to help all patients, regardless of financial need, navigate therapy and support offerings. To enroll your patients in ZYDELIG AccessConnect, fax this completed Enrollment Form to ZYDELIG AccessConnect at **1-855-553-8672**.

1. PATIENT INFORMATION

Patient Name (First, MI , Last): Birth Date (MM/DD/YYYY): Gender: ☐ Male ☐ Female

Address: City: State: ZIP code:

Email: Language: ☐ English ☐ Other (please indicate):

Phone #: Best time to contact: ☐ Morning ☐ Afternoon ☐ Evening

☐ Home ☐ Cell ☐ OK to leave detailed messages

Alternate contact: Phone #: Relationship:

2. INSURANCE INFORMATION

Please attach front and back copies of all Medical and Pharmacy Insurance Cards

Is patient insured? ☐ Yes ☐ No Primary insurance: Insurance telephone:

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

Policyholder name (First, Last): Policyholder relationship to patient:

3. REQUESTED PATIENT SUPPORT OFFERINGS

All support offerings include Full Reimbursement Support, Co-pay Coupon, Independent Foundation Information, QuickStart, and Patient Assistance Program (PAP).

☐ All support offerings

If all support offerings are not required, please identify specific support needed:

☐ Co-pay Coupon or Independent Foundation Information
☐ Benefits Investigation/Prior Authorization Support
☐ PAP

4. PHARMACY PREFERENCE

☐ Onsite dispense

Preferred Specialty Pharmacy:

☐ Accredo Health Group Inc. ☐ CVS Specialty ☐ Onco360 ☐ OptumRx ☐ Biologics

☐ I have sent a prescription to the pharmacy
☐ I need AccessConnect to send the prescription to the pharmacy

5. DIAGNOSIS AND PRESCRIPTION INFORMATION

Pharmacy prescription product: **ZYDELIG (idelalisib) tablets** Dose: ☐ 150 mg taken orally, twice daily ☐ 100 mg taken orally, twice daily

Line of therapy: ☐ 2L ☐ 3 L ☐ 4L ☐ Other : Quantity: Day supply: Refills:

Diagnosis (ICD-10 code):

Patients experiencing insurance delays of greater than 5 days may be eligible for QuickStart. QuickStart is dosed at 150 mg orally, twice daily. Eligible patients will receive 60 tablets for a 30-day supply. Please complete the QuickStart authorizations.

Additional directions:

6. PRESCRIBER INFORMATION AND CERTIFICATE OF STATEMENT OF MEDICAL NECESSITY

Prescriber name (First, Last):

Phone #: Fax #: Email:

Facility/Practice name:

Specialty: NPI #: State license #:

Clinical/Medical contact: Phone #:

Reimbursement contact: Phone #:

Address: City: State: ZIP code:

By signing this form, I certify that I am personally prescribing or furnishing Gilead medication for the patient identified in Section 1. 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, 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 1 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 to 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 1 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 1-844-622-2377 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 1, 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 1, 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 agents and contractors for the purposes of assessing the patient's insurance coverage and eligibility for participation in ZYDELIG AccessConnect, 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 Health Information in Section 9. 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 ZYDELIG AccessConnect. I understand that Gilead may, if authorized by the patient, contact the patient directly to verify ZYDELIG AccessConnect eligibility and updates to insurance coverage, as well as to confirm the receipt of Gilead medication through the PAP.

I authorize ZYDELIG AccessConnect to act on my behalf for the limited purposes of transmitting this prescription by any means allowed under applicable law to the appropriate pharmacy designated by the patient utilizing their benefit plan. The prescriber shall comply with state-specific prescription requirements. Any noncompliance with state-specific requirements could result in outreach to the prescriber.

X **PRESCRIBER SIGNATURE** (REQUIRED) —DISPENSED AS WRITTEN: **NO STAMP ALLOWED** **DATE:**

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7. QUICKSTART PROGRAM AUTHORIZATIONS

The QuickStart Program provides eligible patients with 1 free bottle that includes a 30-day supply of ZYDELIG 150 mg tablets. There is no purchase obligation by virtue of a patient's participation in the QuickStart Program. A minimum 5-business-day insurance verification period is required for patients to be eligible for the QuickStart Program. Patients must have an on-label prescription for ZYDELIG, consistent with the FDA-approved label for ZYDELIG, and be enrolled in the ZYDELIG AccessConnect Program to qualify. Free product for the QuickStart Program will only be available through the QuickStart Specialty Pharmacy. Patients receiving free product under the QuickStart Program may not seek reimbursement or credit for this prescription from any insurer, health plan, or government program.

For any patient that is a member of a Medicare Part D plan, this prescription, or any cost associated with it, may not be counted as part of their out-of-pocket cost for prescription drugs. An extension period beyond the initial 30-day supply is limited to commercially insured patients and individual approval is required.

By signing below, if I receive free product through the QuickStart Program, 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.

X **SIGNATURE OF PATIENT or PATIENT'S AUTHORIZED REPRESENTATIVE UNDER FEDERAL OR STATE LAW** (REQUIRED):		**DATE:** / /
PATIENT REPRESENTATIVE'S NAME (IF SIGNING FOR THE PATIENT):	**PATIENT REPRESENTATIVE'S RELATIONSHIP TO PATIENT:**	**PHONE #:** ( ) –

By signing below, I certify that this prescription is on label and the patient has not yet started ZYDELIG treatment. I read and understand the QuickStart Program terms and conditions and I agree that I shall not seek reimbursement for any Gilead medication dispensed to the patient through the QuickStart Program from any government program or third-party insurer.

X **PRESCRIBER SIGNATURE** (REQUIRED) —DISPENSED AS WRITTEN: **NO STAMP ALLOWED**	**DATE:** / /

8. GILEAD PATIENT ASSISTANCE PROGRAM (PAP) APPLICATION

Current Annual Household Income: $ Number of Persons in Household: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ Other:

Social Security #: Are you a US Resident? ☐ Yes ☐ No

Please include current documentation for all sources of income (eg, 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:

Patient's full Social Security number is required to run soft-credit check. This field will be optional. If left blank, PAP may follow up with the patient.

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 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 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 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 this prescription to a dispensing pharmacy on my behalf.

I authorize under the Fair Credit Reporting Act ("FCRA") for 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.

X **SIGNATURE OF PATIENT or PATIENT'S AUTHORIZED REPRESENTATIVE UNDER FEDERAL OR STATE LAW** (REQUIRED): **REQUIRED ONLY IF APPLYING FOR PAP**		**DATE:** / /
PATIENT REPRESENTATIVE'S NAME (IF SIGNING FOR THE PATIENT):	**PATIENT REPRESENTATIVE'S RELATIONSHIP TO PATIENT:**	**PHONE #:** ( ) –

By signing below, I certify that I am prescribing Gilead medication for the patient identified, and I certify that this prescription medication is medically indicated for the patient and that it will be used as directed. I certify that I will be supervising the patient's treatment and verify that the information provided is complete and accurate to the best of my knowledge. I agree that I shall not seek reimbursement for any Gilead medication dispensed to the patient through the PAP from any government program or third-party insurer.

X **PRESCRIBER SIGNATURE** (REQUIRED) —DISPENSED AS WRITTEN: **NO STAMP ALLOWED**	**DATE:** / /

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9. PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PERSONAL AND HEALTH INFORMATION

I understand that Gilead Sciences, Inc., and its agents, contractors, and other partners ("Gilead") will need to obtain, review, use, and disclose my personal and medical information before I can receive assistance through the ZYDELIG **ACCESS**CONNECT program (the "Program") and the Patient Assistance Program ("PAP"). Additional information about how Gilead may use my information can be found at https://www.gilead.com/privacy-statements.

Information to Be Disclosed: My personal information related to my enrollment or participation in the Program, which may include personally identifiable information and Protected Health Information ("PHI") as defined under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") as amended by the Health Information Technology for Economic and Clinical Health ("HITECH") Act (collectively Personal Information or "PI"):

- General information about me, including my name, birth date, and contact information
- Information about my medical condition, including information about my oncology-related status or treatment with this prescription medication and related medical condition
- Information about my health benefits or health insurance coverage
- Financial information (as necessary), such as my income
- All information provided on this enrollment form and otherwise provided by me to the Program or PAP

Persons Authorized to Disclose and Use My Information: I authorize the following parties to disclose my PI to Gilead and its partners:

- My healthcare providers, including any pharmacy that fills my prescription medication. I understand that my pharmacy providers may receive remuneration for disclosing my PI pursuant to this authorization
- Any health plans, including my health insurance company, or programs that provide me with healthcare benefits

I also authorize Gilead and its partners to redisclose my PI to the following parties:

- My healthcare providers, including the pharmacy that fills my prescription medication
- My health plans, including my health insurance company
- My authorized representative under federal or state law (if applicable)

Purposes for Which My Information May Be Used and Disclosed: My PI may be used and disclosed for the following purposes:

- Completing the enrollment process and verifying the information provided on my enrollment form, including confirming my identity and my use or potential use of the medication prescribed by my healthcare provider
- Establishing my eligibility for benefits from my health plan or other programs
- Providing financial assistance and reimbursement support, if I am eligible, and providing other applicable support, including information on third-party resources that may be able to assist me
- Communicating with my healthcare providers and coordinating my prescription and medication through a pharmacy or healthcare provider's office
- Contacting me to evaluate the effectiveness of the Program and/or PAP
- Gilead's internal business purposes and audit and compliance purposes
- Confirming my receipt of the prescribed Gilead medication through PAP based on my communication preferences above
- Deidentifying the information I provide, which means removing elements like my name and address so that I am no longer reasonably identifiable
- Meeting Gilead's legal requirements

Please continue onto next page >>>

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9. PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PERSONAL AND HEALTH INFORMATION (CONTINUED)

Other Important Points:

- I understand that I may choose not to sign this authorization. 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 PAP
- Once I sign this Patient Authorization and my PI is transmitted to Gilead and its partners, I understand that state and federal privacy laws may no longer protect or prohibit the redisclosure of the PI disclosed to Gilead and its partners by my healthcare provider or others
- I understand that I am entitled to a copy of this signed authorization and that the authorization expires on the earlier of two (2) years from the date it is signed by me or sooner if required under the laws of the state in which I live
- I understand that I may cancel this authorization at any time by notifying Gilead at 1-844-622-2377. 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

☐ **MARKETING COMMUNICATIONS OPT IN OPTIONAL:**
I would like to receive marketing and informational communications from Gilead related to my medical condition, treatment, and/or my prescription medication, including offers, marketing and promotional information, and educational materials, via one or more of the communications methods I agreed to above. I understand that opting in to the marketing and informational communications is not required as a condition of (i) eligibility for health plan benefits or ability to obtain treatment from my healthcare providers, (ii) enrollment in the Program or Patient Assistance Program (PAP), or (iii) purchasing any goods or receiving a co-pay or other support from Gilead. The marketing outreach program is separate from PAP. **NOTE:** ZYDELIG AccessConnect may communicate with me as necessary to administer the Program, including PAP, even if I do not opt in to receive marketing and informational communications from Gilead.

☐ **By checking this box,** I consent to receive marketing and informational communications from Gilead (as described above) to my phone number provided, including text messages, prerecorded messages, and phone calls, which may be sent via autodialer. Text and data rates may apply. I may opt out at any time by texting "STOP."

X **SIGNATURE OF PATIENT or PATIENT'S AUTHORIZED REPRESENTATIVE UNDER FEDERAL OR STATE LAW** (REQUIRED)**:**		**DATE:** / /
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PRINT FORM **FAX COMPLETED FORM TO ZYDELIG ACCESSCONNECT AT 1-855-553-8672**