Patient Name:_____ Date of Birth:_____

SUPPORT PATH PROGRAM
INTAKE FORM

PHONE: 1-855-769-7284 FAX: 1-855-298-8700

1 REQUESTED SERVICE(S) (REQUIRED)

CHECK ALL BOXES THAT APPLY

- ☐ Benefits Investigation
- ☐ Prior Authorization and Appeals Support
- ☐ Patient Assistance Program (PAP) Eligibility Screening

2 GILEAD MEDICATION REQUESTED (REQUIRED)

Product Name:	mg:

3 PRESCRIBER INFORMATION (REQUIRED)

Prescriber Name:	Facility Name:	
Address:		
City:	State:	Zip Code:
Office Contact:	Phone #:	Fax #:
NPI #:	Tax ID #:	
State License #:		

4 DIAGNOSIS / MEDICAL INFORMATION (REQUIRED)

MUST BE COMPLETED BY HEALTHCARE PROVIDER

Diagnosis (Please include ICD-9 code):

- ☐ 070.54 Chronic Hepatitis C
- F Score (Fibrosis Score): _____
- ☐ Other:

HCV Genotype ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ Other genotype:

Patient is (Select one of the following options and indicate below if patient is ready to start therapy):

- ☐ Treatment Naïve
- ☐ Previously Treated
- ☐ Currently on Therapy
- ☐ Clinical Trial Patient

Other HCV Medication(s):

Is patient ready to start therapy? ☐ Yes ☐ No	Actual or Anticipated Start Date:	Therapy Duration:

PRESCRIBER CERTIFICATION AND STATEMENT OF MEDICAL NECESSITY (REQUIRED)

By signing this form, I certify that I am prescribing Gilead medication for the patient identified in Section 5. 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 the patient's treatments 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 Support Path Patient Assistance Program (PAP) or from any government program or third-party insurer.

I certify that I have received the appropriate permission from the patient and met any other applicable requirements imposed under the Health Insurance Portability and Accountability Act of 1996 and/or state law needed to release the above information to Gilead, and contractors designated by Gilead, for the purposes of verifying the patient's insurance coverage, seeking prior authorization if needed, on my patient's behalf, and providing information on appeals for denials of claims.

PRESCRIBER SIGNATURE (REQUIRED)	**DATE:**

Gilead Sciences, Inc. reserves the right to modify or discontinue the Support Path Program or terminate assistance at any time.
Third-party reimbursement is affected by a range of factors; therefore, Gilead Sciences, Inc. cannot guarantee any coverage or reimbursement.

5 PATIENT INFORMATION (REQUIRED)

Patient Name:		Patient's Preferred Language:	
Address:			
City:	State:	Zip Code:	Phone #:
SS #:	DOB:	Gender: ☐ M ☐ F	Resides in U.S./U.S. territories: ☐ Yes ☐ No
Alternate Contact Name:		Phone #:	Relationship:

I authorize Support Path to leave a message, including the prescription name if I am unavailable when they call. ☐ Yes ☐ No

6 INSURANCE INFORMATION (REQUIRED)

PLEASE INCLUDE A COPY OF THE FRONT AND BACK OF INSURANCE CARD(S)

☐ Patient is insured *(Please fill out all of the applicable insurance information below. Attach copy [front and back] of patient card.)*

☐ Patient is uninsured *(No health insurance through any public or private payer.)* **Complete "Additional Insurance Information" below.**

Primary Insurance:		Is this a Medicare Part D plan? ☐ Yes ☐ No	
Plan Name:		Payer Phone Number:	
Subscriber Name:	Policy Holder Name:	Policy Holder Relationship to Patient:	
Policy #:	Group #:	Rx Bin #:	Rx PCN #:

☐ Check box if patient has secondary insurance coverage and fax a copy of insurance cards, if available.

Additional Insurance Information:

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:	

7 PATIENT FINANCIAL INFORMATION

REQUIRED ONLY IF APPLYING FOR THE PATIENT ASSISTANCE PROGRAM (PAP)

Current Annual Household Income: $

Number of People in Household: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ Other:

Please submit current documentation for all sources of income (e.g., tax return, W2, last 2 pay stubs, etc.) and proof of U.S. residency (e.g., utility bill, bank statement, etc.).

APPLICANT DECLARATIONS AND AUTHORIZATIONS (REQUIRED ONLY IF APPLYING FOR THE 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 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 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.

PATIENT SIGNATURE
(REQUIRED ONLY IF APPLYING FOR PAP)

DATE:

FAX COMPLETED FORM TO SUPPORT PATH PROGRAM AT 1-855-298-8700

Patient Name:_____ Date of Birth:_____

8 PATIENT HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) AUTHORIZATION (REQUIRED)

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

I understand that I must complete the application process before I can receive assistance through Gilead Sciences, Inc.'s ("Gilead") Support Path Program and the Patient Assistance Program ("PAP"). As part of this process, Gilead and its agents and contractors will need to obtain, review, use and disclose my personal health information, including information about me (for example, my name, mailing address, financial information, and insurance information), information related to my medical condition (including information about my treatment with this prescription medication and related medical condition), and all information provided on my application form ("PHI").

I hereby authorize my healthcare provider, pharmacy and health plan(s) to disclose my PHI to Gilead and its agents and contractors in connection with completing and verifying my Support Path Program and/or the PAP application. I understand that my pharmacy providers may receive remuneration for disclosing my personal and medical information pursuant to this authorization.

I further authorize Gilead and its agents and contractors, including the third party administrator responsible for the administration of both the Support Path Program and the PAP to use my PHI for the purpose of 1) completing the application process and verifying my application form; 2) establishing my eligibility for benefits from my health plan or other programs; 3) providing financial assistance, support, and referral services, and communicating with my healthcare providers, including, but not limited to, facilitating the provision of my prescription medication to me; 4) contacting me to evaluate the effectiveness of the Support Path Program and/or the PAP; 5) for Gilead's internal business purposes, including quality control; and 6) providing me with educational materials by mail, e-mail, and/or telephone.

I understand that my PHI will be kept confidential and will not be further used or disclosed except for the purposes described above, or as required by law. I understand that information that I authorize to be disclosed hereunder may be re-disclosed and no longer protected by federal or state privacy laws.

I agree that signing this authorization is voluntary and that I may refuse to sign this authorization. Refusal to sign will not affect my eligibility for health plan benefits or ability to obtain treatment by my healthcare providers but I will not have access to the services offered by Support Path Program and/or the PAP. I also understand that I can cancel this Authorization at any time by notifying Gilead in writing at Support Path Program, PO Box 13185, La Jolla, CA 92039-3185. Gilead will stop using this authorization to access my PHI after the cancellation date, but the cancellation will not apply to any PHI already used or disclosed pursuant to this authorization before the cancellation date.

This authorization will expire one (1) year after the date it is signed, below, or, if I receive medication under the PAP, one (1) year after the last date I receive the medication. I have read this authorization or have had it explained to me. I understand that I may request a copy of this authorization once it has been signed by me.

PATIENT SIGNATURE (REQUIRED) **DATE:**

FAX COMPLETED FORM TO SUPPORT PATH PROGRAM AT 1-855-298-8700

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9 SUPPORT PATH: A FREE PATIENT SUPPORT PROGRAM (OPTIONAL)

Support Path includes a free patient support program offered by Gilead that provides customized tips, tools and advice, designed just for you.

Register now and you will receive:

- Information on your Gilead medication
- Tools to create an action plan to help manage your treatment
- Advice to help you work well with your healthcare team
- Ongoing assistance from Support Path

By signing below, I certify that I am at least 18 years of age and want to receive information from Gilead Sciences, Inc., and third parties working on behalf of Gilead. I agree that Gilead may use the information I provide to call me and send me materials about products, disease education, or financial assistance. Gilead also may use my information for market research or to evaluate and improve their services and programs. I understand that I may stop Gilead from contacting me at any time by calling 1-855-7-MYPATH (1-855-769-7284) or by clicking on the "Unsubscribe" link at www.MySupportPath.com. I understand that Gilead, and companies providing services to Gilead, will not sell or rent my personally identifiable information. For more information on Gilead's privacy practices, see our Privacy Policy available at www.Gilead.com.

E-mail:

PATIENT SIGNATURE **DATE:**

FAX COMPLETED FORM TO SUPPORT PATH PROGRAM AT 1-855-298-8700

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SUPPORT PATH PROGRAM
INTAKE FORM

PHONE: 1-855-769-7284 FAX: 1-855-298-8700

INSTRUCTIONS

1. **Complete all applicable sections of the Intake Form.**
   - ***Section 1 (required):*** Check the box next to each service you are requesting from the Support Path Program.
   - ***Section 2 (required):*** Write the name and dosage of the Gilead product you are requesting assistance with from the Support Path Program.
   - ***Section 3 (required):*** Complete all fields with the prescriber's information.
   - ***Section 4 (required):*** A healthcare provider must provide the patient's diagnosis and medical information.
     — The prescriber must sign and date this section.
   - ***Section 5 (required):*** Complete all fields with the patient's information.
   - ***Section 6 (required):*** *Check the appropriate box to indicate if the patient is insured or uninsured.*
     — If the patient is insured, fill in the patient's insurance information and fax a copy (front and back) of the patient's insurance card. If the patient has a secondary insurance, check the box to indicate this and fax a copy of the secondary insurance card.
     — If the patient is uninsured, complete the "Additional Insurance Information" portion.
   - ***Section 7 (required only if applying to the Patient Assistance Program [PAP]):***
     — Provide the patient's annual household income and household size.
     — The patient must sign and date this section if applying to the PAP.
     — Attach documentation for all sources of income and proof of U.S. residency.
   - ***Section 8 (required):*** The patient must sign and date this section.
   - ***Section 9 (optional):*** The patient signs and dates this section to be enrolled in the My Support Path patient support program.
2. **Mail or fax the completed Intake Form and all required documentation to the Support Path Program at the address or fax number below. Both sets of information are necessary to ensure timely application review.**
3. **A Support Path Program reimbursement counselor will notify the requestor about the patient's coverage and benefits, alternate funding options and/or qualification for the PAP, depending on the requested service(s).**
4. **Patients who meet the eligibility criteria for the PAP will be prequalified for the program.**
   - The program will notify the patient and the prescriber of the prequalified status.
   - The prescriber's notification will also include a prescription form.
   - The prescriber will have up to six months from the prequalified date to submit the completed prescription form to the dispensing pharmacy specified on the form.
   - Once the dispensing pharmacy receives the completed prescription form, the patient will be enrolled in the PAP and will receive product free of charge from the pharmacy by mail. A toll-free telephone number is included if additional assistance is needed.

PATIENT CONFIDENTIALITY

Patient confidentiality is of primary importance to us. All patient information will remain confidential. Information may be provided to clinicians, social workers or family members when required to complete the application process and coordinate patient assistance.

IMPORTANT REMINDER

Please be certain that all applicable pages of the Intake Form are completed and include all appropriate documentation when submitting the form. Incomplete forms slow the review process and, in some cases, may require a patient to reapply for the program.

Support Path Program
P.O. Box 13185
La Jolla, CA 92039-3185
TEL 1-855-769-7284
FAX 1-855-298-8700