INSTRUCTIONS

Complete all applicable sections of the Enrollment Form.
• Section 1 (required): Check the box next to each service you are requesting from Advancing Access.
• Section 2 (required): Write the name and dosage of the Gilead product you are requesting assistance with from Advancing Access.
• Section 3 (required): Complete all fields with the patient’s information.
• Section 4 (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 Section 9 to apply to the Patient Assistance Program.
• Section 5 (required): Complete all fields with the prescriber’s information.
• Section 6: A healthcare provider must provide the patient’s diagnosis and medical information.
• Section 7 (required): The prescriber must sign and date this section for reimbursement support and the Patient Assistance Program.
• Section 8 (required): The patient (or the patient’s representative) must sign and date this section.
• Section 9 (required only if applying to the Patient Assistance Program (“PAP”)):
  — Provide the patient’s annual household income and household size and complete the additional insurance information portion.
  — 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.

Mail or fax the completed Enrollment Form and all required documentation to the Advancing Access at the address provided on the form. Incomplete forms slow the review process and, in some cases, may require a patient to reapply.

An Advancing Access 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).

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 enrollment process and coordinate patient assistance.

IMPORTANT REMINDER
Please be certain that all applicable pages of the Enrollment 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.

Gilead Sciences, Inc. reserves the right to modify or discontinue the Advancing Access 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.
**Information to Be Disclosed:** Personal health information ("PHI"), including information about me (for example, my name, mailing address, financial information, and insurance information), my past, current and future medical condition (including information about my HIV-related status or treatment with this prescription medication and related medical condition), and all information provided on this enrollment form.

**Persons Authorized to Disclose My Information:** My healthcare providers, including any pharmacy that fills my prescription medication, and any health plans or programs that provide me healthcare benefits. I understand that my pharmacy providers may receive remuneration for disclosing my PHI pursuant to this authorization. Persons to Which My Information May Be Disclosed: Gilead, including the third party administrator responsible for the administration of the Program and the PAP.

**Purposes For Which the Disclosures Are to Be Made:** Disclosures of PHI may be made to Gilead so that Gilead may use and disclose the PHI for purposes of: 1) completing the enrollment process and verifying my enrollment 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 Program and/or the PAP; 5) for Gilead’s internal business purposes, including quality control and service enhancing surveys; and 6) to send me marketing information, offers, and educational materials related to my treatment and/or my prescription medication, including the customer relationship marketing program (this use of my personal information is optional and by checking the box under the signatures below, I may opt in).

I understand that once my PHI has been disclosed hereunder, federal privacy law may no longer restrict its use or disclosure. I understand further that I may refuse to sign this authorization and that 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 services offered by Program and/or the PAP. I also understand that I may cancel this authorization at any time by notifying Gilead in writing at Advancing Access, PO Box 13185, La Jolla, CA 92039-3185. If I cancel, Gilead will stop using this authorization, and I authorize Gilead to use and disclose the information in accordance with the authorization.

**Persons Authorized to Receive Marketing Information, Offers and Educational Materials:** Non-profit health organizations, including, but not limited to, organizations that advocate for the well-being of individuals with HIV.

**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 Advancing Access becomes aware of any false or inaccurate information 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 medication 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 medication or any cost for items 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 my prescription to a dispensing pharmacy on my behalf.

**SIGNATURE OF PATIENT/PATIENT REPRESENTATIVE:**

**DATE:**

**FAX COMPLETED FORM TO ADVANCING ACCESS AT 1-800-216-6857**