ViiVConnect

DOVATO Bridge Program Enrollment Form

PATIENT INFORMATION (REQUIRED)			
First Name:	MI:	Last Name:	
Preferred Phone: ( )	Street:		
DOB: / /	City:	State: ZIP:	Sex: ☐ Male ☐ Female

INSURANCE INFORMATION - INSURED PATIENTS	
Primary Insurance Name:	Policyholder Name:
Primary Insurance Phone: ( )	Policyholder DOB: / /
Policy ID #:	Policyholder Relationship to Patient:
Group #:	Policyholder Phone: ( )

VIIV HEALTHCARE MEDICATION PRESCRIBED (REQUIRED)	
Product Name: **DOVATO**	Dosage (mg): (dolutegravir 50 mg/lamivudine 300 mg)

PRESCRIBER INFORMATION (REQUIRED)			
Prescriber's First/Last Name:		Office Contact Name:	
Practice Name:		Street:	
Phone: ( )	Fax: ( )	City:	State: ZIP:
Prescriber Tax ID:		Prescriber NPI #:	
Prescriber State License #:		Group NPI #:	
Patient Diagnosis and ICD-9/ICD-10 Code:			

PATIENT AUTHORIZATION AND RELEASE

I certify that the information provided within this Enrollment Form and Patient Authorization and Release is true and correct. I understand that the collection, use, and disclosure of certain information is protected under law. I understand that Information contained in this Enrollment Form, such as my name, address, insurance, prescription, and medical information, is "Protected Health Information." By signing below, I agree to the collection, use, and disclosure of my Protected Health Information as described below. I understand that my healthcare providers will not base any medical treatment decisions on my agreement to sign this Patient Authorization and Release. I understand that once Protected Health Information is collected, used, and/or disclosed based on this executed authorization, federal privacy laws may not prevent the entities described below from further disclosing my information. However, I understand that such entities have agreed to collect, use, or disclose Protected Health Information received only for the purposes described in this authorization or as required by law. I understand that ViiV Healthcare does not charge a fee for participation in ViiVConnect programs. I certify that any product that I receive from ViiV Healthcare is for my own use and will not be sold, bartered, or given to any other person. I certify that the information provided in this application is complete and accurate to the best of my knowledge and agree to notify ViiVConnect of any change in my insurance eligibility or financial status. I understand that this authorization will remain in effect for two (2) years or until my coverage, coding, reimbursement, or other inquiry has been resolved, whichever is longer. 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 220100, Charlotte, NC 28222-0100, 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 Protected Health Information will be prohibited. However, certain information may still be collected, used, and disclosed for administrative purposes by ViiV Healthcare and any other companies that ViiV Healthcare uses to collect, use, and disclose such information.

Enrollment in ViiVConnect: The Patient MUST sign this Patient Authorization and Release.

By signing this Patient Authorization and Release, I authorize ViiV Healthcare and any other companies that ViiV Healthcare uses to collect, use, or disclose my Protected Health Information to do the following:

1. Request and receive from my doctor, healthcare provider, health insurer, or pharmacist information necessary to investigate and resolve my insurance coverage, coding, or reimbursement inquiry, or review my eligibility for patient assistance programs and co-pay assistance.
2. Collect, use, and disclose to each other any information that I provide to ViiVConnect for investigating and resolving my insurance coverage, coding, or reimbursement inquiry.
3. Disclose to my treating physician, healthcare provider, or pharmacist information I provide to ViiVConnect when necessary to resolve my insurance coverage, coding, or reimbursement inquiry. I also authorize my insurer, doctor, healthcare provider, and pharmacist to release information about my prescribed medications and medical condition requested by ViiVConnect.
4. Contact my insurer, on my behalf to determine if I am eligible for health insurance coverage and disclose to them information about my prescribed medications and medical condition that has been provided to ViiVConnect by me or my physician, healthcare provider, or pharmacist.
5. Disclose any information obtained from the sources listed above to third parties if required by law.
6. Request additional documents and information at any time, even if I am already enrolled so that ViiV Healthcare can determine if the information on this form is complete and true.

PATIENT SIGNATURE (REQUIRED)	Name (please print):
Signature:	Date: / /

If I am unavailable when contacted, I authorize ViiVConnect to leave a voicemail with the Access Coordinator's name, a reference to ViiVConnect, and a call back phone number. ☐ Yes ☐ No*

**If I do not authorize ViiVConnect to leave a voicemail with the Access Coordinator's name, a reference to ViiVConnect, and a call back phone number, I will be responsible for contacting ViiVConnect.*

Complete, sign, and fax 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).

Please see DOVATO full Prescribing Information, including Boxed Warning.

ViiV Healthcare

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Dovato
dolutegravir 50 mg/
lamivudine 300 mg tablets