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.

APRETUDE (cabotegravir) Enrollment Form

Services Requested *(Check all that apply):*

- ☐ Benefits Verification
  - ☐ Check here for Benefits Verification ONLY
- ☐ Oral Lead-In (OLI) Fulfillment
- ☐ Claims Support
- ☐ ViiV Healthcare Patient Assistance Program (PAP)* Application
- ☐ Copay Savings Enrollment

Anticipated injection date:

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

2 Insurance Information

Please attach copies of front and back of all insurance cards

Policyholder: ☐ Self ☐ Other *(Please complete to the right)* — Policyholder (First Name, Last Name) | Relationship to Patient

Plan or Policy type: ☐ Commercial/employer ☐ Medicare ☐ Medicaid ☐ None

Medical Insurance Name	Prescription Drug Plan Name
Insurance Phone #	Insurance Phone #
Policy ID # / Group / Prescriber ID *(If applicable)*	Policy ID # *(If applicable)* / Group *(If applicable)* / BIN *(If applicable)* / PCN *(If applicable)*

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

If insurance information is not completed in full, ViiVConnect or the ViiV Healthcare Patient Assistance Program will reach out to you directly to obtain additional information.

Prescriber Office Staff Certification

REQUIRED

I certify that the prescriber's office has obtained all legally required consents, including, but not limited to, patient consents required under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and all applicable state privacy laws, to release the patient's health and personal information to ViiVConnect and the ViiV Healthcare Patient Assistance Program for the purposes of verifying insurance coverage, seeking financial assistance, coordinating the dispensation of the patient's prescription, and for other purposes as described in the Patient Authorization below. ViiVConnect and the ViiV Healthcare Patient Assistance Program may contact our office or the patient with respect to information included on this form and any specific requirements in the enrollment process.

Prescriber Office Staff Name (Please print) | **Prescriber Office Staff Signature** | **Date**

PATIENT AUTHORIZATION

SIGNATURE REQUIRED ON NEXT PAGE

I understand that I must complete and sign this Enrollment Form to participate in ViiVConnect or the ViiV Healthcare Patient Assistance Program. I also understand that in order for me to receive services through ViiVConnect or the ViiV Healthcare Patient Assistance Program, ViiV Healthcare, the GSK Patient Access Programs Foundation and/or its agents ("ViiV") must receive, use, and disclose my personal information.

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.

**The ViiV Healthcare Patient Assistance Program is operated by the GSK Patient Access Programs Foundation, an independent, non-profit organization separate from ViiV Healthcare.*

Form continued on the following page

Patient Authorization and Release continued from previous page

Persons and entities authorized to use and disclose my personal information: I authorize my health care providers, including my doctor and pharmacy, my health plan, and other people involved in my healthcare (collectively, my "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 may be shared among my Care Team and ViiV, and ViiV may use and disclose my personal information to:

1. Process my Enrollment Form, verify information I have provided, and collect any additional information necessary to enroll in ViiVConnect or the ViiV Healthcare Patient Assistance Program.*
2. Identify my health plan benefits and eligibility for health plan coverage and help resolve insurance coverage, coding, or reimbursement issues.
3. Research alternative insurance coverage options and refer me and my Care Team to 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 using my contact information included on this form to provide me information about my health plan benefits, financial assistance services, and my prescribed ViiV Healthcare medications.
6. Provide financial assistance and support services based on ViiV's determination of my eligibility.
7. Improve or develop ViiVConnect or ViiV Healthcare Patient Assistance Program services and for other internal administrative and business purposes, including analytics.

I understand that my Care Team will not condition their provision of any medical treatment or payment on my agreeing to sign this Patient Authorization. I also understand that my agreement to sign this Patient Authorization is not required for my prescription to be filled, and that ViiV may compensate my pharmacy for providing ViiV with my personal information. I understand that once my personal information is disclosed based on this Patient Authorization, certain federal privacy regulations may not apply and it could be re-disclosed. I also understand, however, that ViiV intends to use and disclose my personal information only as described in this Patient Authorization.

I understand that I have a right to receive a copy of this Patient Authorization after I have signed it, and that the authorization 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 ViiVConnect programs. If I do choose to revoke the authorization, my revocation will become effective upon ViiV's receipt of my statement of revocation; however, that will not invalidate any uses or disclosures of my personal information made before such receipt. I am aware that I may learn more about how ViiV handles personal information by reviewing ViiV's privacy notice at **https://privacy.viivhealthcare.com/en-us/**.

Please read the Patient Authorization, then sign below. REQUIRED

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

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

Legal Guardian Name (Please print)	**Legal Guardian Signature**	**Relationship to Patient**	**Date**

PATIENT COMMUNICATION PERMISSIONS

I consent to receive mail, email, autodialed calls, and text messages from and on behalf of ViiVConnect or the ViiV Healthcare Patient Assistance Program at the contact information I have provided.

Below are the best way(s) for ViiVConnect or the ViiV Healthcare Patient Assistance Program to contact me *(Check all that apply)*:

☐ Phone ☐ Voicemail message ☐ Text ☐ Mail ☐ Email

Message frequency may vary. Message and data rates may apply. I may opt out at any time by texting "STOP." I understand that on enrollment, ViiVConnect and the ViiV Healthcare Patient Assistance Program will send program information to me by mail at the address I have provided and may send text messages to verify enrollment. ViiVConnect and the ViiV Healthcare Patient Assistance Program will otherwise make reasonable efforts to communicate with me in accordance with my preferences. I can change my preferences at any time after enrollment by contacting ViiVConnect or the ViiV Healthcare Patient Assistance Program.

Patient Authorization 3.0.0925

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Form continued on the following page

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

APRETUDE (cabotegravir) Enrollment Form

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

List all current medications, over-the-counter medications, and supplements

☐ Check box if list is attached ☐ Check box if none

List all known drug allergies

☐ Check box if none

Previous antiretroviral medications for HIV prevention

Current antiretroviral medications

Date of most recent dose of antiretroviral medication

Date most recent antiretroviral medication was started

3 Injectable Prescription Information

SIGNED PRESCRIPTION REQUIRED FOR ViiV HEALTHCARE PAP FULFILLMENT

This section of the form is intended as an optional way to prescribe. If your state restricts the use of this form to prescribe, or if this form does not meet your requirements to prescribe, please attach a prescription to this form. Prescribers may need to submit an electronic prescription to the specialty pharmacy.

Please check all that apply:

Prescription/Schedule	Medication	Quantity	Refills	Directions
Every-2-Month Dosing				
☐ APRETUDE 600-mg kit	600-mg single-dose vial of cabotegravir	1 dosing kit	1 refill	**Month 1 & Month 2:** 1 injection intramuscularly
☐ APRETUDE 600-mg kit	600-mg single-dose vial of cabotegravir	1 dosing kit	☐ **PRN refills for 1 year** *or* **# of refills** _____	**Month 4+:** 1 injection intramuscularly, every 2 months

REQUIRED **Diagnosis ICD-10 Code:** ☐ Z29.81: Encounter for HIV pre-exposure prophylaxis ☐ Other: _____

4 OPTIONAL Oral Prescription Information

Not required to start APRETUDE

Only complete this section if your Patient will be taking the optional oral lead-in to assess tolerability. If your state restricts the use of this form to prescribe, or if this form does not meet your requirements to prescribe, please attach a prescription to this form. Prescribers may need to submit an electronic prescription to the specialty pharmacy.

Prescription/Schedule	Medication	Quantity	Refills	Directions
☐ **Oral Lead-In** *(Dispensed only by TheraCom)*	cabotegravir 30-mg tablet	30 tablets	None	Take 1 tablet by mouth daily with a meal

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

Street Address | City | State | ZIP Code

5 Prescriber Information

ALL FIELDS REQUIRED

Office contact information is optional

First Name | Last Name | Practice Name | Office Contact Name

Phone # | Fax # | Street Address | City | State | ZIP Code | Office Contact Phone #

Prescriber Tax ID | Prescriber State License # | Prescriber Email Address | Prescriber NPI | Group NPI | Site Tax ID | PTAN/UPIN #

Prescriber Declaration

REQUIRED

By signing below, I certify that the information I have provided in this Enrollment Form is complete and accurate to the best of my knowledge. I authorize ViiVConnect or the ViiV Healthcare Patient Assistance Program* 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. I certify that I have obtained all legally required consents, including, but not limited to, patient consents required under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and all applicable state privacy laws, to release the patient's health and personal information to ViiVConnect and the ViiV Healthcare Patient Assistance Program for the purposes of verifying insurance coverage, seeking financial assistance, coordinating the dispensation of the patient's prescription, and for other purposes as described in the Patient Authorization above.

Prescriber Signature *(Dispense as written)* **OR** **Prescriber Signature** *(Substitution permitted)* **Date**

Supervising/Collaborating MD Name *(Please print, where required)* **Collaborating Physician NPI** *(Please print, where required)*

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Form continued on the following page

APRETUDE (cabotegravir) Enrollment Form

6 Injection Acquisition Information

My practice will acquire the injections through the following method:

☐ Buy & Bill

☐ Specialty Pharmacy *(Select one)**

◯ No preference	◯ Accredo Health Group, Inc	◯ CenterWell Specialty Pharmacy	◯ Mail-Meds Clinical Pharmacy
	◯ AHF Pharmacy	◯ Coordinated Care Network	◯ MediLink RxCare Specialty Pharmacy
	◯ Avita Pharmacy	◯ Curant Health	◯ Optum/Genoa Specialty Pharmacy
	◯ BioPlus Specialty Pharmacy	◯ CVS Specialty Pharmacy	◯ Walgreens Specialty Pharmacy (non-PAP)

☐ The prescription has been sent to the preferred Specialty Pharmacy indicated above

**Preferred Specialty Pharmacy selection will be honored if permitted by Patient's insurance plan.*

☐ In-house Pharmacy

☐ Alternative Site of Care (ASOC) *(Please provide the facility information below in Section 7)*

7 Where Injections Will Be Administered

Please check where the Patient's injections will be administered:

☐ At my office

☐ At the following location/ASOC *(Please complete to the right)*

☐ To be determined *(If selected, ViiVConnect or the ViiV Healthcare Patient Assistance Program† will contact you for additional details)*

Facility Name | Contact Name

Street Address | City | State | ZIP Code

Phone # | Facility NPI | Tax ID

8 ViiV Healthcare Patient Assistance Program (PAP)

This section is required if applying for ViiV Healthcare PAP. 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 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 # ☐

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

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

4. Is the patient enrolled in an Alternate Funding Program? ☐ Yes ☐ No
- *If "yes," patients enrolled in an Alternate Funding Program are not eligible for the ViiV Healthcare 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 Healthcare 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.

†*The ViiV Healthcare Patient Assistance Program is operated by the GSK Patient Access Programs Foundation, an independent, non-profit organization separate from ViiV Healthcare.*
‡*For more information about the ViiV Healthcare Patient Assistance Program, please call 1-888-588-3288 or visit www.ViiVPAP.org.*

View Checklist and Submission Instructions on Next Page

Form continued on the following page

APRETUDE (cabotegravir) Enrollment Form

Checklist

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

☐ **1. Prescriber Office Staff Certification:**
Have you completed the Prescriber Office Staff Certification?

→ If **No**, please sign and date the form on **page 1**.

☐ **2. Patient Authorization:**
Has your patient signed and dated the form?

→ If **No**, please have the patient sign on **page 2** or **scan the QR code below** to complete **via eSignature**.

☐ **3. Prescriber Declaration:**
If you are submitting a prescription, has the prescriber signed and dated the form?

→ If **No**, please sign the **Prescriber Declaration** in **section 5** on **page 3**.

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 HCP 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 8 PM (ET).

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