ViiVConnect ViiVConnect.com / Phone: 1-844-588-3288 / Fax: 1-844-208-7676

Providing support as diverse as the people we serve

For questions or to connect with an Access Coordinator, please call

1-844-588-3288

Monday-Friday, 8 AM-8 PM (ET)

Patient Enrollment/Authorization Form

To be completed by patient or legal guardian

Fill out this form to find out what your health insurance plan covers and any financial support options you may qualify for. This form is not a request for medicine or a guarantee of coverage.

1. **Fill out and email your completed form as an attachment to info@viivconnectportal.com. You can also print and fax this form to 1-844-208-7676.**
2. **After you submit this form, an Access Coordinator may reach out to you in a few days to walk you through next steps and answer any questions.**

START HERE

Which of the following best describes you?

- ☐ I am not taking a ViiV Healthcare medicine yet, but I'm interested in getting support for reimbursement of ViiV products.
- ☐ My doctor has prescribed me a ViiV Healthcare medicine, but I haven't started it yet.
- ☐ I am currently taking a ViiV Healthcare medicine.

Please select the name of the medicine you are interested in/have been prescribed.

- ☐ APRETUDE (cabotegravir)
- ☐ CABENUVA (cabotegravir; rilpivirine)
- ☐ Other

1. TELL US ABOUT YOURSELF

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

Phone # | Email

2. HEALTH INSURANCE INFORMATION

☐ Please check if you do NOT have health insurance.

Fill out the section below or attach copies of the front and back of all your medical and prescription 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 ☐ AIDS Drug Assistance Program (ADAP) ☐ None

Medical Insurance Name

Insurance Phone #

Policy ID # | Group | Prescriber ID *(If applicable)*

Prescription Drug Plan Name

Insurance Phone #

Policy ID # *(If applicable)* | Group *(If applicable)* | BIN *(If applicable)* | PCN *(If applicable)*

I have secondary insurance: ☐ Yes ☐ No If "Yes," indicate insurance name

Form continues on the following page

Patient Enrollment/Authorization Form

3. DOCTOR INFORMATION

First Name | Last Name | Practice Name

Phone Number | Street Address | City | State | ZIP Code

I give permission for my health insurance coverage information to be shared with my doctor.

☐ Yes ☐ No ☐ I do not have a doctor

4. PATIENT AUTHORIZATION

SIGNATURE REQUIRED ON NEXT PAGE

Your signature is needed to allow ViiVConnect to reach out to your health insurance company to learn more about your coverage.

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.

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 I designate as 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 and collect any additional information necessary to enroll in ViiVConnect or the ViiV Healthcare Patient Assistance Program as well as verify any information I have provided for enrollment purposes.
2. Identify my health plan benefits and eligibility for health plan coverage and help resolve my insurance coverage, coding, or reimbursement issues.
3. Research alternative insurance coverage options and refer me and my Care Team to other 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 utilizing my contact information included on this form to provide me information about my health plan benefits, financial assistance services, and 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.

*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 continues on the following page

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 PHI. 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 Authorization 2.0.1224

5. PATIENT COMMUNICATION PERMISSIONS

Optional

☐ By checking this box, 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. Message frequency may vary. Message and data rates may apply. I may opt out at any time by texting STOP or by contacting ViiVConnect or the ViiV Healthcare Patient Assistance Program. I understand communications may mention ViiVConnect, the ViiV Healthcare Patient Assistance Program and medications by name.

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

ViiVConnect and the ViiV Healthcare Patient Assistance Program will make reasonable efforts to communicate with you in accordance with your preferences. You can change your preferences any time by calling ViiVConnect or the ViiV Healthcare Patient Assistance Program.

6. MARKETING AUTHORIZATION AND RELEASE

Optional

☐ By providing my personal information and checking this box, I am giving ViiV and companies working with ViiV permission to market to me across multiple channels or contact me for market research regarding the medical condition(s) in which I have expressed an interest, as well as other health-related information from ViiV, and I consent to ViiV processing my personal information, including my health-related information, such as my interest in ViiV products, for these purposes and as described in ViiV's privacy notice at **https://viivhealthcare.com/en-us/privacy-notice/** and consumer health privacy notice at **https://viivhealthcare.com/en-us/consumer-health-privacy/**. I understand that I may withdraw this permission using the unsubscribe process found in the ViiV privacy notices. By completing this form, I certify that I am at least 18 years old.

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

Patient or Legal Guardian Name (Please print)	**Patient or Legal Guardian Signature**	**Date**

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