

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

**Services Requested** (Check all that apply):

- Benefits Verification
- Check here for Benefits Verification ONLY
- ViiV Healthcare Patient Assistance Program (PAP)\* Application

# Oral Medications Enrollment Form

 **This enrollment form to be used for ViiV Healthcare oral medications ONLY.**

## 1 Patient Information ⚠ ALL FIELDS REQUIRED

First Name	M.I.	Last Name	Preferred Name	D.O.B. (mm/dd/yyyy)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Street Address	Apt/Bldg/Fl	City	State	ZIP Code
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Phone #	Email			Sex: <input type="checkbox"/> M <input type="checkbox"/> F
<input type="text"/>	<input type="text"/>			<input type="text"/>
<input type="checkbox"/> Request Spanish Language Materials				

## 2 Insurance Information – Insured Patients

 **Please attach copies of front and back of all insurance cards, including medical and prescription.**

Primary Insurance Name	Policyholder Name
<input type="text"/>	<input type="text"/>
Primary Insurance Phone #	Policyholder Phone #
<input type="text"/>	<input type="text"/>
Policy ID #	Group #
<input type="text"/>	<input type="text"/>
Subscriber Name	Policyholder Relationship to Patient
<input type="text"/>	<input type="text"/>
<b>Patient has secondary insurance:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes," indicate insurance name <input type="text"/>	

1 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
<input type="text"/>	<input type="text"/>	<input type="text"/>

## 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.

**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.

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

**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.*

<b>Patient Name</b> (Please print)	<b>Patient Signature</b>	<b>Date</b>
<input style="width: 95%; height: 100%;" type="text"/>	<input style="width: 95%; height: 100%;" type="text"/>	<input style="width: 95%; height: 100%;" type="text"/>

<b>Legal Guardian Name</b> (Please print)	<b>Legal Guardian Signature</b>	<b>Relationship to Patient</b>	<b>Date</b>
<input style="width: 95%; height: 100%;" type="text"/>	<input style="width: 95%; height: 100%;" type="text"/>	<input style="width: 95%; height: 100%;" type="text"/>	<input style="width: 95%; height: 100%;" type="text"/>

**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.

# Oral Medications Enrollment Form

## 3 ViiV Healthcare Medication Prescribed

**ALL FIELDS REQUIRED**

**Completed prescription mandatory for all services including ViiV Healthcare PAP.**

**This enrollment form to be used for ViiV Healthcare oral medications ONLY.**

Product Name

Dosage (mg)

**REQUIRED**

Diagnosis Code: ICD-9/ICD-10 Code

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

Street Address

City

State

ZIP Code

## 4 Prescriber Information

**REQUIRED**

**Office contact information is optional**

First Name

Last Name

Practice Name

Phone #

Fax #

Street Address

City

State

ZIP Code

Office Contact Name

Office Contact Phone #

Prescriber Tax ID

Prescriber State License #

Prescriber Email Address

Prescriber NPI

Group NPI

Site Tax ID

PTAN/UPIN #

## 5 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 any state or federal prescription drug coverage plan, such as Medicaid or Puerto Rico's Government Healthcare Program, Mi Salud?  Yes  No

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

3. What is the Patient's ADAP status?  Active  Denied  Wait-listed  Pending  Not Applied/Not Eligible

4. 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 #

5. Is the patient enrolled in an Alternate Funding Program?  Yes  No

• If "yes," patients enrolled in an Alternate Funding Program are not eligible for 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](http://www.ViiVPAP.org).

**View Checklist and Submission Instructions on Next Page** 

# Oral Medications 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 Information:

If you are submitting a prescription, have you filled out the entire Prescriber Information section?

→ If **No**, complete **sections 3 and 4** 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](http://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).