ViiVConnect

ViiVConnect Enrollment Form

ViiVConnect provides comprehensive information on access and coverage to help patients get their prescribed ViiV Healthcare medications. There are 4 ways to enroll a patient:

- Complete and fax this form to 1-844-208-7676
- Via the online portal at www.viivconnect.com
  For HCPs and Patient Designated Representatives
- Talk one-on-one live with a dedicated Access Coordinator at 1-844-588-3288
- Complete and mail this form to ViiVConnect Enrollment PO Box 220100 Charlotte, NC 28222-0100

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

INSURANCE INFORMATION - INSURED PATIENTS **(Include scanned copies of the front and back of all insurance cards, including medical and prescription)**	
Primary Insurance Name:	Policyholder Name:
Primary Insurance Phone:	Policyholder DOB:
Policy ID #: Group #:	Policyholder Relationship to Patient:
Subscriber Name:	Policyholder Phone:

VIIV HEALTHCARE MEDICATION PRESCRIBED (REQUIRED)	
Product Name:	Dosage (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 ASSISTANCE PROGRAM (PAP) - (Complete only if applying for medication at no cost for eligible patients) **Prescription must accompany form.**	
List any known drug allergies:	☐ Check box if none
List any known health conditions:	☐ Check box if none
Number of people living in household who contribute to or are dependent on your household income:	
Social Security Number (SSN)*:	Total Gross Annual Income:
1. Is the patient eligible for 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)? • If "yes," please indicate why assistance is needed:	☐ Yes ☐ No
3. What is the ADAP status of the patient?	☐ Denied ☐ Wait-listed ☐ Pending ☐ Not Applied/Not Eligible
4. Is the patient enrolled in a Medicare Part D prescription drug plan?	☐ Yes ☐ No
5. If "yes" to question 4, has the patient spent $600 or more on prescription expenses since January 1st of the current calendar year? • If "yes," please scan an explanation of benefits or pharmacy receipt(s) indicating the patient paid a total of at least $600 for prescriptions in the current calendar year. Note: Medicare Part D patients cannot enroll by phone.	☐ Yes ☐ No

SHIPPING ADDRESS **(Complete only if applying for the Patient Assistance Program and the medication should be shipped to an address other than the patient address at top of page)**			
Medication will be shipped to: Addressee or Business Name:			
Street:	City:	State:	ZIP:
Specify addressee's relationship to the applicant: ☐ Physician ☐ Patient Designated Representative (must complete Patient Designated Representative information on page 2) ☐ Other (specify relationship):			

*If you do not have an SSN or you are unable to provide it, please note that income documentation may be required to review program eligibility.

Form continued on the following page.

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. There may be a copayment for each prescription filled at a retail pharmacy. If my authorized Patient Designated Representative charges a fee for enrollment or refills of my free medicine received under the Patient Assistance Program, this money is not paid by or paid to ViiV Healthcare. 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 and, if applicable, the Patient Designated Representative MUST sign this Patient Authorization and Release. Patient Designated Representative must define their relationship to the Patient in the designated box below.

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, other potential funding sources, social workers, patient advocacy organizations, and/or patient assistance programs on my behalf to determine if I am eligible for health insurance coverage or other funds 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.

If applicable, I authorize a Patient Designated Representative to act on my behalf pursuant to the Patient Designated Representative Certification below.	☐ Yes	☐ No*
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*
I authorize ViiVConnect to mail me information on my benefits and other communications that contain references to ViiVConnect.	☐ 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.

Patient (REQUIRED)	**Name (please print):**
Signature:	
Date:	

Patient Designated Representative†	**Name (please print):**
Signature (stamped signature not accepted):	
Date:	
Relationship to Patient:	

PATIENT DESIGNATED REPRESENTATIVE CERTIFICATION

By my signature, I certify to the best of my knowledge, that the information on this application is correct and complete. I have no knowledge of any intent to sell, barter, or give any free medicine received under the Patient Assistance Program to any person other than the Patient for whom it has been prescribed. To the best of my knowledge, the information about the Patient on this application is complete. I acknowledge that the programs through ViiVConnect do not constitute health insurance. My signature above also serves as attestation that the Patient has authorized me to act on their behalf. As the Patient's Designated Representative, I authorize ViiV Healthcare and any other companies that ViiV Healthcare uses to collect, use, and disclose the Patient's information. I also understand that I have the right to revoke this authorization on behalf of the Patient 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 or any other companies that ViiV Healthcare uses to collect, use, or disclose such information.

Complete, sign, and electronically submit all pages of this form and applicable corresponding documents (including the prescription‡) through the portal, or 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 EST.

†Only complete this section if the Patient Designated Representative enrolls the Applicant and wants to be the contact person and receive program correspondence on behalf of the Applicant.

‡Prescriptions sent by fax are only valid if faxed directly from a physician's office and accompanied by a cover sheet.