

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

Speak with a live 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: <input type="checkbox"/> Male <input type="checkbox"/> Female	
I, the patient, authorize ViiVConnect to leave a toll-free call-back number if I am unavailable when they call.					<input type="checkbox"/> Yes <input type="checkbox"/> No

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 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:	<input type="checkbox"/> Check box if none
List any known health conditions:	<input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	
2. Does the patient have any private prescription drug coverage (including employer-sponsored plans, private group plans, marketplace plans/exchanges, etc)? <input type="checkbox"/> Yes <input type="checkbox"/> No • If "yes," please indicate why assistance is needed:	
3. What is the ADAP status of the patient? <input type="checkbox"/> Denied <input type="checkbox"/> Wait-listed <input type="checkbox"/> Pending <input type="checkbox"/> Not Applied/Not Eligible	
4. Is the patient enrolled in a Medicare Part D prescription drug plan? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No • 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.	

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: <input type="checkbox"/> Physician <input type="checkbox"/> Patient Designated Representative (must complete Patient Designated Representative information on page 2) <input type="checkbox"/> 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.

PATIENT AUTHORIZATION AND RELEASE TO COLLECT, USE, AND DISCLOSE MEDICAL INFORMATION

I certify that the information provided herein is true and correct. I understand that the collection, use, and disclosure of my health information are protected under law. Information contained in this Enrollment Form, such as my name, address, insurance, prescription, and medical information, is "protected health information." By signing below, for all past, present, and future periods, 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 information about me is released based on this 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 use or disclose 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 this ViiVConnect Program. There may be a co-payment for each prescription filled at a retail pharmacy. If my 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 the ViiVConnect Program 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. Revoking this authorization will prohibit disclosures after the date written revocation is received, except to the extent that action has been taken in reliance on this authorization. This means that after you revoke this authorization, your information may be disclosed among ViiV Healthcare and the company or companies that help ViiV Healthcare administer the programs to maintain records of your participation, but it will not be otherwise disclosed or used.

Enrollment in ViiVConnect: The patient and, if applicable, the Patient Designated Representative **MUST** sign this form. Before signing, you, the patient, should review, understand, and agree to the terms of this authorization and release. If a Patient Designated Representative signs in addition to the patient, please indicate relationship to the patient. By signing below, I authorize ViiVConnect, as well as its agents and assignees and any other companies that ViiV Healthcare uses 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, 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 the purpose of investigating and resolving my insurance coverage, coding, or reimbursement inquiry.
3. Disclose to my treating physician, healthcare provider, or pharmacist information I provided to ViiVConnect when necessary to resolve my insurance coverage, coding, or reimbursement inquiry. By signing below, 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 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. Obtain a consumer report on me (for patients applying for free medication). My consumer report, and the 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 from ViiV Healthcare. Upon request, ViiVConnect will provide me the name and address of the consumer reporting agency that provides the consumer report.
7. Request additional documents and information at any time, even if I am already enrolled so that they can decide if the information on this form is complete and true.
8. (If a Patient Designated Representative is designated by the patient): To use, disclose and receive my protected health information to or from Patient Designated Representative identified below.

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

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

By my signature, I certify to the best of my knowledge, 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 Applicant for whom it has been prescribed. To the best of my knowledge, the information about the Applicant 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 Applicant has authorized me to act on his/her behalf. If a Patient Designated Representative is designated by the patient, I authorize ViiVConnect, as well as its agents and assignees and any other companies that ViiV Healthcare uses to use, disclose and receive the patient's protected health information to or from Patient Designated Representative identified above. This authorization is for all past, present, and future periods. I understand I have the right to revoke this authorization, in writing or verbally by calling 1-844-588-3288 (toll-free).

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 8 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.

