ADVANCING ACCESS®

FOR VEKLURY® (remdesivir) 100 mg for injection

THIS PAGE TO BE COMPLETED BY **PATIENT** OR **PATIENT'S REPRESENTATIVE**

- To avoid delays, please complete this form as accurately as possible
- If HCP requesting **REPLACEMENT PRODUCT** for a Patient Assistance Program (PAP) eligible patient, please complete page 5

PATIENT ENROLLMENT FORM

PHONE: **1-800-226-2056** | FAX: **1-833-445-3239**

PATIENT CONFIDENTIALITY: Patient confidentiality is of primary importance to us. All patient information will remain confidential. Information may be provided to clinicians, social workers, or family members when required to complete the enrollment process and coordinate patient assistance, and to credit bureaus to determine program eligibility with your consent within this Enrollment Form.

1. REQUESTED PATIENT SUPPORT REQUIRED

CHECK ALL BOXES THAT APPLY [X] CLEAR FORM

☐ Benefits Investigation ☐ Prior Authorization and Appeals Information ☐ Patient Assistance Program (PAP) Eligibility Screening ☐ Co-pay Coupon Program

2. GILEAD MEDICATION PRESCRIBED REQUIRED

Product Name: **VEKLURY®** (remdesivir) 100 mg for injection

3. PATIENT INFORMATION REQUIRED

First Name:	Last Name:	MI:	Preferred Name:
Address:	Apt/Unit #:	City:	
State:	ZIP Code:	Phone #: ( ) –	Preferred Language:
Email:	Date of Birth: / /		SSN # (Last 4 digits):
Alternate Contact Name:	Phone #: ( ) –		Relationship:

CONTACT AUTHORIZATION

I authorize Advancing Access to provide me with information on my benefits and other communications that contain reference to the Advancing Access program or the Patient Assistance Program (PAP) dispensing pharmacy through the following. If I do not check any box(es), I understand that all communication will be via phone. (Select all that apply):

☐ Email ☐ Phone call ☐ Text message ☐ US mail

I authorize Advancing Access to leave a detailed message, including the name of my prescription, if I am unavailable when they call.

☐ Yes ☐ No

NOTE:

- I understand that if I do not select a communication preference, all communication will be via phone
- Text message and data rates may apply. You can opt out of such text messages at any time by replying "STOP"

4. INSURANCE INFORMATION REQUIRED

PLEASE INCLUDE A COPY OF THE FRONT AND BACK OF INSURANCE CARD(S)

☐ Patient is uninsured (ie, no health insurance through any public or private payer) — SEE OPTIONAL "PATIENT FINANCIAL INFORMATION" SECTION 5

☐ Patient is insured (Please fill out all of the applicable insurance information below — Include copy [front & back] of all insurance cards, including medical and prescription.)

Primary Insurance:		Is this a Medicare Part D plan? ☐ Yes ☐ No	
Plan Name:		Insurance Phone #: ( ) –	
Subscriber Name:	Policyholder Name:	Policyholder Relationship to Patient:	
Policy #:	Group #:	Rx Bin #:	Rx PCN #:

☐ Check box if patient has secondary insurance coverage and include a copy [front and back] of insurance cards, if available.

5. PATIENT FINANCIAL INFORMATION REQUIRED ONLY IF APPLYING FOR THE PATIENT ASSISTANCE PROGRAM (PAP)

Current annual household income: $ _____
(Documentation for all sources of income may be required)

Number of people in household supported by current annual income: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ Other: _____

ADDITIONAL INSURANCE INFORMATION

Is the patient eligible for Medicaid? ☐ Yes ☐ No If No, state reason *(if denied, include a copy of the denial letter)*: _____	Has the patient applied for Medicaid? ☐ Yes ☐ No If Yes, date of application: / /
Is the patient eligible for Medicare? ☐ Yes ☐ No If No, state reason *(if denied, include a copy of the denial letter)*: _____	Has the patient applied for Medicare? ☐ Yes ☐ No If Yes, date of application: / /
Is the patient eligible for VA benefits? ☐ Yes ☐ No	If Yes, has the patient tried to obtain the medication through the VA? ☐ Yes ☐ No
Is the patient eligible for an insurance plan offered through a state insurance marketplace (also known as an exchange)? ☐ Yes ☐ No If No, state reason: _____	Has the patient applied for an insurance plan offered through a state insurance marketplace (also known as an exchange)? ☐ Yes ☐ No If Yes, date of application: / /

APPLICANT DECLARATIONS AND AUTHORIZATIONS REQUIRED ONLY IF APPLYING FOR THE PAP

By signing below, I certify that all of the information provided in this application, including household income, is complete and accurate. I understand that program assistance will terminate if Advancing Access becomes aware of any false or inaccurate information or if this medication is no longer prescribed for me. Advancing Access may require me to submit proof of identity and income documentation to verify my eligibility into the Patient Assistance Program (PAP) (eg, identification card, tax return, W-2, last two pay stubs, etc).

I understand that completing this application does not ensure that I will qualify for patient assistance. If I receive free product through the PAP, I certify that I will not seek reimbursement or credit for this medication from any insurer, health plan, or government program. If I am a member of a Medicare Part D plan, I will not seek to have this medication, or any cost for items associated with it, counted as part of my out-of-pocket cost for prescription drugs.

I understand that if I receive free product through the PAP, it is for my own use and personal consumption and that I will not offer the product for sale, resale, barter, or trade. I understand that the PAP reserves the right to modify the application form, modify or discontinue this program, or terminate assistance at any time and without notice.

I authorize the PAP and its administrator to forward my prescription to a dispensing pharmacy on my behalf. **I authorize Gilead and its third-party administrator to use the information provided on this form to obtain a personal credit report about me to verify the information on this form and determine my eligibility for the PAP.**

X **SIGNATURE OF PATIENT or PATIENT'S AUTHORIZED REPRESENTATIVE UNDER FEDERAL OR STATE LAW** (REQUIRED):		**DATE:** / /
PATIENT REPRESENTATIVE'S NAME (IF SIGNING FOR THE PATIENT):	**PATIENT REPRESENTATIVE'S RELATIONSHIP TO PATIENT:**	**PHONE #:** ( ) –

PATIENT NAME: _____ **DATE OF BIRTH:** ___/___/___

6. PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION REQUIRED

I understand that Gilead Sciences, Inc., and its agents, contractors, and other partners ("Gilead") will need to obtain, review, use, and disclose my personal and medical information before I can receive assistance through the Advancing Access program (the "Program") and the Patient Assistance Program ("PAP"). Additional information about how Gilead may use my information can be found at https://www.gilead.com/privacy-statements.

Information to Be Disclosed: My personal information related to my enrollment or participation in the Program, which may include personally identifiable information and Protected Health Information ("PHI") as defined under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") as amended by the Health Information Technology for Economic and Clinical Health ("HITECH") Act (collectively Personal Information or "PI"):

- General information about me, including my name, birth date, and contact information
- Information about my medical condition, including information about my treatment with this prescription medication and related medical condition
- Information about my health benefits or health insurance coverage
- Financial information (as necessary), such as my income
- All information provided on this enrollment form and otherwise provided by me to the Program or PAP

Persons Authorized to Disclose and Use My Information: I authorize the following parties to disclose my PI to Gilead and its partners:

- My healthcare providers, including any pharmacy that fills my prescription medication. I understand that my pharmacy providers may receive remuneration for disclosing my PI pursuant to this authorization
- Any health plans, including my health insurance company, or programs that provide me with healthcare benefits

I also authorize Gilead and its partners to redisclose my PI to the following parties:

- My healthcare providers, including the pharmacy that fills my prescription medication
- My health plans, including my health insurance company
- My authorized representative under federal or state law (if applicable)

Purposes for Which My Information May Be Used and Disclosed: My PI may be used and disclosed for the following purposes:

- Completing the enrollment process and verifying the information provided on my enrollment form, including confirming my identity and my use or potential use of the medication prescribed by my healthcare provider
- Establishing my eligibility for benefits from my health plan or other programs
- Providing financial assistance and reimbursement support, if I am eligible, and providing other applicable support, including information on third-party resources that may be able to assist me
- Communicating with my healthcare providers and coordinating my prescription and medication through a pharmacy or healthcare provider's office
- Contacting me to evaluate the effectiveness of the Program and/or the PAP
- Gilead's internal business purposes and audit and compliance purposes
- Confirming my receipt of the prescribed Gilead medication through the PAP based on my communication preferences above
- Deidentifying the information I provide, which means removing elements like my name and address so that I am no longer reasonably identifiable
- Meeting Gilead's legal requirements

Please continue onto next page >>>

PATIENT NAME: _____ **DATE OF BIRTH:** / /

6. PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION (CONTINUED)

REQUIRED

Other Important Points:

- I understand that I may choose not to sign this authorization. If I refuse, my eligibility for health plan benefits or ability to obtain treatment from my healthcare providers will not change, but I will not have access to the support offered by the Program and/or the PAP
- Once I sign this Patient Authorization and my PI is transmitted to Gilead and its partners, I understand that state and federal privacy laws may no longer protect or prohibit the redisclosure of the PI disclosed to Gilead and its partners by my healthcare provider or others
- I understand that I am entitled to a copy of this signed authorization and that the authorization expires on the earlier of two (2) years from the date it is signed by me or sooner if required under the laws of the state in which I live
- I understand that I may cancel this authorization at any time by notifying Gilead at 1-800-226-2056. If I cancel, Gilead will stop using this authorization to obtain, use, or disclose my PI after the cancellation date, but the cancellation will not affect uses or disclosures of any PI that have already been made pursuant to this authorization before the cancellation date

X **SIGNATURE OF PATIENT or PATIENT'S AUTHORIZED REPRESENTATIVE UNDER FEDERAL OR STATE LAW** (REQUIRED):		**DATE:** / /
PATIENT REPRESENTATIVE'S NAME (IF SIGNING FOR THE PATIENT):	**PATIENT REPRESENTATIVE'S RELATIONSHIP TO PATIENT:**	**PHONE #:** ( ) –

ADVANCING ACCESS® VEKLURY® (remdesivir) **PATIENT ASSISTANCE PROGRAM ENROLLMENT FORM** PHONE: **1-800-226-2056** | FAX: **1-833-445-3239**

PATIENT NAME: _____ **DATE OF BIRTH:** / /

7. PRESCRIBER INFORMATION/OUTPATIENT CENTER INFORMATION REQUIRED

MUST BE COMPLETED BY A HEALTHCARE PROVIDER

Prescriber Name:				
Facility Name:			Office Contact:	
Address 1:			Phone #: ( ) –	Fax #: ( ) –
Address 2:			Attention (Unit/Department):	
City:	State:	ZIP Code:	Days on which your office is unable to accept product delivery:	
NPI #:	State License #:		Tax ID #:	PTAN #:

FACILITY ADDRESS WHERE PRODUCT SHOULD BE SHIPPED (FILL OUT IF ADDRESS IS DIFFERENT FROM ABOVE)

Facility Name:			Office Contact:	
Address 1:			Phone #: ( ) –	Fax #: ( ) –
Address 2:			Attention (Unit/Department):	
City:	State:	ZIP Code:	Days on which your office is unable to accept product delivery:	
NPI #:	State License #:		Tax ID #:	

8. DIAGNOSIS/MEDICAL INFORMATION REQUIRED

MUST BE COMPLETED BY A HEALTHCARE PROVIDER

Diagnosis (Please include ICD code[s]):

9. PRESCRIBER CERTIFICATION REQUIRED

By signing below, I certify that I am personally prescribing or furnishing Gilead medication for the patient identified in Section 3 and Section 10. I certify that this prescription medication is medically necessary for the patient and that it will be used as directed. I certify that I will be supervising or coordinating the patient's treatments, in accordance with law, and verify that the information provided as part of my patient's application for the Patient Assistance Program ("PAP") is complete and accurate to the best of my knowledge. I certify that I have not received and shall not seek reimbursement for any Gilead medication dispensed to the patient through the PAP from any government program or third-party insurer. If applicable, I certify that medication provided to me by the PAP for the eligible patient identified in Section 3 will be provided by me to such patient for his or her own use without charge. I certify that I will not otherwise use any such medication or prescribe, provide, furnish, or dispense all or any portion thereof to any other person or patient. I will notify Gilead if all or any portion of the medication provided to me by the PAP for the patient identified in Section 3 is not prescribed, provided, furnished, or dispensed to that patient, and I will ensure such medication is returned to Gilead or its designated representative, by calling 1-800-226-2056 within 30 days. I certify that I will not sell, resell, offer for sale, trade, or barter medication provided to me under the PAP.

I consent that Gilead may perform an audit related to: 1) the applicant identified in Section 3, including but not limited to confirming patient identity and verifying medical necessity; and 2) the dispensing of medication provided to the prescriber through the PAP, including confirming patient receipt of the prescribed Gilead medication and the timely return of any medications received for, but not dispensed to, the patient identified in Section 3, if applicable.

I certify that I have received the appropriate written authorization from the patient, in accordance with the Health Insurance Portability and Accountability Act of 1996, applicable state health information privacy law(s), and any other applicable requirements, in order to release the patient's personal and medical information to Gilead and its agents and contractors for the purposes of assessing the patient's insurance coverage and eligibility for participation in Advancing Access, conducting random audits to verify the information provided on this enrollment form, and for other purposes as outlined in the Patient Authorization For Use and Disclosure of Personal Health Information in Section 6. Gilead is authorized to contact me about the information provided on this form and as needed to facilitate my patient's enrollment and participation in Advancing Access. I understand that Gilead may, if authorized by the patient, contact the patient directly to verify Advancing Access eligibility and updates to insurance coverage, as well as to confirm the receipt of Gilead medication through the PAP.

SPECIAL NOTE: New York prescribers, please submit prescription on an original NY State prescription blank. For all other states, if not faxed, prescription must be on state-specific blank if applicable for your state.

X **PRESCRIBER SIGNATURE** (REQUIRED): NO STAMP ALLOWED **DATE:** / /

10. PRESCRIPTION INFORMATION

PAP FOR OUTPATIENT USE ONLY. NOT NEEDED IF APPLYING FOR THE PAP FOR A PATIENT WHO HAS ALREADY BEEN DISPENSED THE PRODUCT

PLEASE FILL OUT THE BELOW PRESCRIPTION FORM WHICH WILL BE SENT TO THE PAP DISPENSING PHARMACY ONCE YOUR PATIENT IS APPROVED

℞

Prescriber First Name:	Prescriber Last Name:			Prescriber Phone #: ( ) –
Patient First Name:	Patient Last Name:			Date of Birth: / /
Medication: **VEKLURY® (remdesivir) for injection 100 mg/vial**	Quantity: **4 vials max**	Refills: **0**	Allergies: (☐None)	Medication List: (☐None)

Sig (for outpatient): CHOOSE ONE

- ☐ **Veklury 200 mg IV once on Day 1, then Veklury 100 mg IV once daily on Days 2–3**
- ☐ **Veklury 5 mg/kg IV once on Day 1, then Veklury 2.5 mg/kg IV once daily on Days 2–3**

X **PRESCRIBER SIGNATURE** (REQUIRED): NO STAMP ALLOWED **DATE:** / /

HEALTHCARE PROVIDER CONSENT REQUIRED IF COMPLETING SECTION 10

By signing below, I understand that completing this enrollment form does not guarantee that assistance will be provided to my patient. My patient has given consent for me to receive their Gilead medication on their behalf. I will receive and secure my patient's medication at my office until it's provided to my patient, when applicable. I will comply with and abide by my state practitioner dispensing laws for authorized prescribers, when applicable. Any medications supplied by Gilead as a result of this enrollment form are for the use of the patient named on this form only and shall not be sold, traded, bartered, transferred, returned for credit, or submitted to any third party (such as Medicare, Medicaid, or other benefit provider) for reimbursement. The medicine will be provided only to this eligible and enrolled patient at no charge of any kind. The information provided on this enrollment form is subject to random audits and verification. Gilead may change or cancel this program at any time; Gilead also reserves the right to terminate my patient's enrollment at any time. If medicine is not provided to my patient within 30 days of receipt, medicine must be returned to the ARx Patient Solutions Pharmacy. Healthcare facility may be subject to audits by Gilead and its third-party audit firm.

X **PRESCRIBER SIGNATURE** (REQUIRED): NO STAMP ALLOWED **DATE:** / /

PRINT FORM | **FAX COMPLETED FORM TO ADVANCING ACCESS AT 1-833-445-3239**

Continue to next page if requesting VEKLURY PRODUCT REPLACEMENT >>>

PATIENT NAME: _____ **DATE OF BIRTH:** / /

11. ADVANCING ACCESS PRODUCT REPLACEMENT REQUEST

COMPLETE IF SEEKING PAP FOR A PATIENT WHO HAS ALREADY ADMINISTERED THE PRODUCT DUE TO EMERGENCY MEDICAL NEED

MUST BE COMPLETED BY A HEALTHCARE PROVIDER

PRODUCT INFORMATION

Name of Authorized Distributor That Was Used to Purchase the Product:

Date Patient Received VEKLURY: / /

Number of Vials Received:

X **PATIENT INITIALS:**

	LOT NUMBER USED	SERIAL NUMBER OF VIALS USED
1	→	
2	→	
3	→	
4	→	

HEALTHCARE PROVIDER DECLARATION

By signing below, I verify that the information provided on this application is complete and accurate, including Gilead's PAP eligibility criteria. I understand that the patient must meet certain medical and financial criteria to be eligible for assistance. I also understand that the product I receive is not a sample but a replacement of product I previously purchased. I understand that I will not receive any reimbursement from Gilead Sciences, Inc., or the Gilead Advancing Access Patient Assistance Program ("Program"), whether for administration fees or otherwise. Reimbursement for the cost of the product administered to the above patient on the date(s) indicated has not been sought and will not be sought from any source. Acceptance of this replacement product in no way obligates my facility to use the selected product for other patients. Additionally, I understand that the Program reserves the right to conduct periodic audits of the records of all entities receiving product replacement. I accept that reasonable notice will be granted and audits will be conducted during regular business hours. I understand that the Program reserves the right to modify or revoke this program at any time without notice.

My signature confirms that this product was provided free of charge to this patient. I verify that to the best of my knowledge the information set forth in this application is complete and accurate. I agree to retain a copy of this form in the facility's records and to make it available upon request, as applicable.

PRESCRIBER NAME (REQUIRED — PLEASE PRINT):

X **PRESCRIBER SIGNATURE** (REQUIRED): NO STAMP ALLOWED **DATE:** / /

FAX COMPLETED FORM TO ADVANCING ACCESS AT 1-833-445-3239

PRINT FORM