ATRIPLA® Patient Assistance Program

Reimbursement Assistance for Patients in Need

Bristol-Myers Squibb / GILEAD

Reset Form

To receive ATRIPLA (efavirenz 600 mg/ emtricitabine 200 mg/ tenofovir disoproxil fumarate 300 mg) Tablets, please call: 1-866-290-4767

ICD-9 Code for Primary Diagnosis:	ICD-9 Code for Secondary Diagnosis (if applicable):
_____ _____ _____ . _____ _____	_____ _____ _____ . _____ _____
_____ _____ _____ . _____ _____	_____ _____ _____ . _____ _____

PLEASE PRINT

1 Patient Information

Name (First): _____ (Last) _____ (Middle Initial) _____

Address: _____

City: _____ State: _____ ZIP Code: _____ Phone #: (_____) _____

Social Security #: ☐☐☐ – ☐☐ – ☐☐☐☐ | Birth Date: MM ____ / DD ____ / YYYY ____ | Gender: M ☐ F ☐ | U.S. Resident: YES ☐ NO ☐

Patient Language: English ☐ Spanish ☐ Other: _____

Total Annual Household Income (Attach Proof of Income for each Source Listed)

Salary/Wages: $_____ Social Security Disability: $_____ Rental Income: $_____ Pension/Retirement: $_____

Social Security Retirement: $_____ Unemployment: $_____ Workers Compensation: $_____ Other: $_____

Supplemental Security Income: $_____ Alimony/Child Support: $_____ Veterans Benefits: $_____ **TOTAL: $** _____

Household Size (Number of persons who contribute to or are dependent on patient's household income): _____

Insurance Information (Y = Yes, N = No)

Insurer/Payer/Program	Rx Benefits (circle)	Medical Benefits	Insurer/Payer/Program	Rx Benefits (circle)	Medical Benefits	Insurer/Payer/Program	Rx Benefits (circle)	Medical Benefits
Medicare Part D	Y N	Y N	Medicaid	Y N	Y N	AIDS Drug Assistance Program Is applicant eligible? Y ☐ N ☐ If Y, Date of Application: _____ If N, state reason: _____	Y N	Y N
Private Insurance	Y N	Y N	Other _____ List Insurer if Y	Y N	Y N	**No Insurance** Check if Applicable ☐		

Primary Insurance Company: _____ Policy ID#: _____ Group#: _____

Contact Name: _____ Phone #: (_____) _____

Subscriber Name: _____ Date of Birth: _____

Secondary Insurance: Does applicant have additional coverage? YES ☐ NO ☐

If YES, provide name, telephone and policy numbers: _____

Has applicant applied for Medicaid or Medicare Part D?
YES ☐ NO ☐ If YES, date of application: _____

Is applicant eligible? YES ☐ NO ☐ If NO, state reason: _____

Currently enrolled in Medicare Part D? YES ☐ NO ☐

Void where prohibited by law. Patients who are enrolled in Medicaid or have coverage for prescription drugs under any other public program or have such coverage from any other third party payer, are ineligible for the ATRIPLA Patient Assistance Program.

Complete Page Two on Reverse >>

ATRIPLA® Patient Assistance Program PRESCRIPTION VOUCHER

To the Provider or Patient Advocate: Please enter the Voucher ID Number.

ATRIPLA®
(efavirenz 600 mg/emtricitabine 200 mg/
tenofovir disoproxil fumarate 300 mg) Tablets

Voucher ID Number: ☐☐☐☐☐☐☐☐☐☐☐☐

Bin Number: 610020 Group Number: 99990838

Bristol-Myers Squibb / GILEAD

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Rev.12/07

ATRIPLA® Patient Assistance Program
Reimbursement Assistance for Patients in Need

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Applicant Declaration

I verify that the information provided in this application is complete and accurate. I understand that the ATRIPLA Patient Assistance Program may request documentation to verify financial or insurance information, and that any assistance in the form of free medication is contingent upon meeting the program eligibility criteria. I also understand that Bristol-Myers Squibb & Gilead Sciences, LLC reserves the right at any time, and without notice, to modify the application form; modify or discontinue this program and its eligibility criteria; or terminate assistance.

I authorize the ATRIPLA Patient Assistance Program to obtain information from my prescribing physician, insurance company, and other sources as deemed necessary to ensure the accuracy and completeness of this application.

I authorize my healthcare providers and health plans to disclose personal and medical information about me, including information about my HIV status, to Bristol-Myers Squibb & Gilead Sciences, LLC and its agents and contractors ("BMS-Gilead") and I authorize Bristol-Myers Squibb & Gilead Sciences, LLC to use, share and disclose this information to: 1) establish my benefit eligibility; 2) provide support services, including facilitating the provision of ATRIPLA® to me; and to contact me to evaluate therapy and the effectiveness of the program.

I understand that once my health information has been disclosed to Gilead, privacy laws may no longer restrict its use or disclosure, however Gilead agrees to protect my information by using and disclosing it only for the purposes described above or as required by law. I further understand I may refuse to sign this authorization and that if I refuse, my eligibility for health plan benefits and treatment by my doctor will not change, but I will not have access to the services available through this program. I may cancel this authorization at any time by notifying Gilead in writing and submitting it by fax to 1-866-290-4487 or by calling 1-866-290-4767. If I cancel, Gilead will stop using or disclosing my information for the purposes listed above, except as required by law or as necessary for the orderly termination of my participation in the program. I am entitled to a copy of this signed authorization, which expires 10 years from the date it is signed by me.

Patient Signature: _____ Date: _____

2 Prescriber Information

Name: _____ Title: _____

Facility Name: _____ Street Address: _____ City: _____

State: _____ ZIP Code: _____ Phone #: (_____) _____ Fax #: (_____) _____

State License #: _____ DEA #: _____ NP/PA #: _____

3 Patient Advocate Information (If Different from Prescriber)

Name: _____ Title: _____

Facility Name: _____ Street Address: _____ City: _____

State: _____ ZIP Code: _____ Phone #: (_____) _____ Fax #: (_____) _____

State License Type and Number (if applicable): _____

A Patient Advocate may be a healthcare worker involved in the patient's care — a physician, nurse, physician assistant, social worker or case manager. Friends or family members cannot act as Patient Advocates. Patient Advocates are responsible for completing the patient Enrollment Form and working with the patient at specific intervals in the enrollment process.

4 Statement of Medical Necessity

Statement of Medical Necessity for Financially Needy Patients. To the best of my knowledge, this patient has no coverage (including Medicaid or other public programs) for ATRIPLA (efavirenz 600 mg/emtricitabine 200 mg/tenofovir disoproxil fumarate 300 mg) Tablets. I certify that the medication(s) listed above are medically indicated for this patient and that I will be supervising the patient's treatment. As part of my patient's eligibility, I agree to periodically verify continued use of ATRIPLA and resubmit current prescriptions.

Signature: _____ Date: _____

Prescriber ☐ Patient Advocate ☐

Applications are considered complete only if they include all of the following:

- Front and Back Pages of Enrollment Form
- Patient as well as Prescriber or Patient Advocate Signatures
- Documentation of Income Sources and Residency
- Copy of Prescription

When complete, **FAX** application and documentation to: **1-866-290-4487**

ATRIPLA® Patient Assistance Program
P.O. Box 13185
La Jolla, CA 92039-3185
TEL: 1-866-290-4767 FAX: 1-866-290-4487

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ATRIPLA® Patient Assistance Program PRESCRIPTION VOUCHER

To the Patient: Please present this Voucher and your prescription to the Pharmacist to receive ATRIPLA free of charge.

ATRIPLA (efavirenz 600 mg/emtricitabine 200 mg/tenofovir disoproxil fumarate 300 mg) Tablets
Help Line: 1-866-290-4767

To the Pharmacist: When this Voucher is affixed to a prescription for ATRIPLA, it is redeemable for a 30-day supply of the medication. This Voucher may only be used one time. Submit all 11 characters of the Voucher ID Number in your pharmacy claims system. **Pharmacy Help Line: 1-866-486-6906**

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