PATIENT ENROLLMENT FORM INSTRUCTIONS

COMPLETE ALL APPLICABLE SECTIONS OF THE ENROLLMENT FORM

- **SECTION 1, 2** (REQUIRED) Complete all fields with the patient's information.
- **SECTION 3** (REQUIRED) Check the appropriate box to indicate if the patient is insured or uninsured.
  - If the patient is insured, fill in the patient's insurance information and fax a copy (front and back) of the patient's insurance card. If the patient has a secondary insurance, check the box to indicate this and fax a copy of the secondary insurance card.
  - If the patient is uninsured, complete Section 7 to apply to the "Department of Health and Human Services' (HHS's) Ending the HIV Epidemic: Ready, Set, PrEP" free product donation program. If the patient has participated in Gilead's Medication Assistance Program (MAP) for free TRUVADA for PrEP® or DESCOVY for PrEP® within the past twelve (12) months, the patient will not be eligible for the "Department of Health and Human Services' (HHS's) Ending the HIV Epidemic: Ready, Set, PrEP" free product donation program.
- **SECTION 4** (REQUIRED) Complete all fields with the prescriber's information.
- **SECTION 5** (REQUIRED) The prescriber must sign and date this section for reimbursement support.
- **SECTION 6** (REQUIRED) The patient (or the patient's representative) must sign and date this section.
- **SECTION 7** (REQUIRED)* The patient must sign and date this section if applying for free product support.

**Required only if applying to the "HHS Ending the HIV Epidemic: Ready, Set, PrEP" free product donation program ("HHS EHE program").*

Mail or fax the completed Enrollment Form and all required documentation to the address or fax number below. Both sets of information are necessary to ensure timely enrollment form review. You may complete an electronic enrollment form online at https://GetYourPrep.com.

A case manager will notify the requestor about the patient's coverage and benefits, alternate funding options and/or qualification for the HHS EHE program.

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 below.

IMPORTANT REMINDER

Please be certain that all applicable pages of the Enrollment Form are completed and include all appropriate documentation when submitting the form. Incomplete forms slow the review process and, in some cases, may require a patient to reapply for the program.

HHS reserves the right to modify or discontinue the HHS EHE program or terminate assistance at any time. Third-party reimbursement is affected by a range of factors; therefore, HHS cannot guarantee any coverage or reimbursement.

2250 Perimeter Park Dive, Suite #300, Morrisville, NC 27560

PHONE: **1-855-447(HHS)-8410**

FAX: **1-833-200-6302**

READY SET PrEP

ENROLLMENT FORM

PHONE: **1-855-447(HHS)-8410** | FAX: **1-833-200-6302**

READY SET PrEP

1. MEDICATION PRESCRIBED (REQUIRED)

Product Name:	[X] TRUVADA® (for PrEP/Prevention)	[ ] DESCOVY® (for PrEP/Prevention)	mg:
Do you have a valid prescription for this medication?	[X] Yes	[ ] No	
Would you like to receive your prescription in the mail?	[X] Yes	[ ] No	

2. PATIENT INFORMATION (REQUIRED)

First Name: Lane	Last Name: Enget			M.I.:
Address: 706 South 9th St		Apt./Unit #	City: Minneapolis	
State: MN	Zip Code: 55404	Phone #: 701-391-7824	DOB: 05/06/1996	SSN# (Last 4 digits): 4642
Email:			Preferred Language:	
Alternate Contact Name:		Phone #:	Relationship:	

RACE

- [ ] American Indian/Alaska Native
- [ ] Asian
- [ ] Black/African American
- [ ] Native Hawaiian/Other Pacific Islander
- [X] White
- [ ] Multiple Races
- [ ] Prefer not to answer

ETHNICITY

- [ ] Hispanic/Latino
- [X] Not Hispanic/Latino
- [ ] Prefer not to answer

GENDER IDENTITY
(how would you describe yourself)

- [X] Male/Man
- [ ] Female/Woman
- [ ] Female-to-Male (FTM)/ Transgender Male/Trans Man
- [ ] Male-to-Female (MTF)/ Transgender Female/Trans Woman
- [ ] Gender non-conforming, neither exclusively male nor female
- [ ] Prefer not to answer

SEX ASSIGNED AT BIRTH

- [X] Male
- [ ] Female
- [ ] Prefer not to answer

CONTACT AUTHORIZATION

I authorize the case manager to leave a detailed voicemail message, including the name of my prescription, if I am unavailable when they call.	[X] Yes	[ ] No
I authorize HHS EHE Program to send me correspondence via U.S. mail. This includes, but is not limited to approval/denial letters for the Patient Assistance Program, reminder letters for re-enrollment periods, etc. If I select "No", I understand that all communication will be via phone.	[ ] Yes	[X] No
I provided a cell phone number above and I authorize HHS EHE Program to send text messages for medication reminders. Standard messaging and data rates apply.	[X] Yes	[ ] No

3. INSURANCE INFORMATION (REQUIRED)

- [ ] Patient is insured (Please fill out all of the applicable insurance information below. Attach copy — front and back — of patient's insurance card).
- [X] Patient is uninsured (no prescription drug coverage)

Primary Insurance:			
Plan Name:		Insurance Phone #:	
Subscriber Name:			
Policy Holder Name:		Policy Holder Relationship to Patient:	
Policy #:	Group #:	Rx Bin #:	Rx PCN #:

- [ ] Check box if patient has secondary insurance coverage and attach a copy of secondary insurance cards, if available.

4. PRESCRIBER INFORMATION (REQUIRED)

Prescriber Name: Caroline Stowe		Facility Name:	
Address: 548 Market Street, Suite 94061		City: San Francisco	
State: CA	Zip Code: 94104	Office Contact:	
Phone #: 800-321-6879		Fax #:	NPI #:
Tax ID #:		State License #:	

FAX COMPLETED FORM TO 1-833-200-6302

READY SET PrEP

PATIENT NAME: Lane Enget DATE OF BIRTH: 05/06/1996

5. PRESCRIBER CERTIFICATION AND STATEMENT OF MEDICAL NECESSITY (REQUIRED)

By signing this form, I certify that I am prescribing either TRUVADA© or DESCOVY© for the patient identified in Section 2. 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 the patient's treatments and verify that the information provided is complete and accurate to the best of my knowledge. I agree that I shall not seek reimbursement for any TRUVADA© or DESCOVY© (as applicable) dispensed to the patient through the HHS EHE program from any government program or third-party insurer.

I certify that the applicant has been tested for infection and found to be negative, and quarterly testing will be conducted as part of the applicant's care plan. As part of the applicant's eligibility, I agree to periodically verify continued use of TRUVADA© or DESCOVY© (as applicable) and resubmit current prescriptions as appropriate.

I certify that I have reviewed the additional terms available at https://ebvterms.com, which are specifically incorporated herein by reference, and acknowledge and consent to their application and enforceability in regards to this certification.

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 HHS and its agents and contractors for the purposes of: 1) verifying the patient's insurance coverage and eligibility for benefits; 2) providing financial assistance, support, and referral support as needed; 3) facilitating the provision of the patient's prescription medication to the patient; 4) contacting the patient with educational materials about the patient's prescription medication or to evaluate the effectiveness of the HHS EHE program; and 5) for HHS' and its third party agents and contractors' internal business purposes.

X	**PRESCRIBER SIGNATURE** (REQUIRED):	**DATE**:

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

I understand that I must complete this enrollment form before I can receive assistance through the "HHS Ending the HIV Epidemic: Ready, Set, PrEP" free product donation program (the "HHS EHE program"). As part of this process, HHS and its agents and contractors (collectively, "HHS") will need to obtain, review, use and disclose my personal and medical information as described below. I hereby authorize my healthcare providers and health plans to disclose my personal and medical information as described below to HHS in connection with the HHS EHE programs, all in accordance with this authorization, and I authorize HHS to use and disclose the information in accordance with the authorization.

Information to Be Disclosed: Personal health information ("PHI"), including information about me (for example, my name, Social Security number, mailing address, and insurance information), my past, current and future medical condition (including information about my status or treatment with this prescription medication and related medical condition), and all information provided on this enrollment form.

Persons Authorized to Disclose My Information: My healthcare providers, including any pharmacy that fills my prescription medication, and any health plans or programs that provide me healthcare benefits. I understand that my pharmacy providers may receive remuneration for disclosing my PHI pursuant to this authorization.

Persons to Which My Information May Be Disclosed: HHS, Gilead, and TrialCard Incorporated including their respective agents and contractors responsible for the administration of the HHS EHE program.

Purposes for Which the Disclosures Are to Be Made: Disclosures of PHI may be made to HHS so that HHS may use and disclose the PHI for purposes of: 1) completing the enrollment process and verifying my enrollment form; 2) establishing my eligibility for benefits from my health plan or other programs; 3) providing financial assistance, support, and referral support, and communicating with my healthcare providers, including, but not limited to, facilitating the provision of my prescription medication to me; 4) contacting me to evaluate the effectiveness of the HHS EHE; 5) for HHS internal business purposes, including quality control and support enhancing surveys; and 6) to send me marketing information, offers, and educational materials related to my treatment and/or my prescription medication, including the customer relationship marketing program (this use of my personal information is optional and by checking the box above the signatures below, I may opt in).

I understand that once my PHI has been disclosed hereunder, federal privacy law may no longer restrict its use or disclosure. I understand further that I may refuse to sign this authorization and that 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 HHS EHE program. I also understand that I may cancel this authorization at any time by notifying HHS in writing at HHS Ending the HIV Epidemic Program, 2250 Perimeter Park Dive, Suite #300, Morrisville, NC 27560. If I cancel, HHS will stop using this authorization to obtain, use or disclose my PHI after the cancellation date, but the cancellation will not affect uses or disclosures of any PHI that have already been made pursuant to this authorization before the cancellation date. I am entitled to a copy of this signed authorization, which expires the earlier of two (2) years from the date it is signed by me or other time period required under the laws of the state in which I reside.

☐ BY CHECKING THIS BOX, I **OPT OUT** OF RECEIVING A PHYSICAL RETAIL PHARMACY CARD.

X	**SIGNATURE of PATIENT or PATIENT'S REPRESENTATIVE** (REQUIRED): Lane Enget	**DATE:** 07/10/2023

Patient Representative's Name (if signing for the patient):

Patient Representative's Relationship to Patient:

READY SET PrEP

PATIENT NAME: Lane Enget DATE OF BIRTH: 05/06/1996

7. APPLICANT DECLARATIONS AND AUTHORIZATIONS (REQUIRED ONLY IF APPLYING FOR THE HHS EHE PROGRAM)

I certify that all of the information provided in this application is complete and accurate. I understand that program assistance will terminate if HHS becomes aware of any false or inaccurate information or if this medication is no longer prescribed for me. I understand that completing this application does not ensure that I will qualify for patient assistance. If I receive free product through the HHS EHE program, I certify that I do not have insurance and will not seek reimbursement or credit for this medication from any insurer, health plan, or government program. If I receive free product through the program, 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 HHS reserves the right to modify the application form, modify or discontinue this HHS EHE program, or terminate assistance at any time and without notice. **I authorize HHS and its administrator to forward my prescription to a dispensing pharmacy on my behalf. I authorize HHS 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 HHS EHE program.**

X **SIGNATURE of PATIENT or PATIENT'S REPRESENTATIVE** (REQUIRED): Lane Enget DATE: 07/10/2023

FAX COMPLETED FORM TO 1-833-200-6302

Ending the HIV Epidemic
A PLAN FOR AMERICA