TRODELVY® Access Support Enrollment Form

Phone: 1-844-876-3358 | Fax: 1-833-851-4344
Monday – Friday, 9 AM to 7 PM ET

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 the patient's representative 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.

After submitting this form, a dedicated TRODELVY Access Support Case Manager may reach out to you to walk you through the next steps of the process and answer any questions.

CLEAR FORM

1. REQUESTED PATIENT SUPPORT

Check all boxes that apply ☑

☐ Patient Support Offerings *(includes: Benefits Investigation, Prior Authorization and Appeals Information, and Patient Assistance Program [PAP] Eligibility Screening, if applicable)*

☐ Co-pay Coupon Program Eligibility Screening

2. GILEAD MEDICATION PRESCRIBED

Product Name: **TRODELVY® (sacituzumab govitecan-hziy) 180 mg for injection**

3. PATIENT INFORMATION

First name:	Last name:	MI:	Preferred name:
Address:	Apt/Unit #:	City:	
State:	ZIP code:	Phone #: ( ) –	Preferred language:
Email:	Date of birth: / /	Gender: ☐ M ☐ F	SSN (Last 4 digits):
Alternate contact name:	Alternate contact phone #: ( ) –	Relationship to patient:	

CONTACT AUTHORIZATION

I authorize TRODELVY Access Support to provide me with information on my benefits and other communications that contain reference to the TRODELVY Access Support program or the PAP pharmacy through the following (select all that apply): ☐ Phone call ☐ US mail

I authorize TRODELVY Access Support to leave a detailed message, including the name of my prescription, if I am unavailable when they call. ☐ Yes ☐ No

NOTE:

- If I do not select a contact preference, I understand that TRODELVY Access Support will provide program communications to me by phone and/or through my healthcare provider

4. INSURANCE INFORMATION

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

Primary insurance:		Plan name:	Insurance phone #: ( ) –
Subscriber name:		Is this a Medicare plan? ☐ Yes ☐ No	
Policyholder name:		Policyholder relationship to patient:	
Member ID #:	Policy/Group #:	Rx Bin #:	Rx PCN #:

☐ **SECONDARY INSURANCE** (Check this box if patient has secondary insurance coverage and include a copy [front and back] of insurance cards, if available)

Secondary insurance:		Plan name:	Insurance phone #: ( ) –
Subscriber name:		Is this a Medicare plan? ☐ Yes ☐ No	
Policyholder name:		Policyholder relationship to patient:	
Member ID #:	Policy/Group #:	Rx Bin #:	Rx PCN #:

☐ Check this box if patient has tertiary insurance coverage (eg, Supplemental) and include a copy (front and back) of insurance cards, if available.

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

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 ☐ 5 ☐ Other: _____

APPLICANT CONSENT AND DECLARATIONS

REQUIRED ONLY IF APPLYING FOR PAP

I certify that all of the information provided in this application, including household income, is complete and accurate and that I have read, understand, and agree to the Patient Authorization to release my Protected Health Information as indicated on this form (Section 6), including, but not limited to, spoken or written facts about my health and payment benefits that I may have. I understand Protected Health Information may include copies of records from my healthcare providers or health plans about my health or healthcare. I understand, accept, and will comply with all requirements and restrictions described in the eligibility requirements provided in Section 6 of this form.

I understand that my prescription will be shipped directly to the prescriber's office address listed on this form (Section 7). I authorize the prescriber listed on this form, as my agent, to receive my prescription on my behalf. My prescriber, as my agent, will receive and then provide me with my prescription medication.

I understand that program assistance will terminate if TRODELVY Access Support becomes aware of any false or inaccurate information or if this medication is no longer prescribed for me. I understand that I may only use the free product received through the Patient Assistance Program (PAP) for my own use and personal consumption, and that I will not offer the product for sale, resale, barter, or trade.

I understand that completing this application does not ensure that I will qualify for patient assistance. If I receive free product through 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 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 PAP and its administrator to forward my prescription to a dispensing pharmacy on my behalf. TRODELVY Access Support may require me to submit proof of identity and income documentation to verify my eligibility into PAP (eg, identification card, tax return, W-2, last two pay stubs, etc). I may refuse to sign this authorization without any effect on my care or treatment from my healthcare provider. However, if I refuse to sign this form, I acknowledge that I will not be eligible to receive free product through the Gilead PAP. I can cancel this authorization at any time by mailing a written request to TRODELVY Access Support, 680 Century Point Lake Mary, FL 32746 or by calling 1-844-876-3358. This cancellation will not affect any use or disclosure of my information made prior to receiving notice of cancellation. 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 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 AND HEALTH INFORMATION

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 TRODELVY ACCESS SUPPORT 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 oncology-related status or 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 PAP
- Gilead's internal business purposes and audit and compliance purposes
- Confirming my receipt of the prescribed Gilead medication through 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 >>>

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

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 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 1-844-876-3358. 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

☐ **MARKETING COMMUNICATIONS OPT IN OPTIONAL:**
I would like to receive marketing and informational communications from Gilead related to my medical condition, treatment, and/or my prescription medication, including offers, marketing and promotional information, and educational materials, via one or more of the communications methods I agreed to above. I understand that opting in to the marketing and informational communications is not required as a condition of (i) eligibility for health plan benefits or ability to obtain treatment from my healthcare providers, (ii) enrollment in the Program or Patient Assistance Program (PAP), or (iii) purchasing any goods or receiving a co-pay or other support from Gilead. The marketing outreach program is separate from PAP. **NOTE:** TRODELVY Access Support may communicate with me as necessary to administer the Program, including PAP, even if I do not opt in to receive marketing and informational communications from Gilead.

☐ **By checking this box,** I consent to receive marketing and informational communications from Gilead (as described above) to my phone number provided, including text messages, prerecorded messages, and phone calls, which may be sent via autodialer. Text and data rates may apply. I may opt out at any time by texting "STOP."

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 #:** ( ) –

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7. PRESCRIBER INFORMATION

Prescriber name:	Facility name:		
Office contact:	Phone #: ( ) –	Ext:	Fax #: ( ) –
Address:	City:	State:	ZIP code:
Alternate office contact:	Alternate phone #: ( ) –	Ext:	Alternate email:
Days on which your office is unable to accept product delivery:	State license #:		
Tax ID #:	PTAN #:	NPI #:	Group NPI #:
Medicaid provider ID #:	Expiration: / /	Other provider ID (if applicable):	

FACILITY ADDRESS WHERE PRODUCT SHOULD BE SHIPPED **REQUIRED ONLY IF APPLYING FOR PAP**

Facility name:	Office contact:	Place of service code:	
Address 1:	Phone #: ( ) –	Ext:	Fax #: ( ) –
Address 2:	Attention (Unit/Department):		
City: State: ZIP Code:	Days on which your office is unable to accept product delivery:		
Alternate office contact:	Alternate phone #: ( ) –	Ext:	Alternate email:

8. DIAGNOSIS/MEDICAL INFORMATION

Must be completed by a healthcare provider.

Diagnosis (Please include ICD code[s]):

9. PRESCRIPTION INFORMATION **REQUIRED ONLY IF APPLYING FOR PAP**

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: / /	Patient weight (kg):
Medication: **TRODELVY® (sacituzumab govitecan-hziy) for injection for intravenous use, lyophilized powder in single-use vials containing 180 mg per vial**			
Dosage and Directions: _____ **mg (10 mg/kg) once weekly via intravenous infusion on Days 1 and 8 of continuous 21-day treatment cycles**			
Treatment cycles/refills:	Quantity (number of vials) to be dispensed:		

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

10. PRESCRIBER CERTIFICATION

By signing this form, I certify that I am personally prescribing or furnishing Gilead medication for the patient identified in Section 3. 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 PAP from any government program or third-party insurer. If applicable, I certify that medication provided to me by 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 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 1-844-876-3358 within 30 days. I certify that I will not sell, resell, offer for sale, trade, or barter medication provided to me under PAP. Healthcare facility may be subject to audits by Gilead and its third-party audit firm.

I consent that Gilead may perform random audits and verification 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 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 TRODELVY Access Support, 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 TRODELVY Access Support. I understand that Gilead may, if authorized by the patient, contact the patient directly to verify TRODELVY Access Support eligibility and updates to insurance coverage, as well as to confirm the receipt of Gilead medication through PAP.

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.

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:** / /

GILEAD

PRINT FORM **FAX COMPLETED FORM TO TRODELVY ACCESS SUPPORT AT 1-833-851-4344**