ADVANCINGACCESS®
for **YEZTUGO®** (lenacapavir)
injection 463.5 mg/1.5 mL

Patient and Provider resources are available at:
PrEP.AdvancingAccess.com

PATIENT ENROLLMENT FORM

PHONE: **1-800-226-2056** | FAX: **1-800-915-3003**
(Monday through Friday, 9 AM–8 PM EST)

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 medication assistance, and to credit bureaus to determine program eligibility with your consent within this Enrollment Form.

After submitting this form, a dedicated Advancing Access program specialist 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 REQUIRED

CHECK ALL BOXES THAT APPLY ☑

- ☐ Benefits Investigation
- ☐ Co-pay Savings Program
- ☐ Prior Authorization and Appeals Information
- ☐ Medication Assistance Program (MAP) Eligibility Screening

2. GILEAD MEDICATION PRESCRIBED REQUIRED

CHECK ONE OPTION ONLY ☑

Product Name: **YEZTUGO** (lenacapavir)

- ☐ Initiation Dose (tablets/injections)
- ☐ Maintenance Dose (injections)
- ☐ Oral Bridge (tablets)

HEALTHCARE PROVIDER WILL ACQUIRE THE INJECTION THROUGH CHOOSE ONE OPTION ONLY

- ☐ **Specialty Pharmacy** — If checked, enter Name: _____
  ↳ Would you like us to triage this enrollment form, which includes the Rx section, to this preferred pharmacy? ☐ Yes ☐ No
- ☐ **In-house Pharmacy** — If checked, enter Name: _____, NPI #: _____
- ☐ **Healthcare provider (HCP) will buy-and-bill**

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 ARx Patient Solutions Pharmacy through the following (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:
- If I do not select a contact preference, I understand that Advancing Access will provide program communications to me by phone and/or through my healthcare provider
- 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), INCLUDING MEDICAL AND PRESCRIPTION.

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

PRIMARY INSURANCE

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

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

5. PATIENT FINANCIAL INFORMATION

REQUIRED ONLY IF APPLYING FOR THE MEDICATION ASSISTANCE PROGRAM (MAP)

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: _____

ADDITIONAL INSURANCE INFORMATION

Has the patient applied for the pre-exposure prophylaxis (PrEP) Drug Assistance Program (DAP)? ☐ Yes ☐ No

If Yes, date of application: ___/___/___

What is the PrEP DAP status of the patient? ☐ Not applied ☐ Pending ☐ Wait-listed ☐ Denied (include denial letter)
☐ Not eligible, reason: _____

Is the patient eligible for Medicaid? ☐ Yes ☐ No If No, state reason *(if denied, include a copy of the denial letter)*:	If Yes, 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)*:	If Yes, 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:	If Yes, 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: ___/___/___

PATIENT CONSENT/APPLICANT CONSENT AND DECLARATIONS

REQUIRED

BY CHECKING THIS BOX ☐, 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.

BY SIGNING BELOW, I certify that all of the information provided in this application, including household income, is complete and accurate.

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. **Note:** YEZTUGO (lenacapavir) will be shipped directly to the HCP.

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. I understand that I may only use the free product received through the Medication Assistance Program (MAP) 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 medication assistance. If I receive free product through the MAP, 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 the MAP 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 MAP and its administrator to forward my prescription to a dispensing pharmacy on my behalf. Advancing Access may require me to submit proof of identity and income documentation to verify my eligibility into the MAP (eg, identification card, tax return, W-2, last two pay stubs, etc). **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 MAP. 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 MAP and forward my prescription to my pharmacy on the physician's behalf.**

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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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 vendors, agents, contractors, and other partners, (collectively, "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 Medication Assistance Program ("MAP"). 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 use or potential use of YEZTUGO and related support that may be available to me, including through enrollment or participation in the Program or the MAP. This 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"), including, but not limited to:

- General information about me, including my name, birth date, and contact information
- Information about my past, current, or future medical conditions, including information about my HIV-related status or treatment with this prescription medication and related medical conditions
- 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 MAP

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

- 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 and/or making the communications to me that are described in this authorization
- Any health plans, including my health insurance company, or programs that provide me with healthcare benefits

I also authorize Gilead 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 MAP
- Contacting me to provide marketing and informational communications from Gilead related to my medical condition, treatment, and/or my prescription medication, including educational information and promotional information about offers and services that may be of interest to me

Please continue onto next page >>>

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

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

REQUIRED

(cont'd) Purposes for Which My Information May Be Used and Disclosed:

- Conducting sales and marketing research and analytics
- Gilead's internal business purposes and audit and compliance purposes
- Confirming my receipt of the prescribed Gilead medication through the MAP 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
- Data aggregation, which may involve combining information about me with other information obtained by Gilead or its partners
- Meeting Gilead's legal requirements

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 MAP
- 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 or patientsupport@gilead.com. 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** (REQUIRED): / /
PATIENT REPRESENTATIVE'S NAME (IF SIGNING FOR THE PATIENT):	**PATIENT REPRESENTATIVE'S RELATIONSHIP TO PATIENT:**	**PHONE #:** ( ) –

 THIS PAGE TO BE COMPLETED BY **PRESCRIBER** FOR **MAP ENROLLMENT**

PHONE: **1-800-226-2056**
FAX: **1-800-915-3003**

ADVANCING ACCESS® YEZTUGO® (lenacapavir) MEDICATION ASSISTANCE PROGRAM (MAP) ENROLLMENT FORM

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

7. PRESCRIBER INFORMATION REQUIRED

MUST BE COMPLETED BY A HEALTHCARE PROVIDER

Prescriber Name:		Facility Name:	
Address:		City:	State: ZIP Code:
Office Contact:		Phone #: ( ) –	Fax #: ( ) –
NPI #:	State License #:	PTAN #:	Tax ID #:

8. MEDICAL INFORMATION/REASON FOR ENCOUNTER REQUIRED

MUST BE COMPLETED BY A HEALTHCARE PROVIDER

Reason for encounter (Please include ICD code[s]):

9. PRESCRIPTION INFORMATION REQUIRED FOR MAP ONLY

▶▶ **INJECTION MUST BE ADMINISTERED BY HCP**

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

℞

Patient First Name:	Last Name:	Date of Birth: ___/___/___
Is this the patient's first treatment of YEZTUGO (lenacapavir)? ☐ Yes ☐ No		Known medication allergies: (☐ None)

FOR PATIENTS ON YEZTUGO (CHOOSE ONE OPTION ONLY)

☐ **INITIATION** (tablets/injections)

YEZTUGO ORAL ONLY
Oral 300 mg tablet | **QUANTITY:** 4 | **REFILLS:** 0
SIG: Take 2 tablets (600 mg) PO once on Day 1, then 2 tablets (600 mg) PO once on Day 2

YEZTUGO INJECTION ONLY
Injection 927 mg SubQ | **QUANTITY:** 2 x 1.5 mLs | **REFILLS:** 1
SIG: Inject 2 x 1.5 mL subcutaneously on Day 1, then repeat every 6 months (26 weeks)

☐ **MAINTENANCE** (injections)

YEZTUGO INJECTION ONLY
Injection 927 mg SubQ
QUANTITY: 2 x 1.5 mLs | **REFILLS:** 1
SIG: Inject 2 x 1.5 mL subcutaneously every 6 months (26 weeks)

☐ **ORAL BRIDGE** (tablets)

YEZTUGO ORAL ONLY
Oral 300 mg tablet
QUANTITY: 4 | **REFILLS:** _____
SIG: Take 1 tablet PO once every 7 days, as directed, up to 6 months

NOTE: *For planned missed injection*

REQUIRED Anticipated Start Date: ___/___/___

NOTE:
- ▶ Both YEZTUGO oral and injection doses will be shipped directly to the prescriber's office
- ▶ YEZTUGO injections should be administered in a healthcare setting by a healthcare professional

10. PRESCRIBER CERTIFICATION REQUIRED

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 Medication Assistance Program ("MAP") 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 MAP from any government program or third-party insurer. If applicable, I certify that medication provided to me by the MAP 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 MAP 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 MAP. 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 the MAP, 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 8. 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 MAP. 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. I authorize ARx Patient Solutions Pharmacy to act on my behalf for the limited purposes of transmitting this prescription by any means allowed under applicable law to the appropriate pharmacy designated by the patient utilizing their benefit plan.

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.

REQUIRED *(sign one)* NO STAMP ALLOWED	X	**PRESCRIBER SIGNATURE** (DISPENSE AS WRITTEN):	**DATE:** ___/___/___	X	**PRESCRIBER SIGNATURE** (SUBSTITUTIONS ALLOWED): **DATE:** ___/___/___

11. HEALTHCARE PROVIDER CONSENT REQUIRED

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:** ___/___/___

FAX COMPLETED FORM TO ADVANCING ACCESS AT 1-800-915-3003

PRINT FORM

GILEAD