Common Patient Assistance Program Application (HIV)

PROGRAM DESCRIPTION

The purpose of this enrollment tool is to collect information that numerous pharmaceutical companies and foundations providing the donated products of pharmaceutical companies require for enrollment in various HIV patient assistance programs (PAPs). These PAPs provide medicines at little or no cost to eligible patients. To facilitate enrollment in multiple PAPs, this tool consolidates all of the necessary information in one place. In each instance in which the tool refers to "PAPs" it means all of the PAPs for which the applicant may be eligible. **Each PAP will determine a patient's eligibility for assistance based on their individual program requirements.**

Further, each PAP requires its own application and that, once completed, can be printed out multiple times and submitted to individual PAPs with the required attachments.

IMPORTANT INFORMATION

1. PAPs cannot process incomplete applications.
2. Make sure all required information and accompanying documents are complete and signed before they are submitted to each PAP.
3. Page 2, Patient General Information, line 5: indicate the correct contact for additional follow-up. If none is selected, the default is the provider.
4. Page 2, Coverage Information: respond for each category of coverage.
5. Page 2, Alternate Shipping Information: this address is used if the PAP will ship to a location other than the physician/prescriber. Note that not all PAPs will ship to an alternate address.
6. Page 2, Advocate Information: indicate if an advocate is applying on behalf of a patient, and be sure to include a signature. If no advocate is involved, leave this section blank.
7. Page 3, IMPORTANT: check the “Required Attachments” carefully. Different attachments may be required by different PAPs. Especially note whether an original prescription form is required.
8. Page 4, IMPORTANT: signatures from the patient (or the patient’s legal representative) and the provider are ALWAYS required.
9. IMPORTANT: send completed, signed, Common PAP Applications to the corresponding addresses listed for EACH COMPANY from which medication is sought.
10. Complete the form using either blue/black pen or via computer, responding to all required questions.

This tool was developed with the assistance of the Department of Health and Human Services/Health Resources and Services Administration.

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PATIENT GENERAL INFORMATION

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

Mailing Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ ☐ Ok to call? E-mail *(optional)* _____ Language: ○ English ○ Spanish ○ Other: _____

Gender: ○ M ○ F Date of birth: _____ Number in Household (circle): 1 2 3 4 5 6 7 8 9 Current Annual Household Income: $ _____

Follow-Up point of contact: ○ Provider (*default*) ○ Caseworker ○ Patient ○ Other: _____

COVERAGE INFORMATION

AIDS Drug Assistance Program: ○ Enrolled ○ Not Eligible ○ Denied ○ Pending ○ Not Applied ○ Waitlisted

Medicaid: ○ Enrolled ○ Not Eligible ○ Denied ○ Pending ○ Not Applied

Medicare: ○ Enrolled ○ Not Eligible ○ Denied ○ Pending ○ Not Applied

Medicare Part D: ○ Enrolled ○ Not Eligible ○ Denied ○ Pending ○ Not Applied

Private Insurance Drug Coverage: ○ Enrolled ○ Not Enrolled

If enrolled, Insurer Name: _____

Veterans' Administration Health Benefits: ○ Enrolled ○ Not Eligible

Other: _____

PHYSICIAN/PROVIDER/PRESCRIBER INFORMATION

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

Business/Facility Name: _____ Phone: _____ Fax: _____

Office Contact Name (First): _____ (M.I.): _____ (Last): _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Professional Designation/Specialty: _____ National Provider Identifier: _____

Tax ID #: _____ DEA #: _____ State License #: _____

ALTERNATE SHIPPING INFORMATION *(some PAPs require medication to be shipped to physician/prescriber while others will ship to the patient's alternate shipping address of choice)*

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

Business/Facility Name: _____ Phone: _____ Fax: _____

Shipping Address: _____ City: _____ State: _____ Zip: _____

Relationship to patient: _____

Reason for alternate: _____

ADVOCATE INFORMATION *(if applying on behalf of patient)*

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

Business/Facility Name: _____ Phone: _____ Fax: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Relationship to patient: _____

_____ Advocate Signature

_____ Date

Please send general feedback and questions on the Common Patient Assistant Program Application form to commonPAPform@nastad.org.
For any questions about eligibility and status of a submitted application, please contact the corresponding company.

IMPORTANT: Send completed, signed, Common PAP Applications to the corresponding addresses listed for EACH COMPANY from which medication is sought.

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ATTACHMENTS: *(requirements vary by program)*

1. Copy of recent paystub
2. Copy of first page of most recent Federal income tax return
3. Copy of social security check or awards letter
4. Copy of insurance card (if Part D or insured)
5. Copy of drug receipts (if Part D or insured)
6. Original prescription form
7. Allergy & Health Information: list of any known drug allergies and current medications

AbbVie Patient Assistance Foundation P.O. Box 270, Somerville, NJ 08876 — Phone: 800-222-6885 Fax: 866-483-1305 ☐ Kaletra® (lopinavir/ritonavir) ☐ Norvir® (ritonavir)	*If there is a need for an urgent delivery of medication, the health care provider should call the program directly to discuss options. **Original "ink" signature required to complete enrollment. No stamped signatures are accepted.	App. submitted via: ○Fax ○Mail ○Ship to Physician Attachment Req.: 6 If insured but cannot afford treatment: 4 & 5
Boehringer Ingelheim Cares Foundation Inc. **Patient Assistance Program c/o Express Scripts SDS, Inc.** P.O. Box 66565, St. Louis, MO 63166 — Phone: 800-556-8317 Fax: 800-639-9118 ☐ Aptivus® (tipranavir) ☐ Viramune XR® (nevirapine)	*Once the patient is accepted, the patient can expect to receive medicine within 48 hours. **Original "ink" signature required to complete enrollment. No stamped signatures are accepted.	App. submitted via: ○ Fax ○ Mail ○Ship to Provider Attachment Req.: 2; 5 if Part D enrollee *Applications submitted via fax MUST be from a physician's office with a cover note.
Bristol-Myers Squibb Access Virology Patient Assistance Program P.O. Box 221430, Charlotte, NC 28222 Phone: 888-281-8981 Fax: 888-281-8985 ☐ Reyataz® (atazanavir sulfate) ☐ Sustiva® (efavirenz)	*Original "ink" signature required to complete enrollment. No stamped signatures are accepted.	App. submitted via: ○Fax ○Mail Attachment Req.: 1, 2 or 3; 4, 5, & 6
Bristol-Myers Squibb & Gilead Sciences, LLC Atripla Patient Assistance Program P.O. Box 13185, La Jolla, CA 92039 — Phone: 866-290-4767 Fax: 866-290-4487 ☐ Atripla® (efavirenz/emtricitabine/tenofovir disoproxil fumarate)	*Patients that are pre-screened and determined to be eligible for the program may receive a voucher for the immediate pickup of a 30-day supply at the pharmacy of their choice. **Original "ink" signature required to complete enrollment. No stamped signatures are accepted.	App. submitted via: ○Fax ○Mail Attachment Req.: 1, 2 or 3; 4 & 5
Gilead Advancing Access: Reimbursement Solutions for Patients in Need P.O. Box 13185, La Jolla, CA 92039 — Phone: 800-226-2056 Fax: 800-216-6857 ☐ Complera® (emtricitabine/rilpivirine/tenofovir disoproxil fumarate) ☐ Emtriva® (emtricitabine) ☐ Emtriva Oral Solution® (emtricitabine oral solution) ☐ Hepsera® (adefovir dipivoxil) ☐ Stribild™ (elvitegravir/cobicistat/emtricitabine/tenofovir disoproxil fumarate) ☐ Truvada® (emtricitabine and tenofovir disoproxil fumarate) ☐ Viread® (tenofovir disoproxil fumarate) 300mg ☐ Viread® (tenofovir disoproxil fumarate) 150/200/250mg ☐ Vistide® (cidofovir injection)	*Immediate access is available for all products except Vistide and Hepsera. Patients that are pre-screened and determined to be eligible for the program may receive a voucher for the immediate pick-up of a 30-day supply at the pharmacy of their choice. **Original "ink" signature required to complete enrollment. No stamped signatures are accepted.	App. submitted via: ○Fax ○Mail Attachment Req.: 1, 2 or 3; 4 & 5
Johnson & Johnson Patient Assistance Foundation, Inc. P.O. Box 221857, Charlotte, NC 28222 — Phone: 800-652-6227 Fax: 888-526-5168 ☐ Edurant® (rilpivirine) ☐ Is the patient currently taking? ☐ Intelence® (etravirine) ☐ Is the patient currently taking? ☐ Prezista® (darunavir) ☐ Is the patient currently taking?	*Immediate access is available through the use of pharmacy card. At the request of the physician, a pharmacy card number will be provided to the patient ONLY, immediately upon eligibility approval. He/she can then go to the pharmacy to pick up their medicine.	App. submitted via: ○Fax ○Mail ○Pharmacy Card (Pick Up) ○Ship to Physician Attachment Req.: 2, 4 & 6 Prescription only needed if drug is shipped to physician
Merck SUPPORT™ Program P.O. Box 305, San Bruno, CA 94066 — Phone: 800-850-3430 Fax: 866-410-1913 ☐ Crixivan® (indinavir sulfate) ☐ Isentress® (raltegravir)	*This Program has an emergency shipment process for patients that are in jeopardy of experiencing an interruption in therapy. This is a 24-hour turnaround to provide medication directly to the patient's home. These are made on exception basis only and approval is a result of discussions between the Program and the patient or physician. **Merck requires both original "ink" signed enrollment tool and "ink" signed doctor prescription. No copies or stamps are accepted. If the tool is started by fax, the patient must follow up by mailing in the original enrollment process and prescription. ***This Program does not accept an advocate signature on behalf of the patient.	App. submitted via: ○Fax ○Mail ○Ship to Provider ○Ship to Patient Attachment Req.: 6 & 7 *Faxed applications still require a follow up hard copy with signature to be mailed.
ViiV Healthcare Patient Assistance Program P.O. Box 52037, Phoenix, AZ 85072 — Phone: 877-784-4842 Fax: 877-784-4004 ☐ COMBIVIR® (lamivudine/zidovudine) ☐ EPIVIR® (lamivudine) ☐ EPZICOM® (abacavir sulfate and lamivudine) ☐ LEXIVA® (fosamprenavir calcium) ☐ RESCRIPTOR® (delavirdine mesylate) ☐ RETROVIR® (zidovudine) ☐ SELZENTRY® (maraviroc) ☐ TIVICAY® (dolutegravir) ☐ TRIZIVIR® (abacavir sulfate, lamivudine, and zidovudine) ☐ VIRACEPT® (nelfinavir mesylate) ☐ ZIAGEN® (abacavir sulfate)	*Patients who need medicine that same day must have an Advocate (i.e., anyone involved in the delivery of the patient's healthcare) enroll them by phone. Same day access is not available for Medicare Part D participants. Patients eligible for same day access can pick up the medicine at any retail pharmacy with a valid prescription.They can get up to two fills at a local pharmacy when they initially enroll. There is a $10 co-pay per retail fill at a pharmacy. The Advocate must also sign the application in the Advocate Information section when enrolling the patient for same day access. **Medicare Part D participants must have spent $600 out of pocket on prescription drugs during the current calendar year (as one of the eligibility criteria) to qualify for assistance. ***Original "ink" signature required to complete enrollment. No stamped signatures are accepted.	App. submitted via: ○Fax ○Mail ○Phone (for immediate access by an advocate) ○Pharmacy Pick-Up (if immediate access required and approved via phone by an advocate) Attachment Req.: 1, 2, and/or 3; 6; 4 & 5 if Part D enrollee Prescriptions must be faxed with a cover sheet from the prescribing physician.

IMPORTANT: This application is not complete unless both the authorization and the certification are signed by the appropriate individuals.

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PATIENT AUTHORIZATION

By my signature, I authorize each Program and their agents to do the following:

1. Use any information that I provide in my application for the purpose of enrolling in or to administer the PAPs;
2. Contact my doctor, healthcare provider, or pharmacist about my application for the PAPs, and disclose to them information contained in my application, in order to help me receive Programs' products under the PAPs and ensure that PAPs' guidelines are being met;
3. Request information from my insurer, doctor, healthcare provider, or pharmacist about the prescribed medications I receive or will receive under the PAPs and about my medical condition. This information will be used only to determine my eligibility for the PAPs and to administer the PAPs. By signing below, I also authorize my insurer, doctor, healthcare provider, or pharmacist to release information about my prescribed medications and medical condition that is requested by Programs or their agents;
4. Contact my insurer, other potential funding sources, including the Centers for Medicare and Medicaid Services, social workers or patient advocacy organizations on my behalf in order to determine if I am eligible for health insurance coverage or other funds, and disclose to them information contained in my PAP applications or information about my prescribed medications and medical condition that has been provided by my physician, healthcare provider or pharmacist; and
5. Disclose any information obtained from the sources listed above to third parties if required by law.

By my signature, I am signifying that I understand the following:

1. Once medical information about me has been disclosed in reliance upon this Authorization, the information may no longer be protected by federal privacy laws and may be further disclosed; however, Programs agree to protect my information by using and disclosing it only for the purposes described above or as required by law.
2. Programs and their agents will only ask for the information that is needed to process my application, renew my application or provide me with help throughout my Program participation. Each Program will only have access to the information needed for that Program and will not have access to information required for enrollment in any other PAP.
3. This Authorization will remain in effect for as long as I participate in the Program and a period of 5 years after my participation in the Program ends, and that I am entitled to request a copy of this signed Authorization.
4. I have the right to revoke this authorization at any time by mailing a signed written statement of my revocation to the address(es) used on page 2. Such a revocation would end my eligibility to participate in the PAPs. Revoking this authorization will prohibit disclosures after the date written revocation is received, except to the extent that action has been taken in reliance on my authorization.
5. Any assistance in the form of product at no cost is contingent upon my ability to meet the eligibility criteria for the Program.
6. The program assistance may change or be discontinued at any time without any notice to me.
7. I agree that the Program does not have any liability in providing PAP services to me.

Finally, I 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.

If I receive any free product from Programs, I certify that I will not seek reimbursement from any public or private prescription drug plan for the use of such product.

I certify that the information in this application is complete and accurate to the best of my knowledge and agree to notify PAPs of any change in my insurance eligibility or financial status within 30 days by providing that information to the address(es) used on page 2.

Signature (Patient or Legal Representative) _____ Date _____

PHYSICIAN/PRESCRIBER CERTIFICATION

By my signature, I certify:

1. To the best of my knowledge, the information on this patient is correct and complete and consistent with applicable privacy laws and regulations, and I understand that Program and/or their agents are relying on this representation.
2. I have no knowledge of any intent to sell, barter or give this product to any person other than the patient for whom it has been prescribed.
3. No reimbursement of the cost of product will be accepted by me from public or private sources, including patients, for any treatments where product will be provided free-of-charge by Program.
4. The medication(s) covered by the PAPs are medically indicated for this patient and that I will be supervising the patient's treatment.
5. I agree to periodically verify continued use of Programs' medication and resubmit current prescriptions.
6. My State license is currently in good standing, I am not prohibited from participating in Federally-funded health care programs, nor am I on the List of Excluded Individuals/Entities maintained by the HHS Office of Inspector General.

I authorize the Program to forward this prescription to a dispensing pharmacy on behalf of myself and my patient, or to send the medication directly to the patient, or to send the medication to my office for dispensing to my patient in accordance with individual program requirements.

Signature _____ Date _____