ViiVConnect

ViiVCONNECT.COM · PHONE: 1-844-588-3288 · FAX: 1-844-208-7676

ViiVConnect provides comprehensive information on access and coverage to help Patients get their prescribed ViiV Healthcare medications.

CABENUVA (cabotegravir; rilpivirine) Enrollment Form

ViiVConnect Services Requested:
Check all that apply

- ☐ Benefits Verification
  - ☐ Check here for Benefits Verification ONLY
- ☐ Oral Lead-In (OLI) Fulfillment
- ☐ Claims Support
- ☐ Patient Assistance Program (PAP) Application
- ☐ Copay Savings Enrollment

THE FOLLOWING INFORMATION SHOULD BE FILLED OUT BY THE PATIENT

1 Patient Information

ALL FIELDS REQUIRED

First Name | M.I. | Last Name | Preferred Name | D.O.B. (mm/dd/yyyy)

Street Address | Apt/Bldg/Fl | City | State | ZIP Code | Sex: ☐ M ☐ F | Gender Identity

Phone # | Email

☐ Request Spanish Language Materials

PATIENT AUTHORIZATION AND RELEASE

SIGNATURE REQUIRED ON NEXT PAGE

I understand that I must complete and sign this Enrollment Form to participate in ViiVConnect. I also understand that ViiV Healthcare or its agent ("ViiV") may receive and disclose my personal information for services provided to me.

Information that will be used and disclosed: My personal information, such as my name, address, date of birth, insurance information, financial information, medications, prescriptions, medical information, and any other information contained in this Enrollment Form.

Persons and entities authorized to use and disclose my personal information: I authorize my doctor, health plan, healthcare providers, pharmacy and other people I authorize to act on my behalf ("Care Team") to disclose my personal information to ViiV, and I authorize ViiV to collect, use, and disclose my personal information for the purposes identified below.

Purposes for the use and disclosure of my personal information: My personal information will be used by and shared with the persons and entities described in this authorization to:

1. Process my Enrollment Form and collect any additional information necessary to enroll in ViiVConnect as well as verify any information I have provided for enrollment purposes.
2. Identify my health plan benefits and eligibility for health plan coverage and help resolve my insurance coverage, coding, or reimbursement issues.
3. Research alternative insurance coverage options and refer me and my Care Team to other advocacy organizations, health plans, patient support, or patient assistance programs that may be able to help me with access to my medications.
4. Communicate with my Care Team and other healthcare providers and pharmacies about my prescriptions, treatment and medical condition(s).
5. Communicate with me by phone, voicemail, text, mail, and email utilizing my contact information included on this form to provide me information about my health plan benefits, financial assistance services, and ViiV Healthcare medications. I consent to receive autodialed calls and text messages from and on behalf of ViiVConnect at the phone number I have provided. Message frequency may vary. Message and data rates may apply. I may opt out at any time by texting STOP or by contacting ViiVConnect. I understand communications may mention ViiVConnect and medications by name.
6. Provide financial assistance and support services based on ViiV's determination of my eligibility.
7. Improve or develop ViiVConnect services and for other internal administrative and business purposes, including analytics.
8. Disclose any of my personal information to third parties if required by law.

Form continued on the following page

Patient Authorization and Release continued from previous page

I understand that my Care Team will not base any medical treatment decisions on my agreement to sign this Patient Authorization and Release. I also understand that my agreement to sign this Patient Authorization and Release and enroll in ViiVConnect is not required for my valid prescription to be filled. I understand that once my personal information is collected, used, and/or disclosed based on this executed authorization, state and federal privacy laws may not prevent the persons or organizations described above from further disclosing my information.

I understand that I have a right to receive a copy of this signed authorization which will remain in effect for two (2) years, unless a shorter time period is mandated by state law. I also understand that I have the right to revoke this authorization at any time by calling 1-844-588-3288 or mailing a signed, written statement of my revocation to ViiVConnect, PO Box 5490, Louisville, KY 40255, but that such a revocation would end my eligibility to participate in the programs as described. Upon receipt and processing of written revocation of this authorization, further disclosures of your personal information will be prohibited. However, certain information may still be collected, used, and disclosed for administrative purposes by ViiV and any other companies that ViiV uses to collect, use, and disclose such information. For additional information on how ViiV handles your information, please see our privacy notice at **https://privacy.viivhealthcare.com/en-us/**

Authorization for the Sale of My Information to ViiV: I authorize my Care Team (including my healthcare providers, health plans, health insurers, and pharmacies) to disclose my personal information for the purposes described in this authorization and I further authorize my Care Team to accept payment from ViiV in exchange for providing my information.

Please read the Patient Authorization and Release, then sign below. REQUIRED

If the Patient is under 18 years of age, provide Legal Guardian information and signature.

Patient Name (Please print) | **Patient Signature** | **Date**

Legal Guardian Name (Please print) | **Legal Guardian Signature** | **Relationship to Patient** | **Date**

PATIENT COMMUNICATION PERMISSIONS

I do not wish to receive communication via the following (check all that apply): ☐ Phone ☐ Voicemail ☐ Text ☐ Mail ☐ Email

Communication permissions can be updated at any time by calling ViiVConnect.

MARKETING AUTHORIZATION AND RELEASE Optional

I request and authorize ViiV or companies working for or with ViiV to contact me for marketing purposes, including providing me with information about my medication, refill reminders, surveys, and other information and alerts that ViiV believes may be of interest to me (and some of which may be sent directly to my phone). ViiV will not sell or transfer your name, address, or email address to any other party for their marketing use. For additional information regarding how ViiV Healthcare handles your information, please see our privacy notice at **https://viivhealthcare.com/en-us/privacy-notice/**.

Patient or Legal Guardian Name (Please print) | **Patient or Legal Guardian Signature** | **Date**

Patient Authorization and Release 1.0.0823

2 Insurance Information

Please attach copies of front and back of all insurance cards

Policyholder: ☐ Self ☐ Other *(Please complete to the right)* — Policyholder (First Name, Last Name) | Relationship to Patient

Plan or Policy type: ☐ Commercial/employer ☐ Medicare ☐ Medicaid ☐ ADAP ☐ None

Medical Insurance Name

Insurance Phone #

Policy ID # | Group | Prescriber ID *(If applicable)*

Prescription Drug Plan Name

Insurance Phone #

Policy ID # *(If applicable)* | Group *(If applicable)* | BIN *(If applicable)* | PCN *(If applicable)*

Patient has secondary insurance: ☐ Yes ☐ No If "yes," indicate insurance name

If insurance information is not completed in full, ViiVConnect will reach out to you directly to obtain additional information.

Form continued on the following page

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CABENUVA (cabotegravir; rilpivirine) Enrollment Form

Patient First Name | M.I. | Patient Last Name | D.O.B. (mm/dd/yyyy)

List all current medications, over-the-counter medications, and supplements

☐ Check box if list is attached ☐ Check box if none

List all known drug allergies

☐ Check box if none

3 Injectable Prescription Information (Choose Every-2-Month or Once-Monthly Injections)

SIGNED PRESCRIPTION REQUIRED FOR PAP FULFILLMENT

This section of the form is intended as an optional way to prescribe. If your state restricts the use of this form to prescribe, or if this form does not meet your requirements to prescribe, please attach a prescription to this form. Prescribers may need to submit an electronic prescription to the specialty pharmacy.

Please check all that apply:

Prescription/Schedule	Medication	Quantity	Refills	Directions
Every-2-Month Dosing				
☐ CABENUVA 600-mg/900-mg kit	600-mg/900-mg kit: 600-mg single-dose vial of cabotegravir + 900-mg single-dose vial of rilpivirine	1 dosing kit	1 refill	**Month 1 & Month 2:** 2 injections intramuscularly
☐ CABENUVA 600-mg/900-mg kit	600-mg/900-mg kit: 600-mg single-dose vial of cabotegravir + 900-mg single-dose vial of rilpivirine	1 dosing kit	☐ **PRN refills for 1 year** *or* **# of refills** _____	**Month 4+:** 2 injections intramuscularly, every 2 months
Once-Monthly Dosing				
☐ CABENUVA 600-mg/900-mg kit	600-mg/900-mg kit: 600-mg single-dose vial of cabotegravir + 900-mg single-dose vial of rilpivirine	1 dosing kit	None	2 injections intramuscularly, once
☐ CABENUVA 400-mg/600-mg kit*	400-mg/600-mg kit: 400-mg single-dose vial of cabotegravir + 600-mg single-dose vial of rilpivirine	1 dosing kit	☐ **PRN refills for 1 year** *or* **# of refills** _____	2 injections intramuscularly, every month

**For use in once-monthly dosing schedule only.*

REQUIRED **Diagnosis ICD-10 Code:** ☐ B20: Human immunodeficiency virus (HIV) disease ☐ Other: _____

4 OPTIONAL Oral Prescription Information

Not required to start CABENUVA

Only complete this section if your Patient will be taking the optional oral lead-in to assess tolerability. If your state restricts the use of this form to prescribe, or if this form does not meet your requirements to prescribe, please attach a prescription to this form. Prescribers may need to submit an electronic prescription to the specialty pharmacy.

Prescription/Schedule	Medication	Quantity	Refills	Directions
☐ **Oral Lead-In** *(Dispensed only by TheraCom)*	cabotegravir 30-mg tablet	30 tablets	None	Take 1 tablet by mouth daily with a meal
	rilpivirine 25-mg tablet	30 tablets	None	Take 1 tablet by mouth daily with a meal

Ship oral medications to: ☐ Prescriber's Office ☐ Patient's Home Address ☐ Other *(Please complete below)* ▼

▸ Street Address | City | State | ZIP Code

5 Prescriber Information

ALL FIELDS REQUIRED

Office contact information is optional

First Name | Last Name | Practice Name

Phone # | Fax # | Street Address | City | State | ZIP Code

Office Contact Name | Office Contact Phone # | Office Contact Fax #

Prescriber Tax ID | Prescriber State License # | Prescriber Email Address | Prescriber NPI | Group NPI | Site Tax ID | PTAN/UPIN #

Prescriber Declaration

REQUIRED

By signing below, I certify that the information I have provided in this Enrollment Form is complete and accurate to the best of my knowledge. I authorize ViiVConnect 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.

Prescriber Signature *(Dispense as written)* OR **Prescriber Signature** *(Substitution permitted)* **Date**

Supervising/Collaborating MD Name *(Please print, where required)* **Collaborating Physician NPI** *(Please print, where required)*

Form continued on the following page

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6 Injection Acquisition Information

My practice will acquire the injections through: ☐ Buy & Bill ☐ Specialty Pharmacy *(Select one)** ▼ ☐ Alternative Site for Administration (ASA) ☐ Unknown/Undecided

◯ No preference
◯ Accredo Health Group, Inc
◯ AHF Pharmacy
◯ Avita Pharmacy
◯ BioPlus Specialty Pharmacy
◯ CenterWell Specialty Pharmacy
◯ Coordinated Care Network
◯ Curant Health
◯ CVS Specialty
◯ Kroger Specialty Pharmacy
◯ Mail-Meds Clinical Pharmacy
◯ MediLink RxCare Specialty Pharmacy
◯ Optum Specialty Pharmacy
◯ Walgreens Specialty Pharmacy

☐ The prescription has been sent to the preferred Specialty Pharmacy indicated above

**Preferred Specialty Pharmacy selection will be honored if permitted by Patient's insurance plan.*

7 Injections Will Be Administered at:

Please check where the Patient's injections will be administered:

☐ At my office ☐ At the following *(Please complete to the right)*

☐ To be determined *(If selected, ViiVConnect will contact you for additional details)*

Facility Name | Contact Name

Street Address | City | State | ZIP Code

Phone # | Facility NPI | Tax ID

8 Patient Assistance Program (PAP)

This section is required if applying for PAP. Prescription must accompany form†

# of People Living in Household Who Contribute to, or are Dependent on, Patient's Household Income

Total Household Income

1. What is the Patient's ADAP status? ☐ Active ☐ Denied ☐ Wait-listed ☐ Pending ☐ Not Applied/Not Eligible

2. Is the Patient enrolled in a Medicare plan, including Part A, Part B, Part D, or Advantage plans? ☐ Yes ☐ No

- *If "yes," eligibility requires documentation indicating the Patient paid at least $600 on prescription drugs in the current calendar year and including the Member Benefit ID# (MBI).*

MBI#

3. Is the Patient eligible for any state or federal prescription drug coverage plan, such as Medicaid or Puerto Rico's Government Healthcare Program, Mi Salud? ☐ Yes ☐ No

4. Does the Patient have any private prescription drug coverage (including employer-sponsored plans, private group plans, Marketplace plans/exchanges, etc)? ☐ Yes ☐ No

- *If "yes," please indicate why assistance is needed.*

5. Is the patient enrolled in an Alternate Funding Program? ☐ Yes ☐ No

- *If "yes," patients enrolled in an Alternate Funding Program are not eligible for ViiV PAP assistance.*

I authorize ViiV to obtain a consumer report on me. My consumer report and information derived from public and other sources will be used to estimate my income as part of the process to decide if I am eligible to receive free medication through the ViiV Patient Assistance Program. I understand that upon request, ViiV will provide me the name and address of the consumer reporting agency that provided the consumer report.

†*Visit ViiVConnect.com or call 1-844-588-3288 for information on Patient eligibility for PAP.*

View Checklist and Submission Instructions on Next Page

Form continued on the following page

CABENUVA (cabotegravir; rilpivirine) Enrollment Form

Checklist

Before you submit this form, please ensure you've completed all necessary steps:

☐ **1. Have you signed and dated the form?**
If not, please sign the Prescriber Declaration at the bottom of the page 3.

☐ **2. Has your Patient signed and dated the form?**
If not, please have your patient sign the Patient Authorization section on page 2.

☐ **3. Have you selected the appropriate number of refills?**
If not, please complete section 3 on page 3.

Two Ways to Submit This Form

Complete, sign, and electronically submit all pages of this form and applicable corresponding documents (including the prescription) by following one of the methods below:

Upload the form to the ViiVConnect Provider Portal at ViiVConnectPortal.com

Fax the form to 1-844-208-7676 (toll-free)

For assistance, please call 1-844-588-3288 (toll-free), Monday through Friday, 8 AM to 11 PM (ET).