# ZYDELIG® AccessConnect® Nurse Support Enrollment Form

**Monday–Friday, 8AM to 5PM ET**
**Phone: 1-844-6ACCESS (1-844-622-2377)**
**Fax: 1-855-553-8672**
www.ZYDELIGAccessConnect.com

Remembering to take your medication can be challenging, and you may need some assistance. The ZYDELIG® AccessConnect® Nurse Support program offers a team of dedicated patient support nurses who can answer questions and provide tips related to your therapy. To enroll in the ZYDELIG AccessConnect Nurse program directly, complete these 5 easy steps!

**1.** Ensure to date and sign your name in the Patient Authorization section.
**2.** Complete all fields of the Patient Information section.
**3.** Indicate on this form if you are interested in more information about additional AccessConnect Support Offerings, including Access and Financial support.
**4.** Provide contact details for your healthcare provider so AccessConnect can work together with him or her.
**5.** Submit this complete Enrollment Form to ZYDELIG® AccessConnect® by:
- **Fax 1-855-553-8672 or**
- **Mail 200 Pinecrest Plaza, Morgantown, WV 26505.**

For any questions, please contact ZYDELIG® AccessConnect® at **1-844-6ACCESS** or 1-844-622-2377 anytime from 8AM–5PM ET.

## 1. Patient Information

Patient Name (First, MI, Last): _____ Birth Date (MM/DD/YYYY): _____ Gender: ☐ Male ☐ Female

Address: _____ City: _____ State: _____ ZIP Code: _____

Email: _____ Language: ☐ English ☐ Other (please indicate): _____

Phone: _____ Best Time to Contact: ☐ Morning ☐ Afternoon ☐ Evening

☐ Home ☐ Cell

Alternate Contact: _____ Phone: _____ Relationship: _____

## 2. Support Requested

I am requesting information:

☐ Nurse Support
☐ Other ZYDELIG® AccessConnect® Support Offerings, including Access and Financial support

If selecting Other ZYDELIG® AccessConnect® Support Offerings, an AccessConnect Case Specialist will contact you.
Your Case Specialist will work with you and your doctor to obtain the requested information, but cannot guarantee access to support.

## 3. Prescriber Information

Prescriber Name (First, Last): _____

Phone: _____ Fax: _____ Email: _____

Facility Name: _____

Address: _____ City: _____ State: _____ ZIP Code: _____

AccessConnect Nurses want to work with your healthcare provider to obtain the support information you need. We will stay in touch with him or her throughout the process.

Please see full Prescribing Information, including Medication Guide with **important warnings** at zydelig.com.

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Zydelig® (idelalisib) 150 mg 100 mg tablets
ACCESS CONNECT®

## 4. Patient Authorizations

I understand that I must complete this enrollment form before I can receive assistance through Gilead Sciences, Inc.'s Access Connect ("Program") and the Patient Assistance Program ("PAP"). As part of this process, Gilead and its agents and contractors (collectively, "Gilead") 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 Gilead in connection with the Program and/or the PAP, all in accordance with this authorization, and I authorize Gilead 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, mailing address, financial information, and insurance information), my health information, such as my current and future medical condition (including information about my 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 Whom My Information May Be Disclosed: Gilead, including the third-party administrator responsible for the administration of the Program and the PAP.

Purposes for Which the Disclosures Are to Be Made: Disclosures of PHI may be made to Gilead so that Gilead may use and disclose the PHI for purposes of: 1) completing the enrollment process and verifying my enrollment form; including but not limited to confirming my identity and my use or potential use of this prescription medication and prescribed through my relationship with the prescriber identified in Section 3; 2) establishing my eligibility for benefits from my health plan or other programs; 3) providing financial assistance and reimbursement support, if I am eligible, and providing other applicable support, including, but not limited to information on third-party resources that may be able to assist me; 4) communicating with my healthcare providers, including, but not limited to, verifying my enrollment and facilitating the provision of my prescription medication to me; 5) contacting me to evaluate the effectiveness of the Program and/or the PAP; 6) Gilead's internal business purposes, including quality control; 7) audit and compliance purposes, including but not limited to case reviews and support enhancing surveys; 8) sending me marketing information, offers, and educational materials related to my medical condition, 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 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 AccessConnect and/or the PAP. I also understand that I may also cancel this authorization at any time by **writing a letter to Gilead and faxing to 1-855-553-8672 or by calling 1-844-622-2377.** If I cancel, Gilead 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 ten (10) years from the date it is signed by me or other time period required under the laws of the state in which I reside.

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## 4. Patient Authorizations (continued)

☐ (OPTIONAL) By checking this box, I agree to receive marketing information on offers, educational materials, and market research related to my medical condition, treatment and/or my prescription medication. I also agree to participate in any future customer relationship marketing program, if requested.

Ensure this form is filled out completely and sign your name in this section prior to submitting.

**Patient Name:** _____

**Patient Signature:** _____ **Date:** _____

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