ZYDELIG® AccessConnect® Enrollment Form

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

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

ZYDELIG AccessConnect is a central resource with tools designed to help all patients, regardless of financial need, navigate therapy and support offerings.
To enroll your patients in ZYDELIG AccessConnect, fax this completed Enrollment Form to ZYDELIG AccessConnect at **1-855-553-8672**.

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 ☐ OK to leave detailed messages

Alternate Contact: _____ Phone: _____ Relationship: _____

2. Insurance Information

Please attach front and back copies of all Medical and Pharmacy Insurance Cards

Is patient insured? ☐ No ☐ Yes Primary Insurance: _____ Insurance Telephone: _____

Policy ID # : _____ Group #: _____ Rx BIN #: _____ Rx PCN #: _____

Policyholder Name (First, Last): _____ Policyholder Relationship to Patient: _____

3. Requested Patient Support Offerings

All support offerings include Full Reimbursement Support, Nurse Support, Copay Coupon Card, Independent Foundation Information, QuickStart, and Patient Assistance Program Referral.

☐ All Support Offerings

If all support offerings are not required, please identify specific support needed:

☐ Copay Coupon Card or Independent Foundation Information
☐ Nurse Support Program
☐ Patient Assistance Program Referral

4. Pharmacy Preference

☐ Onsite Dispense

Preferred Specialty Pharmacy:
☐ Accredo ☐ OptumRx ☐ Biologics ☐ CVS Specialty ☐ Onco360

☐ I have sent a prescription to the pharmacy
☐ I need AccessConnect to send the prescription to the pharmacy

5. Diagnosis and Prescription Information

Pharmacy Prescription Product: ZYDELIG Dose: ☐ 150 mg taken orally, twice daily ☐ 100 mg taken orally, twice daily

Line of Therapy: ☐ 2L ☐ 3L ☐ 4L ☐ Other: _____ Quantity: _____ Day Supply: _____ Refills: _____

Diagnosis (ICD-10 code): _____

Patients experiencing insurance delays of greater than 5 days may be eligible for QuickStart. QuickStart is dosed at 150 mg orally, twice daily.
Eligible patients will receive 60 tablets for a 30-day supply. Please complete the QuickStart authorizations.

Additional Directions: _____

6. Prescriber Information and Certificate of Statement of Medical Necessity

Prescriber Name (First, Last): _____

Phone: _____ Fax: _____ Email: _____

Facility/Practice Name: _____

Specialty: _____ NPI #: _____ State License #: _____

Clinical/Medical Contact: _____ Phone: _____

Reimbursement Contact: _____ Phone: _____

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

By signing this form, I certify that I am prescribing Gilead medication for the patient identified in Section 1. 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 the patient's treatments and verify that the information provided is complete and accurate to the best of my knowledge. I agree that I shall not seek reimbursement for any Gilead medication dispensed to the patient through the ZYDELIG Patient Assistance Program (PAP) or from any government program or third-party insurer.

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: 1) verifying the patient's insurance coverage and eligibility for benefits; 2) seeking prior authorization if needed on the patient's behalf; 3) providing financial assistance, support, and referral support as needed; 4) facilitating the provision of the patient's prescription medication to the patient; 5) contacting the patient with educational materials about the patient's prescription medication or to evaluate the effectiveness of the AccessConnect and/or the Patient Assistance Program; and 6) for Gilead's internal business purposes. I authorize Gilead to transmit this prescription to the appropriate pharmacy designated by the patient utilizing their benefit plan.

Prescriber Signature REQUIRED – (no stamp allowed): _____ **Date:** _____

DISPENSE AS WRITTEN

Please see full Prescribing Information, including **BOXED WARNING** at ZYDELIG.com.

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7. QuickStart Program Authorizations

The QuickStart Program provides eligible patients with 1 free bottle that includes a 30-day supply of ZYDELIG 150 mg tablets. There is no purchase obligation by virtue of a patient's participation in the QuickStart Program. A minimum 5-business-day insurance verification period is required for patients to be eligible for the QuickStart Program. Patients must have an on-label prescription for ZYDELIG, consistent with the FDA-approved label for ZYDELIG, and be enrolled in the ZYDELIG AccessConnect Program to qualify. Free product for the QuickStart Program will only be available through the QuickStart Specialty Pharmacy. Patients receiving free product under the QuickStart Program may not seek reimbursement or credit for this prescription from any insurer, health plan, or government program.

For any patient that is a member of a Medicare Part D plan, this prescription, or any cost associated with it, may not be counted as part of their out-of-pocket cost for prescription drugs. An extension period beyond the initial 30-day supply is limited to commercially insured patients and individual approval is required.

By signing below, if I receive free product through the QuickStart Program, I certify that I will not seek reimbursement or credit for this prescription 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 prescription or any cost associated with it counted as part of my out-of-pocket cost for prescription drugs.

Patient/Patient Representative Name: _____ **Relationship to Patient:** _____

Patient/Patient Representative Signature: _____ **Date:** _____

By signing below, I certify that this prescription is on label and the patient has not yet started ZYDELIG treatment. I read and understand the QuickStart Program terms and conditions and I agree that I shall not seek reimbursement for any Gilead medication dispensed to the patient through the QuickStart Program from any government program or third-party insurer.

Prescriber Name: _____

Prescriber Signature (no stamps allowed): _____ **Date:** _____

8. Gilead Patient Assistance Program (PAP) Application

Phone Number: 1-855-536-7102 Fax Number: 1-855-850-3007

Current Annual Household Income: $ _____ Number of Persons in Household: 1 2 3 4 5 6 _____

Social Security Number: _____ Are you a U.S. Resident? ☐ Yes ☐ No

Please include current documentation for all sources of income (e.g., most recent tax return, W-2, last 2 pay stubs, 1099, SSI award letter etc.).
If patient household income is $0, indicate how the patient is being supported: _____

Patient's full Social Security Number is required to run soft-credit check. This field will be optional. If left blank, PAP may follow up with the patient.

I certify that all of the information provided in this application, including household income, is complete and accurate. I understand that program assistance will terminate if the program becomes aware of any fraud or if this medication is no longer prescribed for me. I understand that completing this application does not ensure that I will qualify for patient assistance. If I receive product through the PAP, I certify that I will not seek reimbursement or credit for this prescription 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 prescription or any cost associated with it counted as part of my out-of-pocket cost for prescription drugs. I understand that the 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 the PAP and its administrator to forward this prescription to a dispensing pharmacy on my behalf.
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 PAP.

Patient/Patient Representative Name: _____ **Relationship to Patient:** _____

Patient/Patient Representative Signature: _____ **Date:** _____

(REQUIRED ONLY IF APPLYING FOR PAP)

By signing below, I certify that I am prescribing Gilead medication for the patient identified, and I certify that this prescription medication is medically indicated for the patient and that it will be used as directed. I certify that I will be supervising the patient's treatment and verify that the information provided is complete and accurate to the best of my knowledge. I agree that I shall not seek reimbursement for any Gilead medication dispensed to the patient through the Patient Assistance Program (PAP) from any government program or third-party insurer.

Prescriber Name: _____

Prescriber Signature (no stamps allowed): _____ **Date:** _____

(REQUIRED ONLY IF APPLYING FOR PAP)

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9. 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 ZYDELIG 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 6; 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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9. Patient Authorizations

☐ (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/Patient Representative Name (REQUIRED): _____ **Relationship to Patient:** _____

Patient/Patient Representative Signature (REQUIRED): _____ **Date:** _____

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