TRODELVY™ ACCESS SUPPORT

2730 S. Edmonds Ln, Suite 300, Lewisville, TX 75067
Phone: 1-844-876-3358 | Fax: 1-833-851-4344 | Monday-Friday, 9 AM to 7 PM ET

Patient Enrollment Form

☐ Benefits Investigation and Coverage Determination for **TRODELVY™ (sacituzumab govitecan-hziy) 180 mg for injection**

☐ Refer patient to TRODELVY™ Savings Program (Patient to complete and sign on page 2)

PATIENT INFORMATION

First name:		Last name:		DOB:
Address:				City:
State:	ZIP:	SSN:	US Resident: ☐ Yes ☐ No	Gender: ☐ Male ☐ Female
Cell phone:		Home phone:		Email:
Alternate contact/caregiver:			Alternate contact/caregiver phone:	
Preferred contact method: ☐ Cell # ☐ Home # ☐ Email			Best time to call: ☐ Morning ☐ Afternoon ☐ Evening	

INSURANCE INFORMATION

Please attach a front and back image of the patient's insurance card. This section does not need to be filled out if images of the patient's insurance card are attached.

☐ No insurance

Primary insurance name:		Secondary insurance name:	
Phone:	Subscriber name:	Phone:	Subscriber name:
Medicaid Provider ID #:		Medicaid Provider ID #:	
Subscriber ID #:		Subscriber ID #:	
Policy/Group #:		Policy/Group #:	
Site of Service:			
Diagnosis:	Has the patient tried 2 prior therapies? ☐ Yes ☐ No	ICD-10 code:	

PATIENT CERTIFICATION AND SIGNATURE

My signature below certifies that I have completed all of the above sections completely, accurately, and to the best of my knowledge, and that I have read, understand, and agree to the Patient Authorization to release my Protected Health Information as indicated on the reverse side of this form (page 2), including, but not limited to, spoken or written facts about my health and payment benefits that I may have. I understand Protected Health Information may include copies of records from my healthcare providers or health plans about my health or healthcare. I understand, accept, and will comply with all requirements and restrictions described in the eligibility requirements provided on the back of this form.

Patient signature: X		Date:
Guardian signature: X	Relationship to patient:	Date:

Please be sure the applicant signs and dates this section in each place indicated. This enrollment cannot be processed without the patient's signatures.

PRESCRIBER INFORMATION

First name:		Last name:		Practice name:
Address:				City:
State:	ZIP:	Tax ID #:	NPI #:	Group NPI #:
Office contact:		Office phone:		Office fax:

PHYSICIAN CERTIFICATION AND SIGNATURE

By signing this enrollment form, I certify that I have prescribed TRODELVY™ based on my professional judgment of medical necessity for an FDA-approved indication, and that I will supervise the patient's medical treatment. I authorize the release of medical and/or other patient information relating to TRODELVY™ therapy to agents and service providers of Gilead (including, but not limited to, Sonexus Health LLC) to use and disclose as necessary for fulfillment of the prescription and to furnish any information on this form to the insurer of the above-named patient for the purpose of verifying benefit eligibility and obtaining coverage authorization.

Prescriber's signature: X_____ *(No stamps accepted)* *(Original signature required-*If required by applicable law, please attach copies of all prescriptions on official state prescription forms)*	Date:

Please be sure the Physician signs and dates this section in each place indicated. This enrollment cannot be processed without the Physician's signature.

Click here for the full Prescribing Information, including BOXED WARNING, and Patient Information.

TRODELVY™
sacituzumab govitecan-hziy
180 mg for injection

GILEAD

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PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PERSONAL AND HEALTH INFORMATION

By signing this Authorization, I authorize each of my physicians, pharmacists, including any specialty pharmacy that receives my prescription for TRODELVY™, and other healthcare providers (together "Healthcare Providers"), and each of my health insurers (together, "Insurers"), to disclose my Protected Health Information, including, but not limited to, medical records, information related to my medical condition and treatment, my health insurance coverage, my name, address, telephone number, Social Security number, insurance plan and/or group numbers (together, "Protected Health Information") to Gilead, its affiliated companies, vendors, agents, collaboration partners, and representatives (together, "Gilead") including providers of alternate sources of funding for prescription drug costs, and other service providers supporting access programs for Healthcare Providers and patients for the purposes described below.

Specifically, I authorize disclosure of my Protected Health Information in order to:

I. Enroll me in, and contact me about, TRODELVY™ ACCESS SUPPORT, including benefits investigation support, and verify eligibility for TRODELVY™ Savings Program and Patient Assistance Program
II. Provide me with educational materials, information, and services related to my treatment experience with TRODELVY™
III. Verify, investigate, assist with, and coordinate my coverage for TRODELVY™ with my Insurers
IV. Contact me to conduct surveys in relation to my experience with TRODELVY™ ACCESS SUPPORT
V. Allow for data analytics, market research, other internal-related business activities, and use for communications with healthcare providers

I understand once my Protected Health Information has been disclosed to Gilead, federal privacy laws no longer protect the information. However, Gilead agrees to protect my Health Information by using and disclosing it only for the purposes described in this Authorization or as permitted by law.

I understand that I may refuse to sign this Authorization. My choice about whether to sign will not change the way my Healthcare Providers or Insurers treat me. If I refuse to sign the Authorization, or revoke my Authorization later, I understand that this means I will not be able to participate or receive assistance from TRODELVY™ ACCESS SUPPORT.

☐ I do not want to receive any marketing educational materials, or be contacted to conduct surveys or marketing research.

This Authorization will last until I am no longer participating in TRODELVY™ ACCESS SUPPORT. I understand that I may cancel this Authorization at any time by mailing a request to 2730 S. Edmonds Ln, Suite 300, Lewisville, TX 75067 or by calling 1-844-876-3358. I understand that revoking this Authorization will end further uses and disclosure of my Protected Health Information by the parties identified above except to the extent those uses and disclosures have been made in reliance upon this Authorization as permitted by applicable law. I am entitled to receive a copy of this Authorization.

PATIENT CONSENT FOR TRODELVY™ SAVINGS PROGRAM

I understand that completing this form does not ensure that I will qualify for the TRODELVY™ Savings Program. I represent that the information provided in this enrollment form is complete and accurate. I agree to notify and shall be responsible for notifying the program administrator for the TRODELVY™ Savings Program if I no longer meet the criteria for the TRODELVY™ Savings Program or if my insurance status changes. I understand that Gilead reserves the right at any time and without notice to me to modify and/or discontinue any or all of the TRODELVY™ Savings Program, including modification of eligibility criteria and immediate termination of assistance provided by the TRODELVY™ Savings Program. I understand that I may decline to sign this form and decline being considered for the TRODELVY™ Savings Program.

I request assistance with out-of-pocket costs of TRODELVY™ and hereby authorize and direct the TRODELVY™ Savings Program, sponsored by Gilead, to issue payment directly to the practice infusing the drug.

Patient name:	Signature: X	Date:
Name of legal representative:	Signature: X	Date:

Please be sure the applicant signs and dates this section in each place indicated. This enrollment cannot be processed without the patient's signatures.

Click here for the full Prescribing Information, including BOXED WARNING, and Patient Information.

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