TRODELVY™ ACCESS SUPPORT

Patient Enrollment Form

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

☐ 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

CLEAR FORM

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:		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 form, I certify that I am personally prescribing or furnishing Gilead medication to the patient identified in the section above. I certify that this prescription medication is medically necessary for the patient. I certify that I will be supervising or coordinating the patient's treatments, in accordance with law, and verify that the information provided as part of the patient's application is complete and accurate to the best of my knowledge.

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 assessing the patient's insurance coverage and eligibility for participation in Trodelvy Access Support, conducting random audits to verify the information provided on this enrollment form, and for other purposes as listed in the patient Authorization For Use and Disclosure of Personal Health Information. Gilead is authorized to contact me about the information provided on this form and as needed to facilitate my patient's enrollment and participation in Trodelvy Access Support. I understand that Gilead may, if authorized by the patient, contact the patient directly to verify eligibility and updates to insurance coverage.

PRESCRIBER'S SIGNATURE: (NO STAMPS ACCEPTED) X_____ *(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

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PERSONAL AND HEALTH INFORMATION

I understand that Gilead Sciences, Inc., and its agents, contractors, and other partners ("Gilead") will need to obtain, review , use and disclose my personal and medical information before I can receive assistance through the TRODELVY™ ACCESS SUPPORT program (the "Program").

Information to Be Disclosed: My personal Information ("PI") may include:

- Information about me, including my name, birth date, and contact information
- Protected Health Information ("PHI") as defined under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") as amended by the Health Information Technology for Economic and Clinical Health Act ("HITECH"), such as information about my medical condition, including information about my status or treatment with this prescription medication and related medical condition
- Information about my health benefits or health insurance coverage, and important financial information (as necessary)
- All information provided on this enrollment form

Persons Authorized to Disclose and Use My Information: I authorize the following parties to disclose my PI to Gilead and its partners:

- My healthcare providers, including any pharmacy that fills my prescription medication. I understand that my pharmacy providers may receive remuneration for disclosing my PI pursuant to this authorization
- Any health plans or programs that provide me with healthcare benefits

I also authorize Gilead and its partners to disclose my PI to the following parties:

- My healthcare providers, including the pharmacy that fills my prescription medication
- My health plans
- My authorized representative under federal or state law (if applicable)

Purposes for Which My Information May Be Used and Disclosed: My PI may be used and disclosed for the following purposes:

- Completing the enrollment process and verifying the information provided on my enrollment form, including confirming my identity and my use or potential use of the medication prescribed by my prescriber
- Establishing my eligibility for benefits from my health plan or other programs
- Providing financial assistance and reimbursement support, if I am eligible, and providing other applicable support, including information on third-party resources that may be able to assist me
- Communicating with my healthcare providers and coordinating my prescription and medication through a pharmacy or healthcare provider's office
- Contacting me to evaluate the effectiveness of the Program
- Gilead's internal business purposes and audit and compliance purposes
- Confirming my receipt of the prescribed Gilead medication through the PAP based on my communication preferences above

Length and Terms of Patient Authorization:

- I understand that I may choose not to sign this authorization. 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 the Program
- I understand that I am entitled to a copy of this signed authorization, which expires the earlier of two (2) years from the date it is signed by me or other time period required under the laws of the state in which I reside
- I understand that I may cancel this authorization at any time by notifying Gilead at 1-844-876-3358. If I cancel, Gilead will stop using this authorization to obtain, use, or disclose my PI after the cancellation date, but the cancellation will not affect uses or disclosures of any PI that have already been made pursuant to this authorization before the cancellation date

☐ **Marketing Communications Opt-in (OPTIONAL):** By checking this box, I agree to receive marketing information, offers, and educational materials related to my medical condition, treatment, and/or my prescription medication, including the customer relationship marketing program, via one or more of the communication methods agreed to above. The marketing outreach program is separate from the PAP. I understand that opting in to the marketing outreach program is not required as a condition of purchasing any goods or receiving a co-pay or other support from Gilead.

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.

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