GILEAD

PATIENT ASSISTANCE PROGRAM

With the Gilead Patient Assistance Program (PAP), patients who are uninsured or underinsured may be eligible to obtain access to TRODELVY® (sacituzumab govitecan-hziy) 180 mg for injection at no cost.

To determine eligibility:

☑ Fax completed form to **1-833-851-4344** or mail to:

TRODELVY™ ACCESS SUPPORT
2730 S. Edmonds Ln, Suite 300
Lewisville, TX 75067

☑ Please make sure that both the **healthcare provider** (page 1) and **patient** (page 2) sign and date the application

A Case Manager will contact your office with determination of patient eligibility. Should you have any questions about the services offered through the PAP, please contact:

TRODELVY™ ACCESS SUPPORT
1-844-876-3358
Monday through Friday, 9 AM–7 PM ET

CLEAR FORM

▶ **Has the patient tried 2 prior therapies?** ☐ **Yes** ☐ **No**

ADMINISTERING PROVIDER INFORMATION

Administering Provider Name:				
Facility Name:		Facility Address:		
City/State/ZIP Code:				
Primary Contact Name:		Title:		
Phone:			Extension:	Fax:
Tax ID #:	NPI #:	State License #:	Medicaid Provider ID #:	Expiration:

DIRECT-TO-HEALTHCARE PROVIDER DISTRIBUTION

COMPLETE ONLY IF THE SHIPPING ADDRESS IS DIFFERENT FROM THE ADMINISTERING PROVIDER ADDRESS

Site:	Contact Name for Shipment:	
Address:		
City/State/ZIP Code:		
Business Hours:	Phone:	Fax:

PRESCRIPTION AND HEALTHCARE PROVIDER CERTIFICATION:
TRODELVY® (sacituzumab govitecan-hziy) 180 mg for injection

Patient Name:	Patient DOB:	Patient Weight (lbs/kg):
Patient Address:		
Diagnosis:	ICD-10 code:	
TRODELVY® (sacituzumab govitecan-hziy) for injection for intravenous use, lyophilized powder in single-use vials containing 180 mg per vial		
Dosage and Directions: _____mg (10 mg/kg) once weekly on Days 1 and 8 of continuous 21-day treatment cycles.	Quantity (number of vials) To Be Dispensed:	
Number of Treatment Cycles/Number of Refills:		

By signing this form, I certify that I am personally prescribing or furnishing Gilead medication for the patient identified 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 my patient's application for the Patient Assistance Program ("PAP") is complete and accurate to the best of my knowledge. I certify that I have not received and shall not seek reimbursement for any Gilead medication administered to the patient through the PAP from any government program or third-party insurer. If applicable, I certify that medication provided to me by the PAP for the eligible patient identified will be provided by me to such patient for his or her own use without charge. I certify that I will not otherwise use any such medication or prescribe, provide, furnish, dispense, or administer all or any portion thereof to any other person or patient. I will notify Gilead if all or any portion of the medication provided to me by the PAP for the patient identified is not prescribed, provided, furnished, dispensed, or administered to that patient, and I will ensure such medication is returned to Gilead or its designated representative, by calling 1-844-876-3358 within 30 days. I certify that I will not sell, resell, offer for sale, trade, or barter medication provided to me under the PAP.

II consent that Gilead may perform an audit related to: 1) the applicant identified, including but not limited to confirming patient identity and verifying medical necessity; and 2) the dispensing of medication provided to the prescriber through the PAP, including confirming patient receipt of the administered Gilead medication and the timely return of any medications received for, but not dispensed to, the patient identified, if applicable.

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, conducting random audits to verify the information provided on this enrollment form, and for other purposes as outlined 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 PAP. I understand that Gilead may, if authorized by the patient, contact the patient directly to verify eligibility and updates to insurance coverage, as well as to confirm the receipt of Gilead medication through the PAP.

I understand that completing this enrollment form does not guarantee that assistance will be provided to my patient. My patient has given consent for me to receive their Gilead medication on their behalf. I will receive and secure my patient's medication at my office until it's administered to my patient, when applicable. Any medications supplied by Gilead as a result of this enrollment form are for the use of the patient named on this form only and shall not be sold, traded , bartered, transferred, returned for credit or submitted to any third party (such as Medicare, Medicaid, or other benefit provider) for reimbursement. The medicine will be provided only to this eligible and enrolled patient at no charge of any kind. The information provided on this enrollment form is subject to random audits and verification. Gilead may change or cancel this program at any time; Gilead also reserves the right to terminate my patient's enrollment at any time. If medicine is not provided to my patient within 30 days of receipt, medicine must be returned to the Sonexus Health Pharmacy Solutions. Healthcare facility may be subject to audits by Gilead and its third-party audit firm.

HEALTHCARE PROVIDER SIGNATURE: X_____ If you are requesting access to TRODELVY™ and you are a New York State Prescriber, attach your order for TRODELVY™ on your NYS official prescription form.	**DATE:**

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

The patient must sign the authorization below and submit it with the rest of the application. If approved, the patient's TRODELVY® (sacituzumab govitecan-hziy) 180 mg for injection will be sent to their treating facility.

PATIENT INFORMATION

Patient Name:		Patient DOB:	
Patient Address:			
City/State/ZIP Code:		Legal US Resident: ☐ Y ☐ N	Gender:
Patient Phone:	Patient Email:	OK to Contact? ☐ Y ☐ N	
Insurance Status: ☐ Uninsured ☐ Insured			
If insured, please provide the reason for this application. If uninsured, PAP will require documentation of denied coverage:			
Diagnosis:			
Primary Insurance:	Policy #:	Phone #:	

PATIENT FINANCIAL INFORMATION (TO BE PROVIDED BY THE PATIENT)

Annual Household Income: $	**NOTE:** Income documentation may be required to assess Gilead PAP eligibility for uninsured patients. Acceptable forms of documentation include the most recent copy of US federal tax return, Social Security income statements, recent pay stubs, etc.
Number of people in the household dependent on said income:	

PATIENT AUTHORIZATION FOR PAP

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 Gilead PAP becomes aware of any false or inaccurate information or if this medication is no longer prescribed for me. Gilead PAP may require me to submit proof of identity and income documentation to verify my eligibility into the Patient Assistance Program (PAP) (eg, identification card, tax return, W-2, last two pay stubs, etc).

I understand that completing this application does not ensure that I will qualify for patient assistance. If I receive free product through the PAP, I certify that I will not seek reimbursement or credit for this medication from any insurer, health plan, or government program.

I understand that if I receive free product through the PAP, it is for my own use and personal consumption and that I will not offer the product for sale, resale, barter, or trade. 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 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. I may refuse to sign this authorization without any effect on my care or treatment from my healthcare provider. However, if I refuse to sign this form, I acknowledge that I will not be eligible to receive free product through the Gilead PAP. I can cancel this authorization at any time by mailing a written request to TRODELVY™ ACCESSSUPPORT 2730 S. Edmonds Ln, Suite 300, Lewisville, TX 75067 or by calling 1-844-876-3358. This cancellation will not affect any use or disclosure of my information made prior to receiving notice of cancellation.

PATIENT'S OR PATIENT REPRESENTATIVE'S NAME:	**DATE:**
PATIENT OR PATIENT REPRESENTATIVE'S SIGNATURE: X_____	**DATE:**
If signed by the patient's representative, include a description of the representative's relationship to the patient and such person's authority to act for the patient (eg, parent, guardian, etc):	

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