Patient Enrollment Form

To view your patient shipment history, refills and reimbursement alerts, register online at ***www.allyhcpportal.com***

CAYSTON ACCESS PROGRAM®

For Cayston® (aztreonam for inhalation solution)

1-877-7CAYSTON (1-877-722-9786) Fax: 1-877-550-1705

1. Request

☐ Benefit Investigation and Pharmacy Triage
☐ CAP Enrollment (Benefit Investigation/Pharmacy Triage not included)
☐ Patient Assistance Program (PAP)

2. Pharmacy Preference

☐ Accredo Health Group, Inc. ☐ Foundation Care ☐ IV Solutions, a Maxor company
☐ Kroger Specialty Pharmacy ☐ Pharmaceutical Specialties LLC, a Maxor company
☐ Walgreens Specialty

Has the patient's Rx already been sent to the Pharmacy? ☐ Yes ☐ No Pharmacy Name: ____________

3. Patient Information

First Name: ____________ Last Name: ____________ Date of Birth: ____/____/____ Gender: ☐ M ☐ F

Address: ____________ City: ____________ State: ______ Zip Code: ______

Primary Contact: ____________ Relationship: ____________

Home Ph:(____) ____________ Work Ph:(____) ____________ Cell Ph:(____) ____________ Email: ____________

Preferred Ph: ☐ Home ☐ Work ☐ Cell Preferred Language: ☐ English ☐ Other: ____________

Alternate Contact/Caregiver/Parent: ____________ Phone Contact: ____________

4. Insurance Information (If you are attaching copies, you do not need to complete the insurance information below)

☐ Check here if you are attaching a copy (front and back) of the patient's insurance card(s).

Is the patient currently enrolled in or has the patient recently applied for a government-funded program such as Medicare, Medicaid, VA, DoD, or TriCare, a qualified health plan (QHP) or a plan offered on a state or federal marketplace or exchange? ☐ Yes ☐ No

Prescription Drug Card: ☐ Yes ☐ No Prescription Drug Insurer Name: ____________ Phone:(____) ____________

Card Holder Name: ____________ ID #: ____________ Group #: ____________ BIN #: ____________ PCN #: ____________

Primary Insurance: ____________ Phone:(____) ____________ Card Holder Name: ____________

ID #: ____________ Group #: ____________

Secondary Insurance: ____________ Phone:(____) ____________ Card Holder Name: ____________

ID #: ____________ Group #: ____________

5. Prescriber Information

Prescriber First Name: ____________ Prescriber Last Name: ____________ Credentials: ☐ MD ☐ DO ☐ NP ☐ PA ☐ Other: ______

Practice/Institution: ____________

Address: ____________ City: ____________ State: ______ Zip Code: ______

Work Ph:(____) ____________ Ext: ______ Fax:(____) ____________ E-mail: ____________

Tax ID #: ____________ NPI #: ____________ Medicaid ID #: ____________

State License #: ____________

Practice Contact: ____________ Title (choose one): ☐ Nurse ☐ Social Worker ☐ Case Manager ☐ Other: ______

Address: ____________ City: ____________ State: ______ Zip Code: ______

Work Ph:(____) ____________ Ext: ______ Fax:(____) ____________ E-mail: ____________

6. Diagnosis and Clinical Information (This is for insurance purposes only, not to suggest approved uses or indications)

☐ Cystic Fibrosis (E84.9) ☐ Cystic Fibrosis with Pulmonary Manifestations (E84.0) ☐ *Pseudomonas aeruginosa* (B96.5) ☐ Other (Include ICD-10 Code): ____________

FEV_1 Percent Predicted: ☐ <25% ☐ ≥25% - ≤75% ☐ >75%

Other medications: ____________

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Cayston Access Program, 6931 Arlington Road, Suite 308, Bethesda, Maryland 20814, Monday-Friday 8AM - 8PM EST

Gilead Sciences, Inc. reserves the right to modify or discontinue the Cayston Access Program or terminate assistance at any time.
Third-party reimbursement is affected by a range of factors; therefore, Gilead Sciences, Inc. cannot guarantee any coverage or reimbursement.

7. Prescription Information

Is the patient new to Cayston treatment? ☐ Yes ☐ No

Rx Type: ☐ Cayston 75mg per vial, 28-Day Kit
(Note: Altera handset to be included in each shipment)

Qty: ☐ 28-day supply Refills: ____________________

SIG: ____________________

Special Instructions: ____________________

Drug Allergies: ____________________

☐ No Known Allergies

Altera® Nebulizer System
(Includes Controller, 1 additional Altera Handset, Nebulizer Connection Cord, AC Power Supply, 4 AA Batteries)

Dispense: ☐ 1 Altera Nebulizer System

By signing below, I certify that (1) the above therapy is medically necessary; (2) I have received the appropriate permission from the patient and met any other applicable requirements imposed under the Health Insurance Portability and Accountability Act of 1996 and applicable state law needed to release the above information to Gilead and contractors designated by Gilead for the purposes of verifying the patient's insurance coverage for CAYSTON® and the ALTERA®Nebulizer System, seeking prior authorization for CAYSTON and the ALTERA Nebulizer System, if needed, on my patient's behalf, providing information on appeals of denials of claims, coordinating delivery of CAYSTON and the ALTERA Nebulizer System to my patient's preferred site, and providing me and my patient with other educational and support services associated with CAYSTON and the ALTERA Nebulizer System; (3) I will not sell or bill any free product received in my office; and (4) I authorize the above prescription to be forwarded to the pharmacy chosen by the named patient. I understand that I must comply with my state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc.

Prescriber Signature (Required): ____________________ Date (Required): ____________
(No Stamps Allowed – Dispense as written)

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8. Patient Authorization and Consent (Read and Sign)

Patient Name:________________________ Date of Birth: _____/_____/_____

As further described below, I hereby authorize my providers and health plans to share my personal and medical information as described below with Gilead Sciences, Inc., the manufacturer of CAYSTON® (aztreonam for inhalation solution, 75 mg) ("Cayston"), and its contractors for limited purposes, all in accordance with this authorization.

Persons Authorized to Disclose My Information: My healthcare providers, including any pharmacy that fills my prescription for Cayston and other drugs or devices, and any Gilead health plans or programs that provide me healthcare benefits.

Information to Be Disclosed: Personal information about me (for example, my name, mailing address, and insurance information) and my medical information (including information about my cystic fibrosis status) (together all such information is called my "health information" in this authorization). I understand that my pharmacy providers may receive remuneration for disclosing my personal and medical information pursuant to this authorization.

Persons to Which My Health Information May Be Disclosed: Gilead and its contractors and agents, including the third-party administrator responsible for the administration of the Cayston Access Program® (collectively referred to in this authorization as "Gilead").

Use of Information and Purposes for Which the Disclosures Are To Be Made: 1) establish my eligibility for benefits from my health plan or other programs; 2) provide financial assistance, support, and referral services, and communicating with my healthcare providers, including, but not limited to, facilitating the provision of Cayston and the Altera® Nebulizer System to me in certain limited situations; 3) to contact me to evaluate therapy, the effectiveness of the program and to conduct market research; 4) for Gilead's internal business purposes, including quality control, and service enhancing surveys; 5) to ensure the accuracy and completeness of my application for assistance; and 6) to send me marketing information, offers, and educational materials related to cystic fibrosis and/or Cayston, including the customer relationship marketing program (upon my consent, below).

I understand that once my health information has been disclosed to Gilead, privacy laws may no longer restrict its use or disclosure; however, Gilead intends to protect my health information by using and disclosing it for the purposes described above and as required by law. I further understand that I may refuse to sign this authorization and that if I refuse, my eligibility for health plan benefits and treatment by my healthcare providers will not change, but I will not have access to the services available through this program. I may cancel this authorization at any time by notifying Gilead in writing and submitting it by fax to 1-877-550-1705. If I cancel, Gilead will stop using this authorization to access my health information after that cancellation date, but the cancellation will not affect any health information that has already been disclosed in reliance on this authorization before that cancellation date. I authorize the Cayston Access Program to leave a message, including the prescription name if I am unavailable. I am entitled to a copy of this signed authorization, which expires at the earlier of 10 (ten) years or other time period required under the state in which I reside, from the date it is signed by me.

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8. Patient Authorization and Consent (Read and Sign)

☐ I consent to receive text messages by or on behalf of Gilead at the telephone number(s) that I provide. I understand that my consent is not required as a condition of purchasing any goods or services from Gilead. Message and data rates may apply.

☐ I consent to receive marketing information, offers and educational materials related to cystic fibrosis and/or CAYSTON, including the customer relationship marketing program. I understand that my consent is not required as a condition of purchasing any goods or services from Gilead.

***Patient Name:** ______________________ Date of Birth: ____/____/________

Patient Email: ______________________ Cell Phone #: ______________________

Prescriber Name: ______________________ Prescriber Phone #: ______________________

***Signature:** ____
(Patient or Legal Guardian)

Patient or Legal Guardian Printed Name: ____

***Relationship to Patient (if signed by Legal Guardian):** ______________________ ***Date:** ______________

Alternate Contact: ______________________ Relationship to Patient: ______________________

* Required

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Patient Name: ______________________ Date of Birth: ______ / ______ / ______

9. Patient Financial Information (Required only if requesting eligibility screening for the Cayston Patient Assistance Program ("Cayston PAP"))

Current Annual Household Income: $ ______________________

Number of People in Household: ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐Other: ______________

Social Security #: ______________________

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.), proof of residency (e.g., copy of driver's license or state ID).

Applicant Declarations and Authorizations

(Required only if requesting eligibility screening for the Cayston Patient Assistance Program (Cayston 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 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. 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 Cayston 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 Cayston PAP and its administrator to forward this prescription to a dispensing pharmacy on my behalf.

Patient Signature (required only if requesting eligibility screening for the Patient Assistance Program (PAP)):

______________________________ Date: ______________

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