AETC AIDS Education & Training Center Program Southeast

From Prescription to Patient:

Navigating Barriers to HCV Treatment Initiation

Cody A. Chastain, MD

Disclosures

- Research supported by Gilead Sciences Inc.:
  - Site investigator for HIV/HCV SWITCH Registry Study
  - Key personnel for FOCUS HCV Screening Program through Vanderbilt University Medical Center Emergency Department

Special Thanks

- Autumn Zuckerman

Objectives

At the end of this presentation, the learner should be able to:

- Understand how DAA cost impacts access
- Discuss successful navigation from prescription through the prior authorization and appeal process
- Review criteria for patient assistance programs (PAP)
- Be aware of ancillary financial and treatment assistance programs

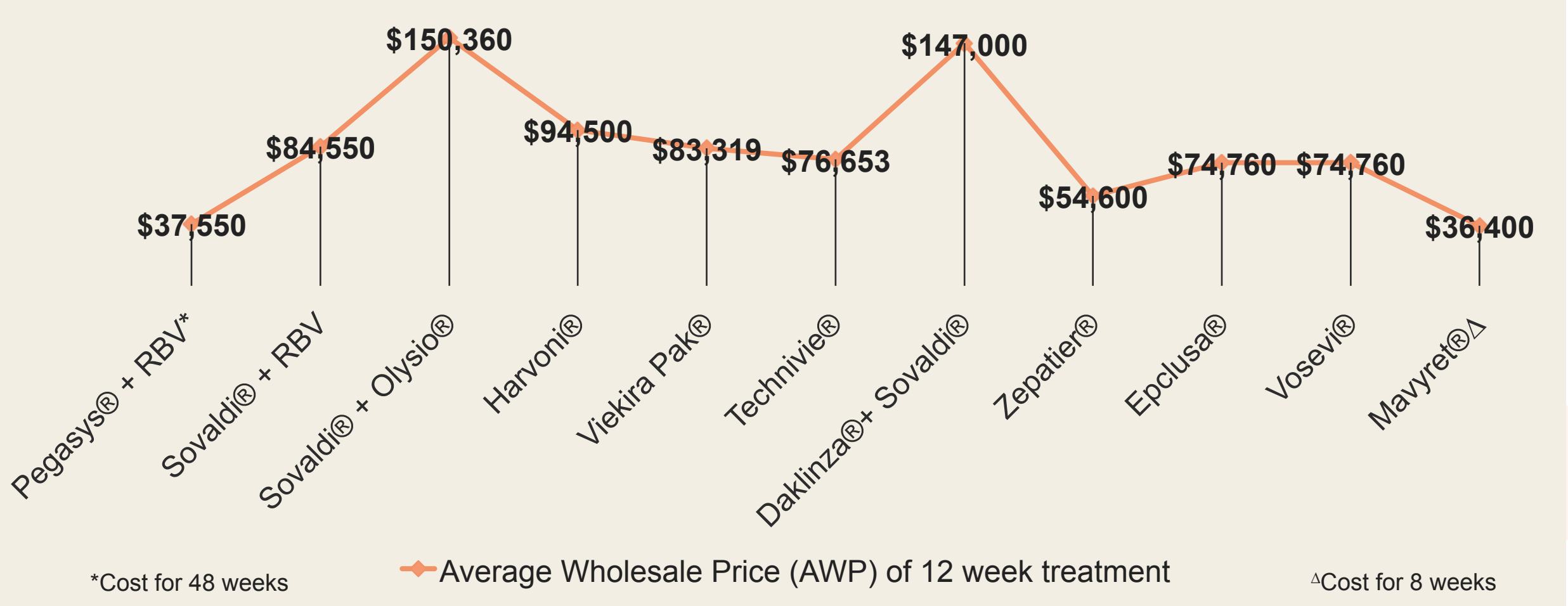
Outline

- Cost
- The Approach to the Insured
  - Prior Authorizations
  - Appeals
  - Accessing Once Approved: Copay Cards and Grants
- The Approach to the Underinsured and Uninsured
  - Patient Assistance Programs (PAPs)
- Provider Resources

Outline

- **Cost**
- The Approach to the Insured
  - Prior Authorizations
  - Appeals
  - Accessing Once Approved: Copay Cards and Grants
- The Approach to the Underinsured and Uninsured
  - Patient Assistance Programs (PAPs)
- Provider Resources

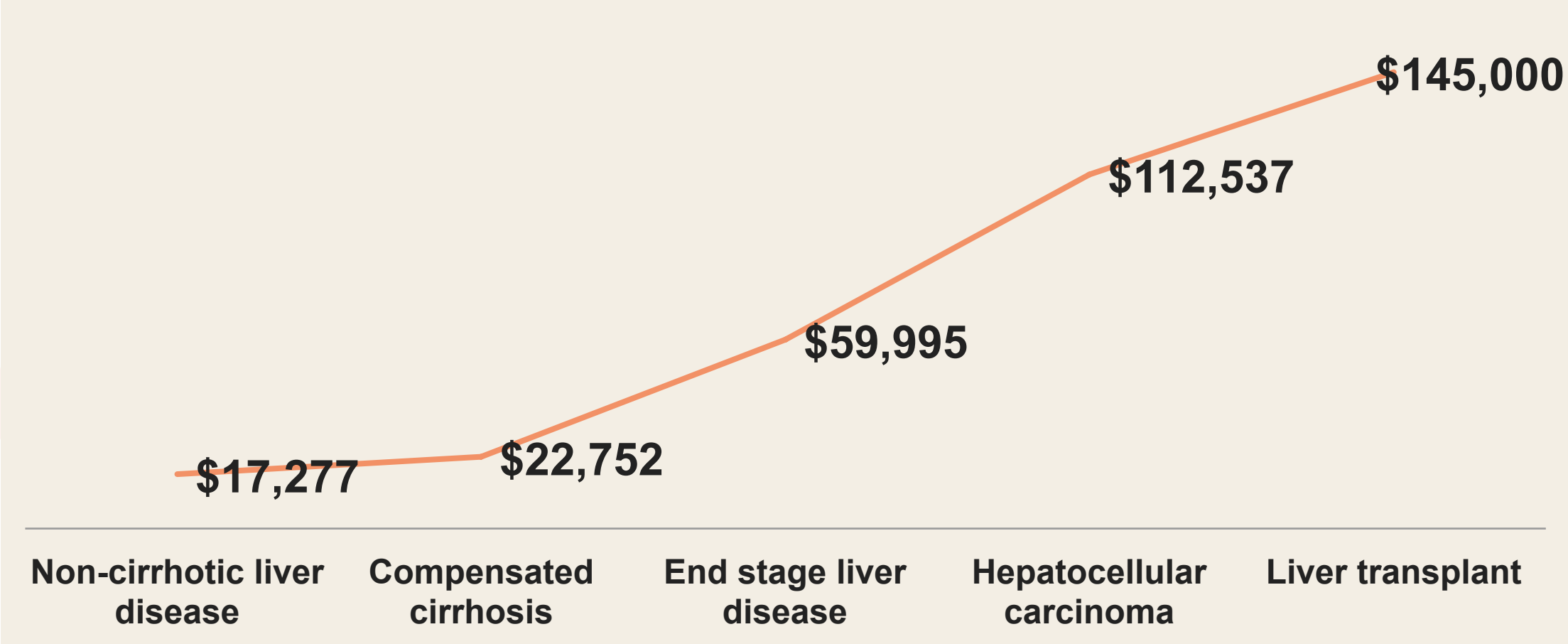
Average Wholesale Price



*Cost for 48 weeks

ΔCost for 8 weeks

Cost related to chronic HCV Infection



Younossi Z, Henry L. The impact of the new antiviral regimens on patient reported outcomes and health economics of patients with chronic hepatitis C. Dig Liver Dis. 2014;46 Suppl 5:S186-96.

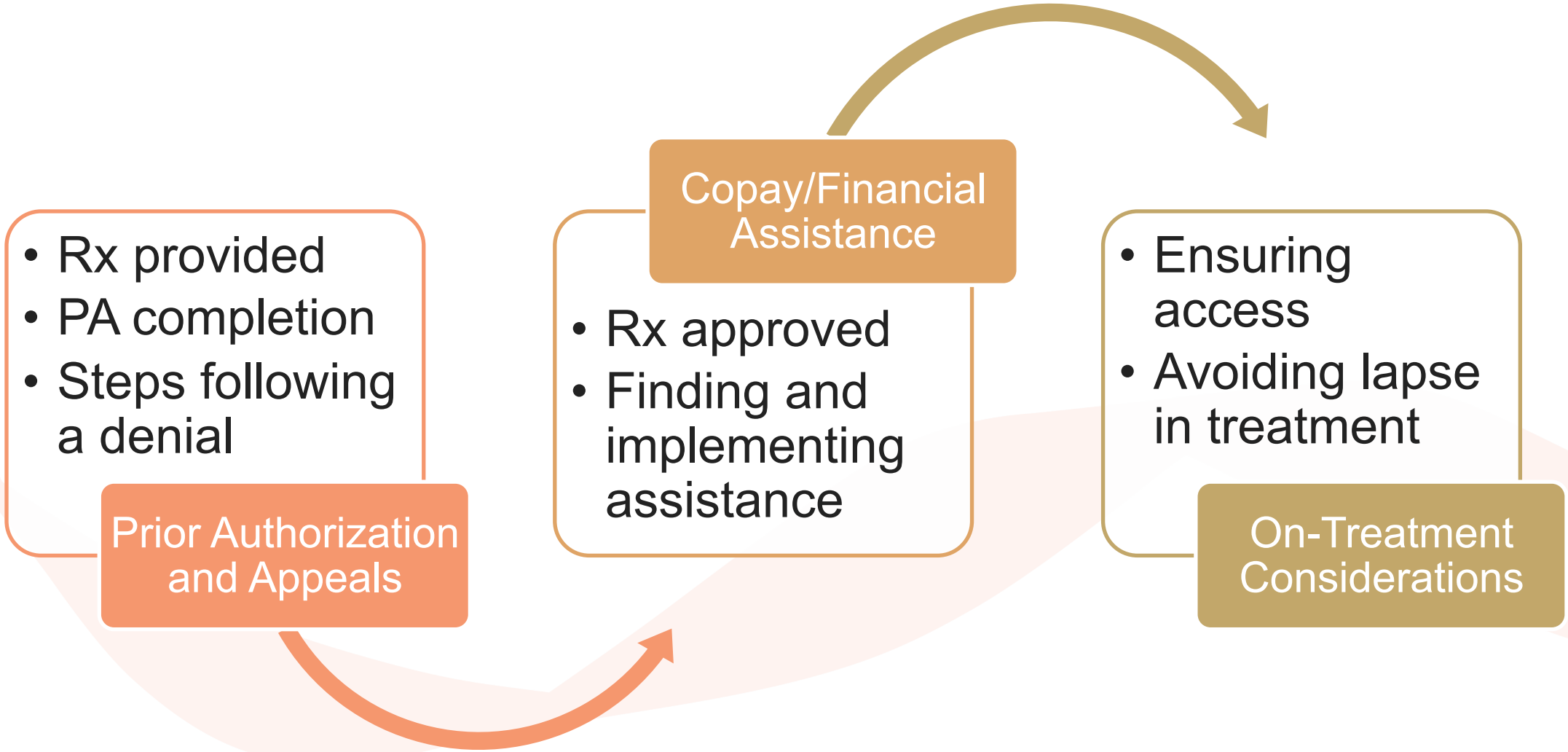
Overview of Cost, Reimbursement, and Cost-effectiveness Considerations for Hepatitis C Treatment Regimens

- Genotype 1: $0 to $31,452 per QALY gained
- "To be clear, this section is informational. As explained below, **actual costs are rarely known.** Accordingly, the HCV Guidance **does not utilize cost-effectiveness** analysis **to guide recommendations at this time.**"

Outline

- Cost
- **The Approach to the Insured**
  - **Prior Authorizations**
  - Appeals
  - Accessing Once Approved: Copay Cards and Grants
- The Approach to the Underinsured and Uninsured
  - Patient Assistance Programs (PAPs)
- Provider Resources

The Insured


• Rx provided
• PA completion
• Steps following a denial
Prior Authorization and Appeals
Copay/Financial Assistance
• Rx approved
• Finding and implementing assistance
• Ensuring access
• Avoiding lapse in treatment
On-Treatment Considerations

Prior Authorization

- Paper Option:
  1. Obtain PA application
     - Call insurance company or obtain forms online
       - Tenncare: Tenncare.Magellanhealth.com
  2. Complete PA paperwork
  3. Gather supporting materials
  4. Fax to insurance/pharmacy benefit manager
- Electronic Option:
  - Covermymeds.com
- Phone Option
  - Primarily used for extension of therapy

Prior Authorization

- What to include to maximize likelihood of approval:
  1. PA application
  2. HCV genotype and viral load
  3. Staging (APRI, FIB-4, Fibrosure®, Fibroscan®, etc.)
  4. Clinical notes
  5. Ancillary items requested by some groups:
     - Resistance testing (i.e. for elbasvir/grazoprevir)
     - Drug screen
     - Alcohol or drug rehabilitation documentation

Consider follow-up if no response in 5 days…

Outline

- Cost
- **The Approach to the Insured**
  - Prior Authorizations
  - **Appeals**
  - Accessing Once Approved: Copay Cards and Grants
- The Approach to the Underinsured and Uninsured
  - Patient Assistance Programs (PAPs)
- Provider Resources

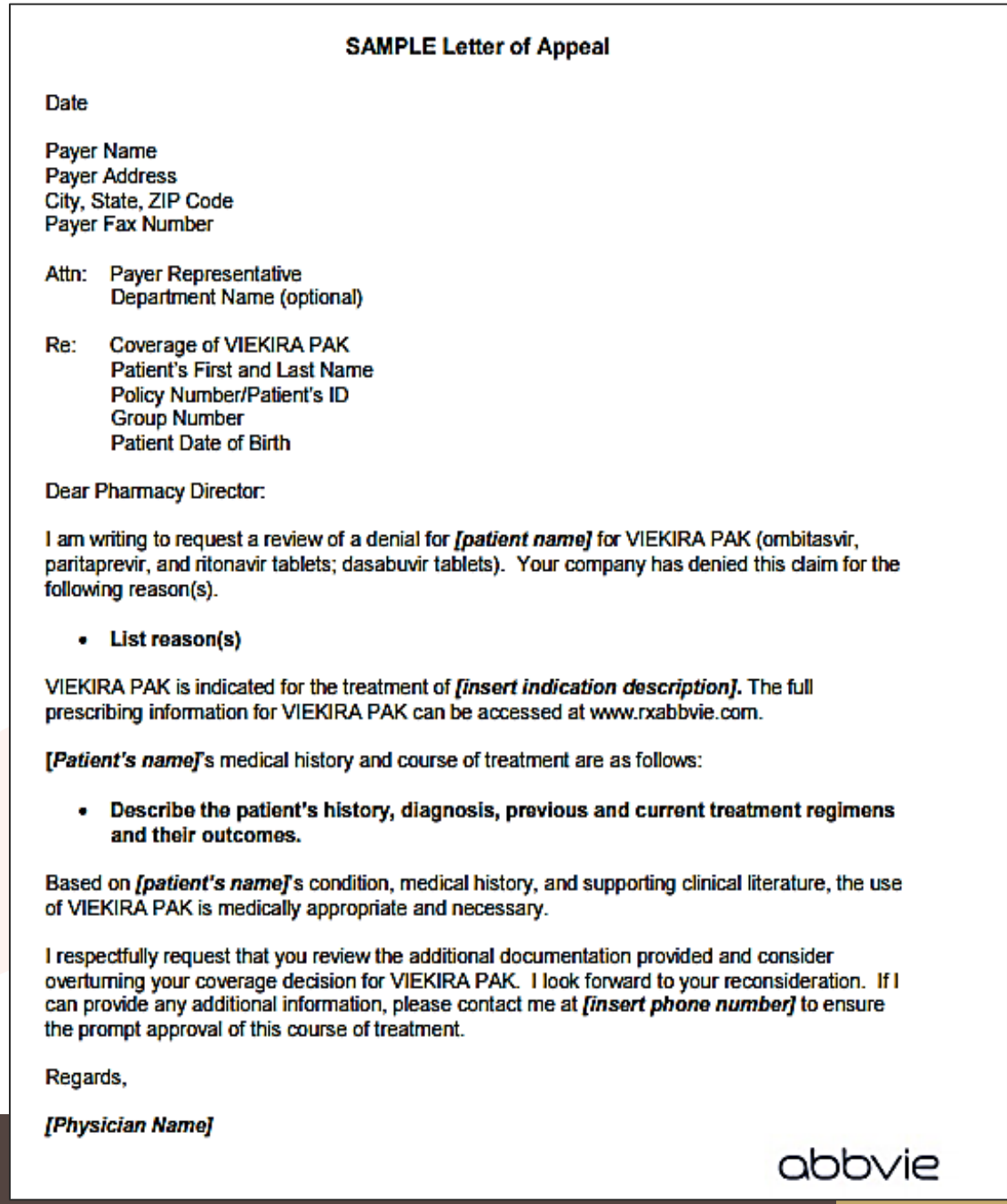
PA Denied - Now What?

1. Review PA rejection
   - Why was it rejected?
     - Call pharmacy benefit manager if needed
   - Is there a preferred agent?
   - What are the next steps?
     - Appeal
     - Peer-to-peer review
     - External review
2. Write appeal letter (most cases)
3. Return appeal, original PA application, and any supporting documentation

Appeal Elements

- Reason for request
- Reason for denial
- Rationale to address each reason for denial, including relevant clinical rationale where applicable
- Relevant overall patient medical history and current condition
- Summary of your professional opinion of likely outcomes with the treatment
- Restatement of request for approval

*Adapted from Abbvie Letter of Medical Necessity Template
Gilead sample Letter of Medical Necessity



SAMPLE Letter of Appeal

Date

Payer Name
Payer Address
City, State, ZIP Code
Payer Fax Number

Attn: Payer Representative
Department Name (optional)

Re: Coverage of VIEKIRA PAK
Patient's First and Last Name
Policy Number/Patient's ID
Group Number
Patient Date of Birth

Dear Pharmacy Director:

I am writing to request a review of a denial for ***[patient name]*** for VIEKIRA PAK (ombitasvir, paritaprevir, and ritonavir tablets; dasabuvir tablets). Your company has denied this claim for the following reason(s).

- **List reason(s)**

VIEKIRA PAK is indicated for the treatment of ***[insert indication description].*** The full prescribing information for VIEKIRA PAK can be accessed at www.rxabbvie.com.

[Patient's name]'s medical history and course of treatment are as follows:

- **Describe the patient's history, diagnosis, previous and current treatment regimens and their outcomes.**

Based on ***[patient's name]***'s condition, medical history, and supporting clinical literature, the use of VIEKIRA PAK is medically appropriate and necessary.

I respectfully request that you review the additional documentation provided and consider overturning your coverage decision for VIEKIRA PAK. I look forward to your reconsideration. If I can provide any additional information, please contact me at ***[insert phone number]*** to ensure the prompt approval of this course of treatment.

Regards,

[Physician Name]

abbvie

Appeal Support Documents

- Required appeal form (if applicable)
- Copy of the denial letter
- Copy of the prescription
- Patient's signature on consent form for treatment
- Patient's complete medication profile including patient's current, previous and discontinued medications
- Patient's medical profile
- Relevant lab results, diagnostics, pathology reports, including drug screening results
- Relevant treatment guidelines
- Relevant peer-reviewed journal articles
- Relevant clinical trial information
- Relevant cost information (if known)

Outline

- Cost
- **The Approach to the Insured**
  - Prior Authorizations
  - Appeals
  - **Accessing Once Approved: Copay Cards and Grants**
- The Approach to the Underinsured and Uninsured
  - Patient Assistance Programs (PAPs)
- Provider Resources

Approved - Now What?

- Determine copay (with pharmacy assistance)
  - Test claim may be run by pharmacy
- Determine if patient qualifies for copay assistance
  - Medicaid: does not qualify for assistance → copay $0-$3
  - Medicare: obtain foundation grant assistance
    - Pharmacy may assist
  - Commercial: obtain copay card if patient copay is >$10
    - Pharmacy may assist

Outline

- Cost
- The Approach to the Insured
  - Prior Authorizations
  - Appeals
  - Accessing Once Approved: Copay Cards and Grants
- **The Approach to the Underinsured and Uninsured**
  - **Patient Assistance Programs (PAPs)**
- Provider Resources

The Underinsured and Uninsured

Patient Assistance Programs (PAP)

- Criteria for approval
- Process of application

Medication Delivery

- Setting up the first fill
- Patient support on therapy

Underinsured

- Process may be convoluted prior to moving to other resources
  - PA denied → Appeal denied → Sent to legal arbitration → FINAL DENIAL
- Apply for patient assistance programs (PAP) once other options exhausted
  - Coverage varies by manufacturer
  - If initially denied by PAP, appeal to exception committee

Uninsured

- Often easiest group to get approved
- Manufacture PAP process relatively simple
- All require the following:

Proof of Income	Proof of residency	Household size
• Tax return • Copy of a disability or Medicare letter • Social security income statement • Retirement and/or pension statement • Pay stub	• State-issued ID • Letter of residency • Rehab • Housing establishment • Caregiver	• All income from anyone in the house

Proof of…

- Letter stating income and/or proof of residency if no other option is available
- Similar approach for other factors

To Whom It May Concern:

I am writing at the request of the Gilead patient assistance program as a statement of my current income. I was previously employed on a farm for seasonal work. However, the farm has not needed my assistance recently. Since that time I have not been able to find another job and therefore do not have any current income.

I live with my wife's uncle and do not pay rent at this time. I use food stamps for my meals. Unfortunately I am unable to afford health insurance at this time. I use a Merriweather Lewis discount card for my other medications.

I am approved for the Vanderbilt Charity Program for my doctor's appointments and would greatly appreciate approval of medication for my HCV infection.

Thank you,

PAP Medication Delivery

- Prescription form sent from PAP to provider for signature
- Delivery set up for provider vs. patient
- Pharmacy calls monthly for prescription refill

Outline

- Cost
- The Approach to the Insured
  - Prior Authorizations
  - Appeals
  - Accessing Once Approved: Copay Cards and Grants
- The Approach to the Underinsured and Uninsured
  - Patient Assistance Programs (PAPs)
- **Provider Resources**

Provider Support

- Multiple types of support
- Vary by pharmaceutical selected
- Services include benefits investigation, prior authorization tracking, electronic resources, and even nursing support
- For novice or low volume treaters, consider engaging with one or two manufacturers to streamline process

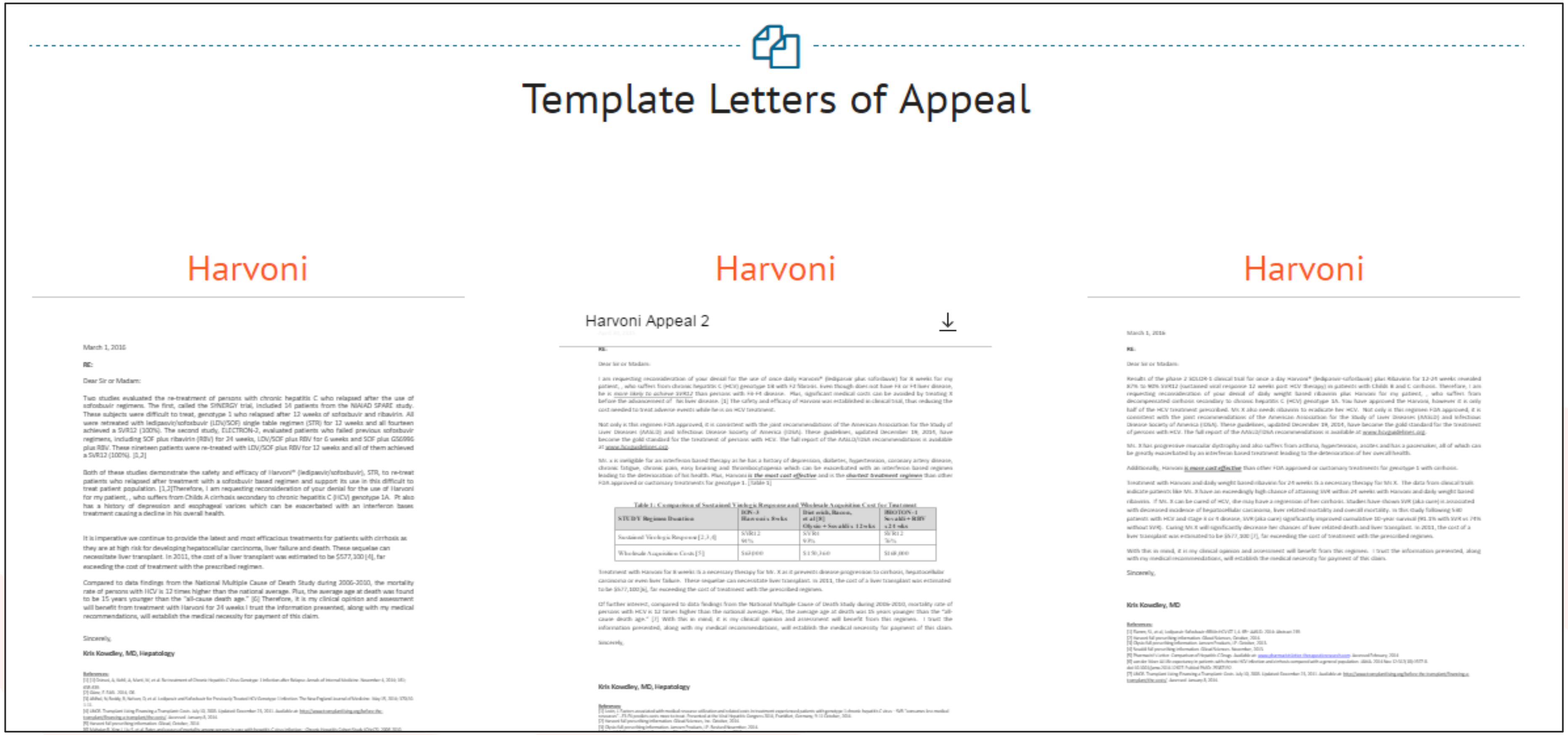
On-Treatment Considerations

- PA may have continuation requirements for refills
  - I.e. Week 4 viral load
- PA extension may be required in some cases
  - When starting later than expected
  - When provider desires to extend treatment course (i.e. on treatment viral load detectable)
- Insurance changes may impact ability to refill
- Refills should be obtain at 7 days prior to running out

RESOURCES

Appeal Support

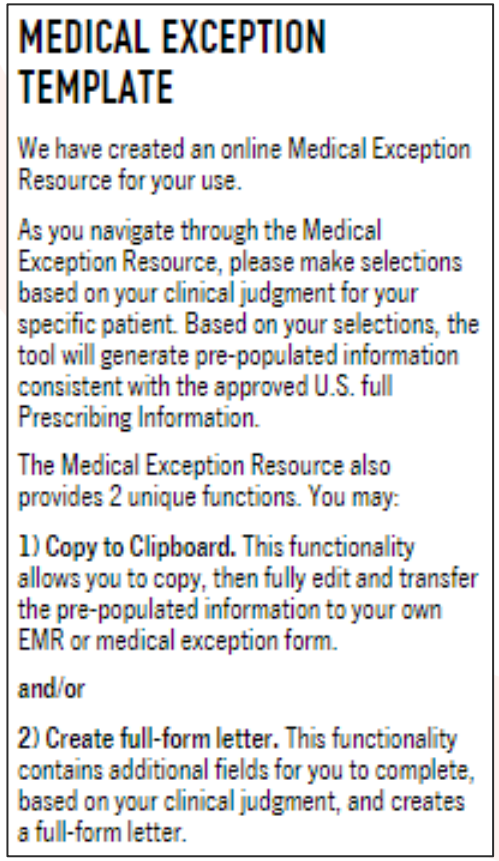
NVHR National Viral Hepatitis Roundtable

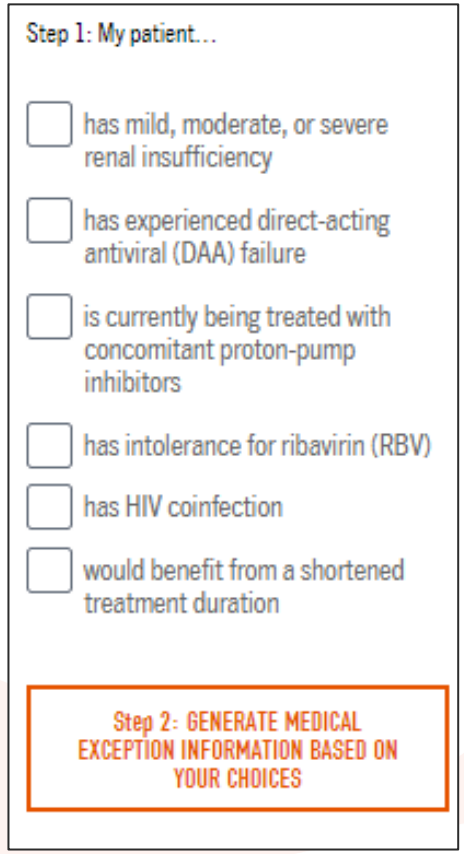


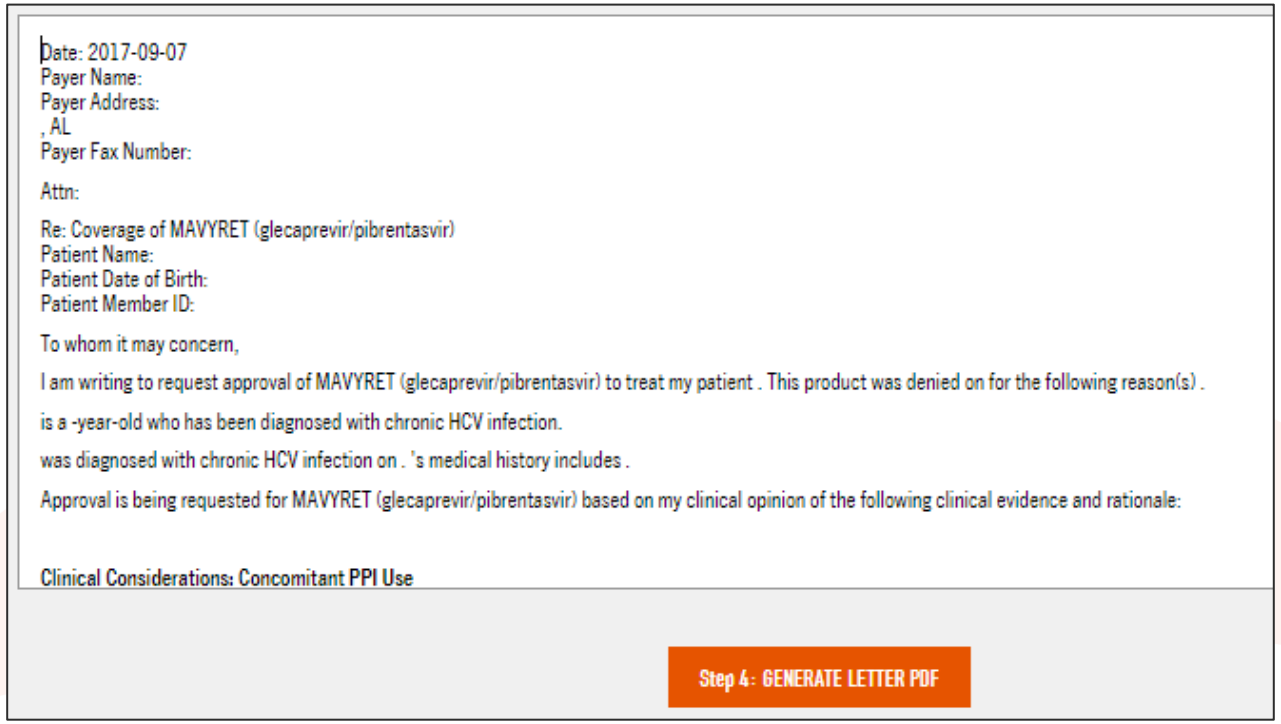
NVHR.org/hepatitis-c-treatment-access

Appeal Support

- Mavyret® Medical Exception Request







Grant Funding

Grant	Patient Cost	Information	Eligibility
Patient Access Network Foundation (PANF)	$0	https://pharmacyportal.panfoundation.org/Home.aspx **Contact**: 1-866-316-7263	-Max of $30,000/year -Reside in US -Income below 400% or 500% FPL -Any insurance
Patient Advocate Foundation (PAF)	$0	https://www.copays.org/diseases/hepatitis-c **Contact**: 1-866-512-3861	-Max of $25,000/year -Reside in US -Income below 400% FPL -Any insurance
Chronic Disease Fund (CDF)	Based on poverty percentage- up to $50	http://www.mygooddays.org/for-patients/patient-assistance/ **Contact:** 1-972-608-7141	-Max of $30,000/year -Reside in US -Any insurance, must pay at least 50% of copay -Income below 500% FPL
Healthwell Foundation	$5/fill	https://www.healthwellfoundation.org/fund/hepatitis-c/ **Contact**: 1-800-675-8416	-Max of $30,000/year -Reside in US -Any insurance -Income below 500% FPL

Copay Cards: Abbvie ProCeed

Drug	Patient Cost	Copay Card Information	Card Details	Eligibility
Viekira XR®	$5	https://www.viekira.com/patient-support/financial-resources	-Max of 25% of the catalog price -Valid for 12 uses -Expires 12 months from 1st redemption	-Resident of US -No state or federally funded programs -Not valid in Massachusetts
Viekira Pak®	$5	https://www.viekira.com/content/pdf/viekira-treatment.pdf		
Technivie®	$5	https://www.viekira.com/content/pdf/viekira-treatment.pdf		
Mavyret®	$5	https://www.mavyret.com/ **Contact:** 1-877-628-9738		

Copay Cards: Bristol-Myers Squibb Patient Support CONNECT

Drug	Patient Cost	Copay Card Information	Card Details	Eligibility
Daklinza®	$0	https://bmsdm.secure.force.com/patientsupportconnect/patient **Contact:** 1-844-442-6663	-Max of $5,000 per 28-day supply of 30mg or 60mg tablets OR up to max of $10,000 per 28-day supply of 90mg	-Resident of US or Puerto Rico -No state or federally funded programs -≥18 years old

Copay Cards: Gilead SupportPath

Drug	Patient Cost	Copay Card Information	Card Details	Eligibility
Harvoni®	$5	https://www.harvoni.com/support-and-savings/co-pay-coupon-registration	-Max of 25% of the catalog price of a 12-week regimen -Valid for 6 months from 1st redemption	-Resident of US, PR, or US territories -No state or federally funded programs -≥18 years old
Sovaldi®	$5	https://www.sovaldi.com/coupons/		
Epclusa®	$5	http://www.epclusainfo.com/support-and-savings/co-pay-coupon-registration		
Vosevi®	$5	https://www.vosevi.com/co-pay-coupon-registration **Contact: 1-855-769-7284**		

Copay Cards: Janssen CarePath

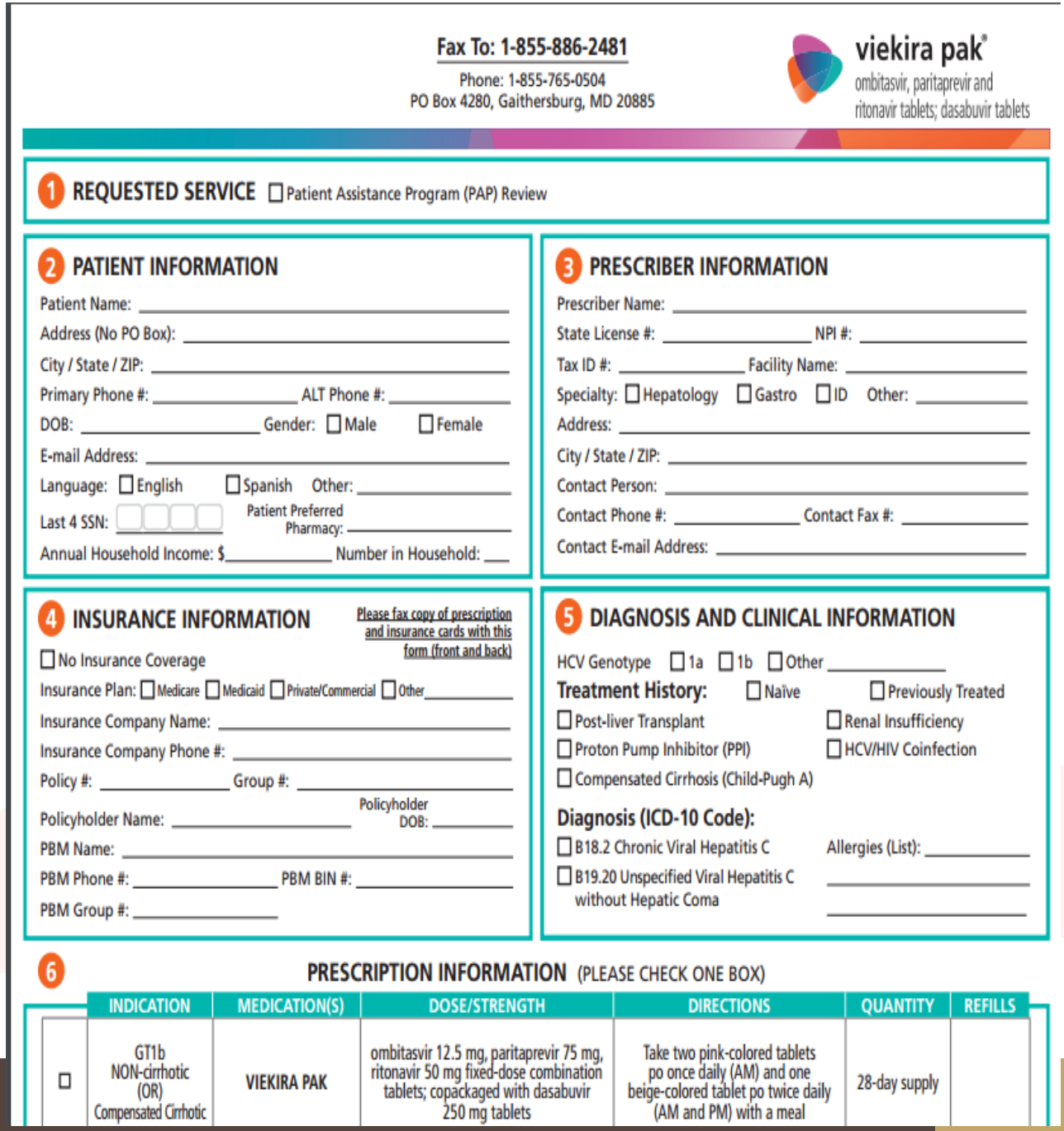
Drug	Patient Cost	Copay Card Information	Card Details	Eligibility
Olysio®	$5	https://olysio.janssencarepathsavings.com/Coupon/Olysio **Contact:** 1-855-565-9746	-Max of $50,000 per calendar year -Program expires 12/31/17	-Resident of US or Puerto Rico -No state or federally funded programs

Copay Cards: Merck

Drug	Patient Cost	Copay Card Information	Card Details	Eligibility
Zepatier®	$5	https://www.merckaccessprogram-zepatier.com/hcp/copay-assistance/ **Contact:** 1-866-251-6013	-Max of 25% of the catalog price per prescription	-Resident of US or Puerto Rico -No state or federally funded programs -≥18 years old

PAP: Abbvie

- https://www.viekirahcp.com/ proceed
- Case-by-case basis:
  - Financial hardship
  - Lack of insurance coverage
  - Medical necessity
- XR criteria:
  - Provide income and household size
  - <$100,000 per year



Fax To: 1-855-886-2481
Phone: 1-855-765-0504
PO Box 4280, Gaithersburg, MD 20885

viekira pak®
ombitasvir, paritaprevir and ritonavir tablets; dasabuvir tablets

1 REQUESTED SERVICE ☐ Patient Assistance Program (PAP) Review

2 PATIENT INFORMATION
Patient Name: _____
Address (No PO Box): _____
City / State / ZIP: _____
Primary Phone #: _____ ALT Phone #: _____
DOB: _____ Gender: ☐ Male ☐ Female
E-mail Address: _____
Language: ☐ English ☐ Spanish Other: _____
Last 4 SSN: ☐☐☐☐ Patient Preferred Pharmacy: _____
Annual Household Income: $_____ Number in Household: ___

3 PRESCRIBER INFORMATION
Prescriber Name: _____
State License #: _____ NPI #: _____
Tax ID #: _____ Facility Name: _____
Specialty: ☐ Hepatology ☐ Gastro ☐ ID Other: _____
Address: _____
City / State / ZIP: _____
Contact Person: _____
Contact Phone #: _____ Contact Fax #: _____
Contact E-mail Address: _____

4 INSURANCE INFORMATION Please fax copy of prescription and insurance cards with this form (front and back)
☐ No Insurance Coverage
Insurance Plan: ☐ Medicare ☐ Medicaid ☐ Private/Commercial ☐ Other _____
Insurance Company Name: _____
Insurance Company Phone #: _____
Policy #: _____ Group #: _____
Policyholder Name: _____ Policyholder DOB: _____
PBM Name: _____
PBM Phone #: _____ PBM BIN #: _____
PBM Group #: _____

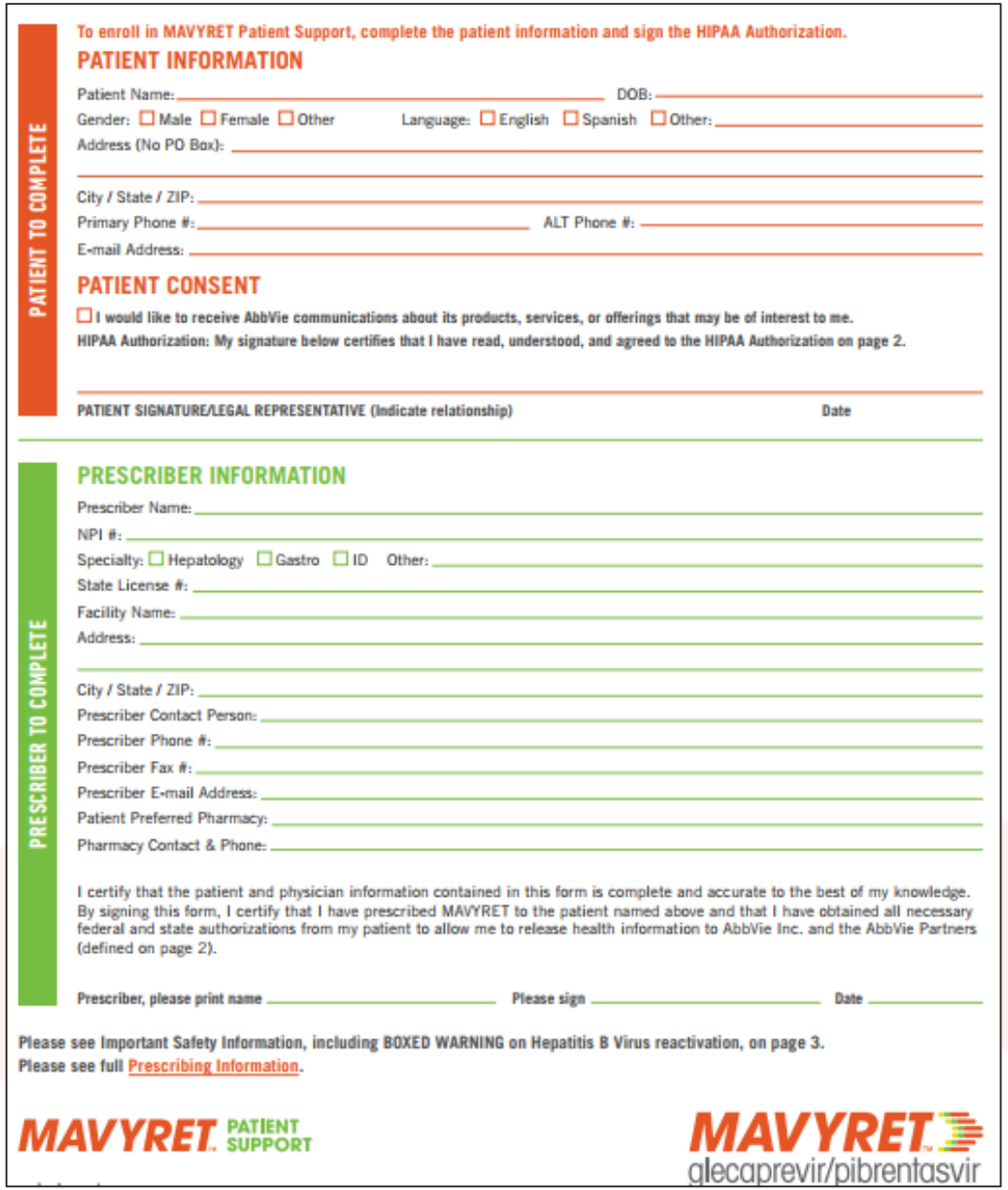
5 DIAGNOSIS AND CLINICAL INFORMATION
HCV Genotype ☐ 1a ☐ 1b ☐ Other _____
Treatment History: ☐ Naïve ☐ Previously Treated
☐ Post-liver Transplant ☐ Renal Insufficiency
☐ Proton Pump Inhibitor (PPI) ☐ HCV/HIV Coinfection
☐ Compensated Cirrhosis (Child-Pugh A)
Diagnosis (ICD-10 Code):
☐ B18.2 Chronic Viral Hepatitis C
☐ B19.20 Unspecified Viral Hepatitis C without Hepatic Coma
Allergies (List): _____

6 PRESCRIPTION INFORMATION (PLEASE CHECK ONE BOX)

	INDICATION	MEDICATION(S)	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐	GT1b NON-cirrhotic (OR) Compensated Cirrhotic	VIEKIRA PAK	ombitasvir 12.5 mg, paritaprevir 75 mg, ritonavir 50 mg fixed-dose combination tablets; copackaged with dasabuvir 250 mg tablets	Take two pink-colored tablets po once daily (AM) and one beige-colored tablet po twice daily (AM and PM) with a meal	28-day supply	

PAP: Abbvie

- Patient Support
- Complete enrollment form
- https://www.mavyret.com/content/dam/abbvie-mavyret-brand/enrollment-form.pdf



To enroll in MAVYRET Patient Support, complete the patient information and sign the HIPAA Authorization.

PATIENT TO COMPLETE

PATIENT INFORMATION

Patient Name: _____ DOB: _____

Gender: ☐ Male ☐ Female ☐ Other Language: ☐ English ☐ Spanish ☐ Other: _____

Address (No PO Box): _____

City / State / ZIP: _____

Primary Phone #: _____ ALT Phone #: _____

E-mail Address: _____

PATIENT CONSENT

☐ I would like to receive AbbVie communications about its products, services, or offerings that may be of interest to me.

HIPAA Authorization: My signature below certifies that I have read, understood, and agreed to the HIPAA Authorization on page 2.

PATIENT SIGNATURE/LEGAL REPRESENTATIVE (Indicate relationship) Date

PRESCRIBER TO COMPLETE

PRESCRIBER INFORMATION

Prescriber Name: _____

NPI #: _____

Specialty: ☐ Hepatology ☐ Gastro ☐ ID Other: _____

State License #: _____

Facility Name: _____

Address: _____

City / State / ZIP: _____

Prescriber Contact Person: _____

Prescriber Phone #: _____

Prescriber Fax #: _____

Prescriber E-mail Address: _____

Patient Preferred Pharmacy: _____

Pharmacy Contact & Phone: _____

I certify that the patient and physician information contained in this form is complete and accurate to the best of my knowledge. By signing this form, I certify that I have prescribed MAVYRET to the patient named above and that I have obtained all necessary federal and state authorizations from my patient to allow me to release health information to AbbVie Inc. and the AbbVie Partners (defined on page 2).

Prescriber, please print name _____ Please sign _____ Date _____

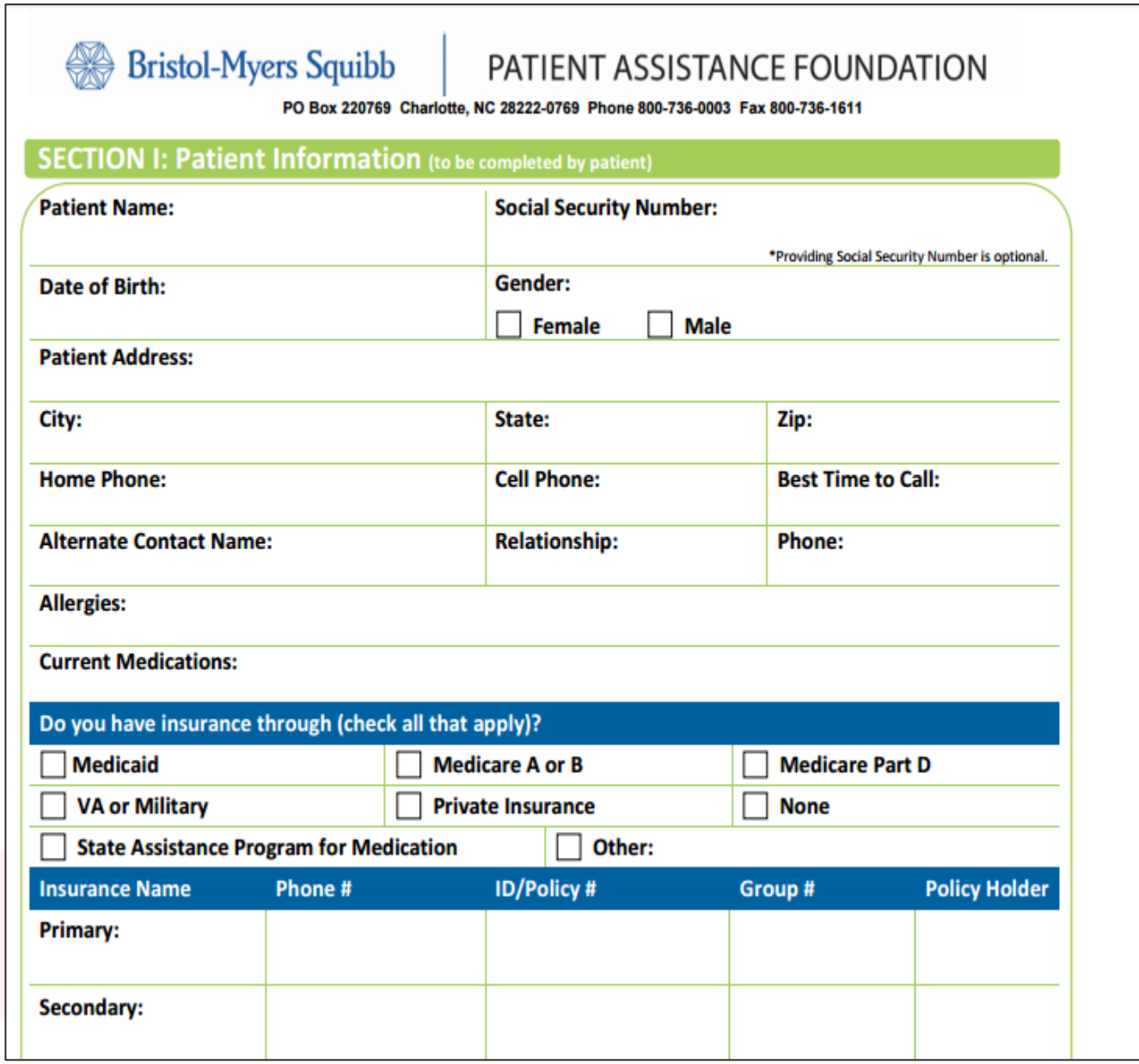
Please see Important Safety Information, including BOXED WARNING on Hepatitis B Virus reactivation, on page 3.
Please see full Prescribing Information.

MAVYRET PATIENT SUPPORT

MAVYRET glecaprevir/pibrentasvir

PAP: BMS

- http://www.bmspaf.org/Pages/Home.aspx
- Eligibility:
  - US resident
  - No insurance or 2 appeals denied by insurance or Medicare Part D and ≥3% household income spent on prescriptions costs/year
  - Household income below 300% of FPL
    - $35,640 for one
    - $48,060 for a couple



Bristol-Myers Squibb | PATIENT ASSISTANCE FOUNDATION

PO Box 220769 Charlotte, NC 28222-0769 Phone 800-736-0003 Fax 800-736-1611

SECTION I: Patient Information (to be completed by patient)

Patient Name:	**Social Security Number:** *Providing Social Security Number is optional.	
Date of Birth:	**Gender:** ☐ Female ☐ Male	
Patient Address:		
City:	**State:**	**Zip:**
Home Phone:	**Cell Phone:**	**Best Time to Call:**
Alternate Contact Name:	**Relationship:**	**Phone:**
Allergies:		
Current Medications:		

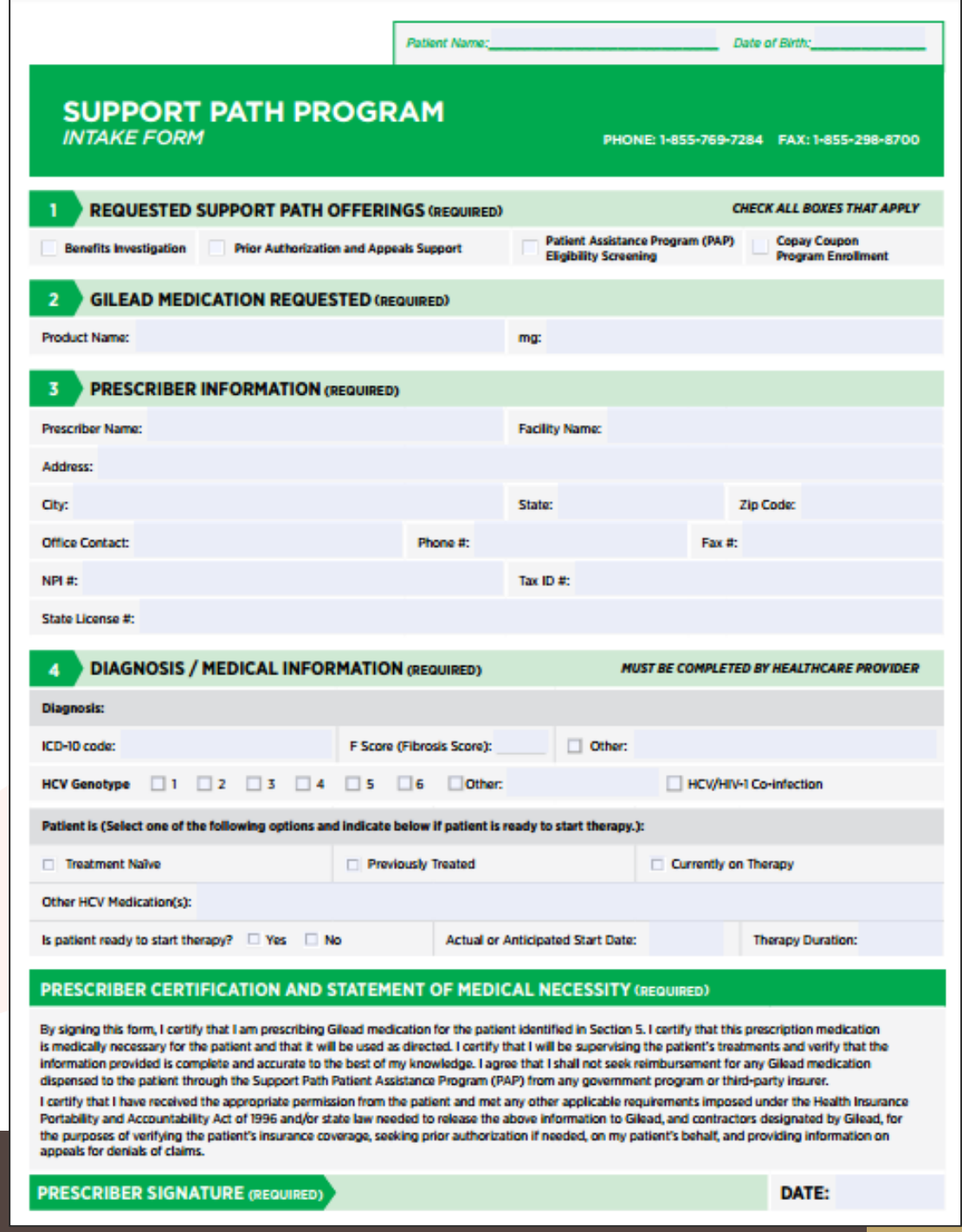
Do you have insurance through (check all that apply)?

☐ Medicaid	☐ Medicare A or B	☐ Medicare Part D
☐ VA or Military	☐ Private Insurance	☐ None
☐ State Assistance Program for Medication	☐ Other:	

Insurance Name	Phone #	ID/Policy #	Group #	Policy Holder
Primary:				
Secondary:				

PAP: Gilead

- http://www.mysupportpath.com/
- Eligibility:
  - Applied and denied for Medicaid and state insurance marketplace
  - Ineligible for VA benefits
  - Provide household income and size



Patient Name: _____ Date of Birth: _____

SUPPORT PATH PROGRAM
INTAKE FORM
PHONE: 1-855-769-7284 FAX: 1-855-298-8700

1 REQUESTED SUPPORT PATH OFFERINGS (REQUIRED) — *CHECK ALL BOXES THAT APPLY*

☐ Benefits Investigation ☐ Prior Authorization and Appeals Support ☐ Patient Assistance Program (PAP) Eligibility Screening ☐ Copay Coupon Program Enrollment

2 GILEAD MEDICATION REQUESTED (REQUIRED)

Product Name: mg:

3 PRESCRIBER INFORMATION (REQUIRED)

Prescriber Name: Facility Name:
Address:
City: State: Zip Code:
Office Contact: Phone #: Fax #:
NPI #: Tax ID #:
State License #:

4 DIAGNOSIS / MEDICAL INFORMATION (REQUIRED) — *MUST BE COMPLETED BY HEALTHCARE PROVIDER*

Diagnosis:

ICD-10 code: F Score (Fibrosis Score): ☐ Other:

HCV Genotype ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ Other: ☐ HCV/HIV-1 Co-infection

Patient is (Select one of the following options and indicate below if patient is ready to start therapy.):

☐ Treatment Naïve ☐ Previously Treated ☐ Currently on Therapy

Other HCV Medication(s):

Is patient ready to start therapy? ☐ Yes ☐ No Actual or Anticipated Start Date: Therapy Duration:

PRESCRIBER CERTIFICATION AND STATEMENT OF MEDICAL NECESSITY (REQUIRED)

By signing this form, I certify that I am prescribing Gilead medication for the patient identified in Section 5. 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 Support Path Patient Assistance Program (PAP) from any government program or third-party insurer.

I certify that 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/or 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, seeking prior authorization if needed, on my patient's behalf, and providing information on appeals for denials of claims.

PRESCRIBER SIGNATURE (REQUIRED) **DATE:**

PAP: Merck

- http://www.merckhelps.com/ZEPATIER
- Eligibility:
  - US resident
  - No insurance or an exception based on case
  - Household income
    - $59,400 for one
    - $80,100 for a couple
    - $121,500 for family of 4

The Merck Access Program
ENROLLMENT FORM

ZEPATIER™
(elbasvir and grazoprevir)
50 mg/100 mg tablets

P: 866-251-6013 **F:** 800-803-3104
The Merck Access Program, PO Box 29067, Phoenix, AZ 85038

COMPLETE THE APPROPRIATE SECTIONS OF THE ENROLLMENT FORM AND FAX TO 800-803-3104.

1 REQUESTED SERVICE(S) Check all circles that apply

- ○ Benefits Investigation, Prior Authorization, or Appeal
- ○ Referral to the Merck Patient Assistance Program (offered through the Merck Patient Assistance Program, Inc.)

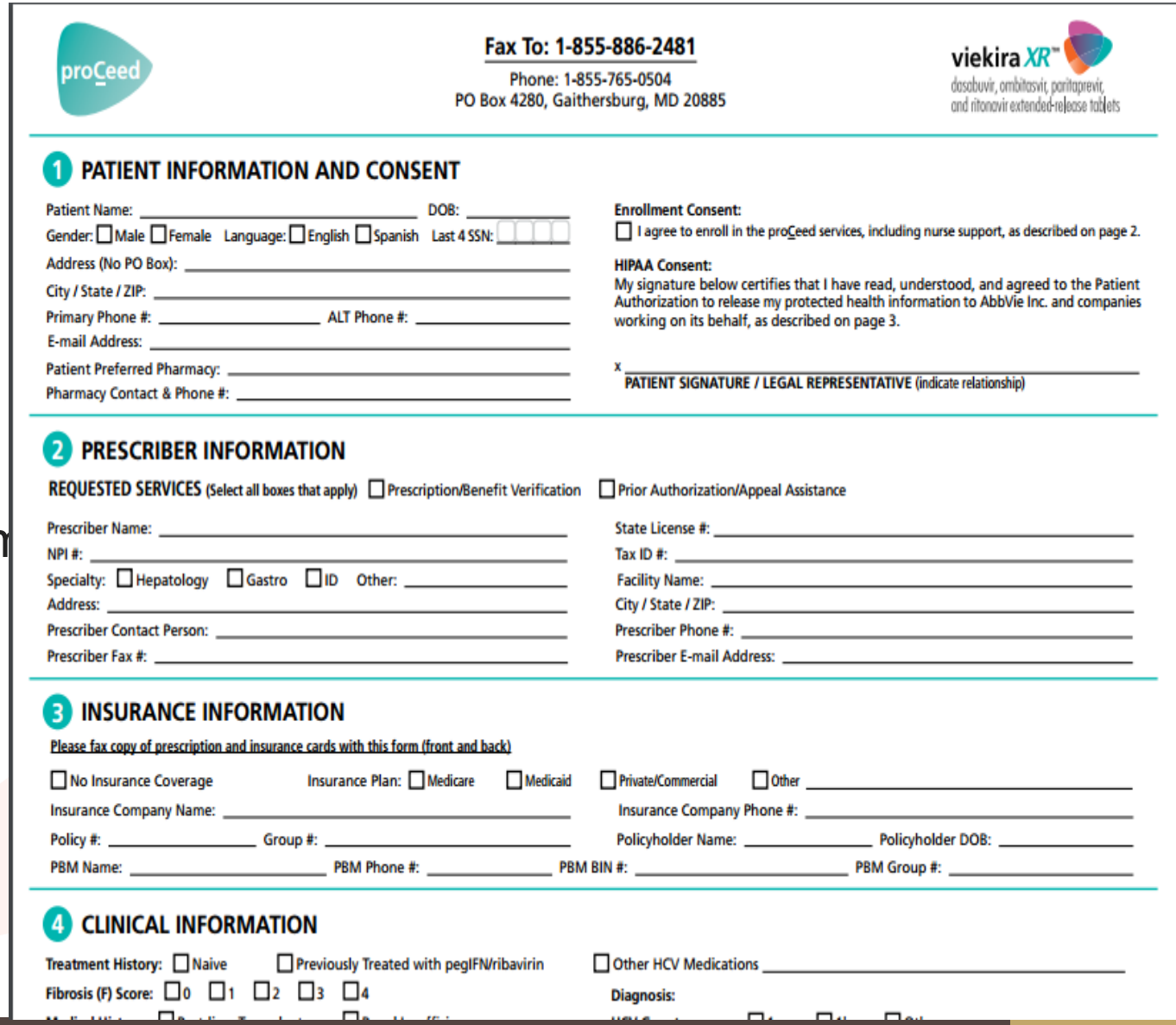
2 PATIENT INFORMATION (REQUIRED)

Patient Name:
Street Address (no PO Box):
City/State/Zip:
Phone (Home): (Work/Other):
DOB (mm/dd/yyyy): Gender: ○ M ◉ F
Resides in US/US Territories: ○ Yes ◉ No

For Merck Patient Assistance Program only

Provider Support: Abbvie ProCeed

- Viekira Pak®/XR®
  - ProCeed
    - Benefits Verification
    - PA/Appeal
      - Obtain the appropriate form
      - Track the PA
    - Triage prescription to the pharmacy
- Mavyret®
  - Patient Support



proCeed

Fax To: 1-855-886-2481
Phone: 1-855-765-0504
PO Box 4280, Gaithersburg, MD 20885

viekira XR™
dasabuvir, ombitasvir, paritaprevir, and ritonavir extended-release tablets

1 PATIENT INFORMATION AND CONSENT

Patient Name: _____ DOB: _____
Gender: ☐ Male ☐ Female Language: ☐ English ☐ Spanish Last 4 SSN: ☐☐☐☐
Address (No PO Box): _____
City / State / ZIP: _____
Primary Phone #: _____ ALT Phone #: _____
E-mail Address: _____
Patient Preferred Pharmacy: _____
Pharmacy Contact & Phone #: _____

Enrollment Consent:
☐ I agree to enroll in the proCeed services, including nurse support, as described on page 2.

HIPAA Consent:
My signature below certifies that I have read, understood, and agreed to the Patient Authorization to release my protected health information to AbbVie Inc. and companies working on its behalf, as described on page 3.

x _____
PATIENT SIGNATURE / LEGAL REPRESENTATIVE (indicate relationship)

2 PRESCRIBER INFORMATION

REQUESTED SERVICES (Select all boxes that apply) ☐ Prescription/Benefit Verification ☐ Prior Authorization/Appeal Assistance

Prescriber Name: _____ State License #: _____
NPI #: _____ Tax ID #: _____
Specialty: ☐ Hepatology ☐ Gastro ☐ ID Other: _____ Facility Name: _____
Address: _____ City / State / ZIP: _____
Prescriber Contact Person: _____ Prescriber Phone #: _____
Prescriber Fax #: _____ Prescriber E-mail Address: _____

3 INSURANCE INFORMATION

Please fax copy of prescription and insurance cards with this form (front and back)

☐ No Insurance Coverage Insurance Plan: ☐ Medicare ☐ Medicaid ☐ Private/Commercial ☐ Other _____
Insurance Company Name: _____ Insurance Company Phone #: _____
Policy #: _____ Group #: _____ Policyholder Name: _____ Policyholder DOB: _____
PBM Name: _____ PBM Phone #: _____ PBM BIN #: _____ PBM Group #: _____

4 CLINICAL INFORMATION

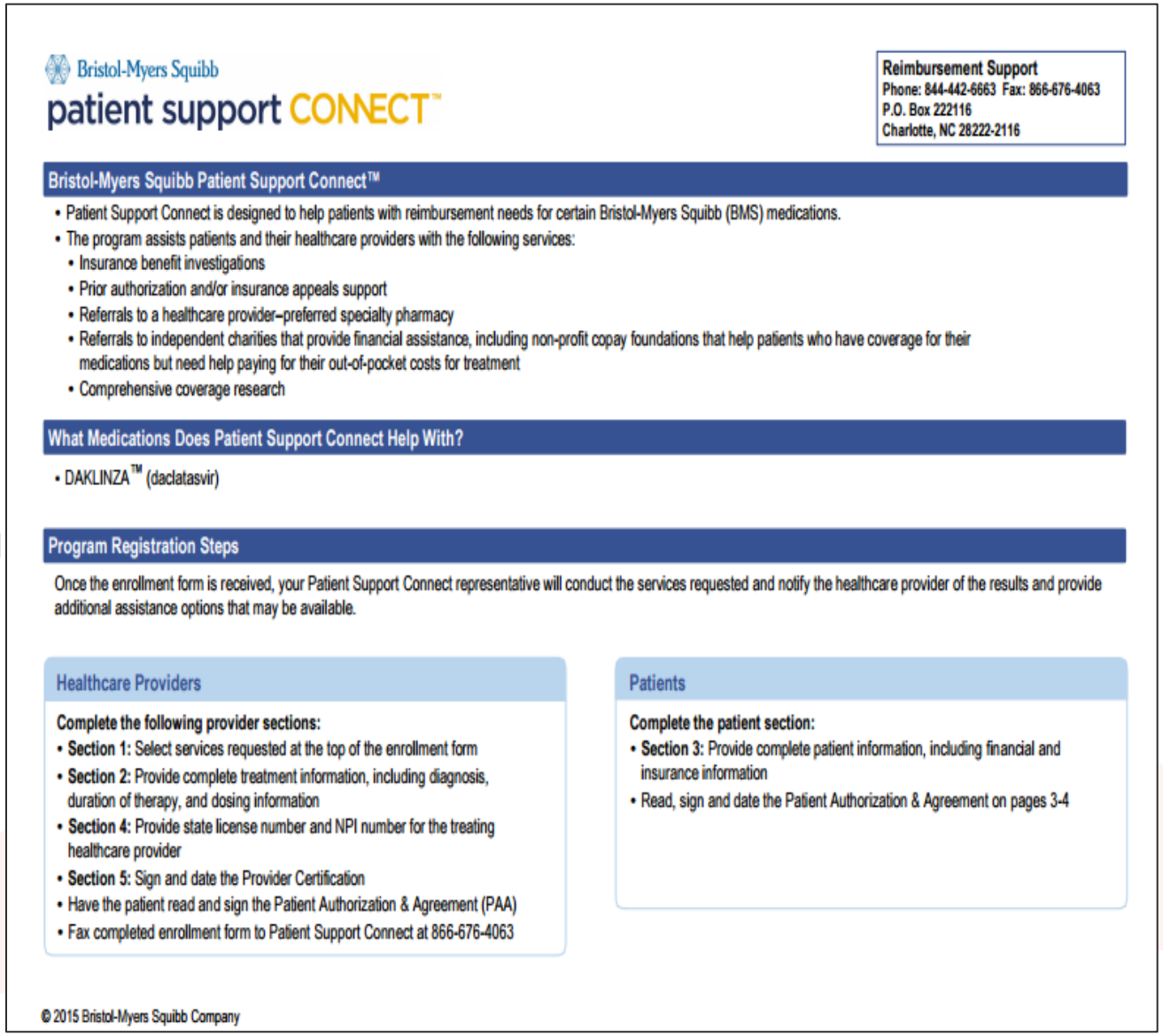
Treatment History: ☐ Naive ☐ Previously Treated with pegIFN/ribavirin ☐ Other HCV Medications _____
Fibrosis (F) Score: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 **Diagnosis:**

Provider Support

- Abbvie Nurse Ambassador
  - Assist with navigating financial information
  - Assigned nurse throughout treatment
  - Call for adherence monitoring
  - Appointment reminder

Provider Support: BMS Patient Support CONNECT

- Benefits investigation
  - 24 hour turnaround
- PA/Appeal
  - Obtain the appropriate form and send to office
  - Tracks PA and appeal
  - Clinical trials data support
- Financial assistance after approval



Bristol-Myers Squibb

patient support CONNECT™

Reimbursement Support
Phone: 844-442-6663 Fax: 866-676-4063
P.O. Box 222116
Charlotte, NC 28222-2116

Bristol-Myers Squibb Patient Support Connect™

- Patient Support Connect is designed to help patients with reimbursement needs for certain Bristol-Myers Squibb (BMS) medications.
- The program assists patients and their healthcare providers with the following services:
  - Insurance benefit investigations
  - Prior authorization and/or insurance appeals support
  - Referrals to a healthcare provider–preferred specialty pharmacy
  - Referrals to independent charities that provide financial assistance, including non-profit copay foundations that help patients who have coverage for their medications but need help paying for their out-of-pocket costs for treatment
  - Comprehensive coverage research

What Medications Does Patient Support Connect Help With?

- DAKLINZA™ (daclatasvir)

Program Registration Steps

Once the enrollment form is received, your Patient Support Connect representative will conduct the services requested and notify the healthcare provider of the results and provide additional assistance options that may be available.

Healthcare Providers

Complete the following provider sections:

- **Section 1:** Select services requested at the top of the enrollment form
- **Section 2:** Provide complete treatment information, including diagnosis, duration of therapy, and dosing information
- **Section 4:** Provide state license number and NPI number for the treating healthcare provider
- **Section 5:** Sign and date the Provider Certification
- Have the patient read and sign the Patient Authorization & Agreement (PAA)
- Fax completed enrollment form to Patient Support Connect at 866-676-4063

Patients

Complete the patient section:

- **Section 3:** Provide complete patient information, including financial and insurance information
- Read, sign and date the Patient Authorization & Agreement on pages 3-4

Provider Support: Gilead Support Path

Help Along the Way

Support Path is ready to assist patients along the way toward treatment completion

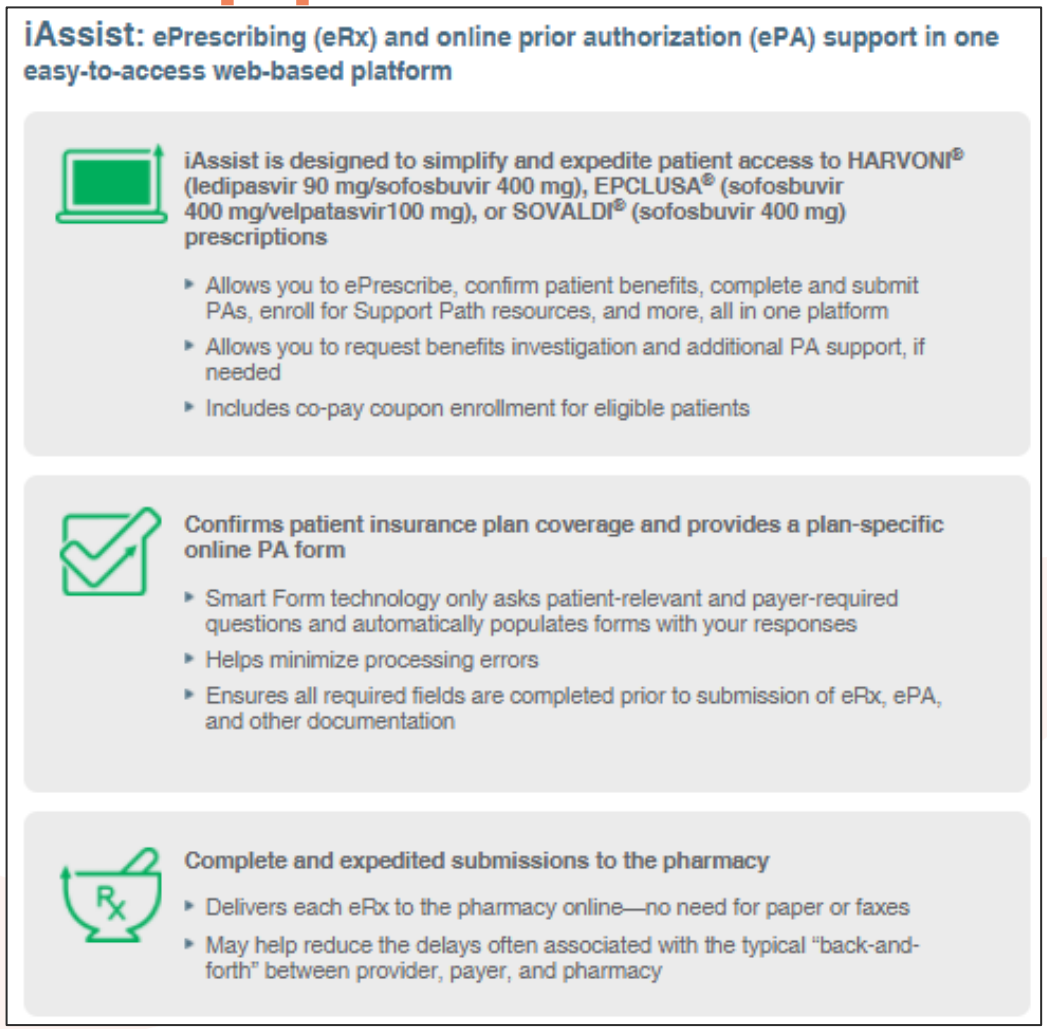
Educational resources, support for adherence, and progress tracking

A **24/7** help line with nurses on call to provide answers and assistance

Ongoing support for access and reimbursement, including help with refill authorizations

Complete the **intake form** now to enroll and access the full range of resources or call **1-855-7-MYPATH** (1-855-769-7284) to learn more about resources that are available to help patients along the way toward treatment completion

Provider Support: Gilead iAssist



Provider Support: Merck Access Program

- Benefits investigation
- PA/Appeal
  - Obtain the appropriate form and send to office
- Financial assistance after approval

The Merck Access Program

ENROLLMENT FORM

ZEPATIER™
(elbasvir and grazoprevir)
50 mg/100 mg tablets

P: 866-251-6013 **F:** 800-803-3104
The Merck Access Program, PO Box 29067, Phoenix, AZ 85038

COMPLETE THE APPROPRIATE SECTIONS OF THE ENROLLMENT FORM AND FAX TO 800-803-3104.

1 REQUESTED SUPPORT Check all circles that apply

- ○ **Benefits Investigation**, and/or information about the **Prior Authorization** or **Appeals Process**.
- ○ Evaluation of eligibility for the **Merck Patient Assistance Program** (offered through the Merck Patient Assistance Program, Inc.)

2 PATIENT INFORMATION (REQUIRED)

Patient Name:
Street Address (no PO Box):
City/State/Zip:
Phone (Home): (Work/Other):
DOB (mm/dd/yyyy): Gender: ○ M ○ F
Resides in US/US Territories: ○ Yes ○ No

For Merck Patient Assistance Program only

Current annual gross household income: $
(Please include: before-tax wages, pension, interest/dividends, Social Security benefits, and any other sources of income)
Number of household members (including patient):

Other Access Resources

- National Viral Hepatitis Roundtable
  - NVHR.org/hepatitis-c-treatment-access
- Hepatitis C New Drug Research
  - http://hepatitiscnewdrugresearch.com/hcv-drugs-financial-support.html
- American Liver Foundation
  - http://hepc.liverfoundation.org/resources/what-if-i-need-financial-assistance-to-pay-for-treatment/
- Life Beyond Hepatitis C
  - http://www.lifebeyondhepatitisc.com/medical-information/financial-assistance/

QUESTIONS?