ZYDELIG® AccessConnect® Nurse Support Enrollment Form

Monday–Friday, 8AM to 8PM ET
Phone: 1-844-6ACCESS (1-844-622-2377)
Fax: 1-855-553-8672
www.ZYDELIGAccessConnect.com

Remembering to take your medication can be challenging, and you may need some assistance. The ZYDELIG® AccessConnect® Nurse Support program offers a team of dedicated patient support nurses who can answer questions and provide tips related to your therapy. To enroll in the ZYDELIG AccessConnect Nurse program directly, complete these 5 easy steps!

1. Ensure to date and sign your name in the Patient Authorization section.
2. Complete all fields of the Patient Information section.
3. Indicate on this form if you are interested in additional AccessConnect Support Offerings, including Access and Financial support.
4. Provide contact details for your healthcare provider so AccessConnect can work together with him or her.
5. Submit this complete Enrollment Form to ZYDELIG® AccessConnect® by:
- **Fax 1-855-553-8672 or**
- **Mail 200 Pinecrest Plaza, Morgantown, WV 26505.**

For any questions, please contact ZYDELIG® AccessConnect® at **1-866-6ACCESS** or 1-844-622-2377 anytime from 8AM-8PM ET.

1. Patient Information

Patient Name (First, MI, Last): _____ Birth Date (MM/DD/YYYY): _____ Gender: ☐ Male ☐ Female

Address: _____ City: _____ State: _____ ZIP Code: _____

Email: _____ Language: ☐ English ☐ Other (please indicate): _____

Phone: _____ Best Time to Contact: ☐ Morning ☐ Afternoon ☐ Evening

☐ Home ☐ Cell

Alternate Contact: _____ Phone: _____ Relationship: _____

2. Support Requested

I am requesting:

☐ Nurse Support
☐ Other ZYDELIG® AccessConnect® Support Offerings, including Access and Financial support

If selecting Other ZYDELIG® AccessConnect® Support Offerings, an AccessConnect Case Specialist will contact you.
Your Case Specialist will work with you and your doctor to obtain the support you need.

3. Prescriber Information

Prescriber Name (First, Last): _____

Phone: _____ Fax: _____ Email: _____

Facility Name: _____

Address: _____ City: _____ State: _____ ZIP Code: _____

AccessConnect Nurses want to work with your healthcare provider to ensure you are getting the support you need. We will stay in touch with him or her every time we talk to you.

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Zydelig® (idelalisib) 150 mg 100 mg tablets
ACCESS CONNECT®

4. Patient Authorizations

I understand that I must complete this enrollment form before I can receive assistance through Gilead Sciences, Inc.'s Access Connect ("Program") and the Patient Assistance Program ("PAP"). As part of this process, Gilead and its agents and contractors (collectively, "Gilead") will need to obtain, review, use and disclose my personal and medical information as described below. I hereby authorize my healthcare providers and health plans to disclose my personal and medical information as described below to Gilead in connection with the Program and/or the PAP, all in accordance with this authorization, and I authorize Gilead to use and disclose the information in accordance with the authorization.

Information to Be Disclosed: Personal health information ("PHI"), including information about me (for example, my name, mailing address, financial information, and insurance information), my past, current and future medical condition (including information about my treatment with this prescription medication and related medical condition), and all information provided on this enrollment form.

Persons Authorized to Disclose My Information: My healthcare providers, including any pharmacy that fills my prescription medication, and any health plans or programs that provide me healthcare benefits. I understand that my pharmacy providers may receive remuneration for disclosing my PHI pursuant to this authorization.

Persons to Whom My Information May Be Disclosed: Gilead, including the third-party administrator responsible for the administration of the Program and the PAP.

Purposes for Which the Disclosures Are to Be Made: Disclosures of PHI may be made to Gilead so that Gilead may use and disclose the PHI for purposes of: 1) completing the enrollment process and verifying my enrollment form; 2) establishing my eligibility for benefits from my health plan or other programs; 3) providing financial assistance, support, referral services, adherence reminders and support, and communicating with my healthcare providers, including, but not limited to, facilitating the provision of my prescription medication to me; 4) contacting me to evaluate the effectiveness of the Program and/or the PAP; 5) for Gilead's internal business purposes, including quality control and service enhancing surveys.

I understand that once my PHI has been disclosed hereunder, federal privacy law may no longer restrict its use or disclosure. I understand further that I may refuse to sign this authorization and that 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 services offered by AccessConnect and/or the PAP. I may also cancel my permission at any time by writing a letter to Gilead and faxing to 1-855-553-8672 or by calling 1-844-622-2377. If I cancel, Gilead will stop using this authorization to obtain, use or disclose my PHI after the cancellation date, but the cancellation will not affect uses or disclosures of any PHI that have already been made pursuant to this authorization before the cancellation date. I am entitled to a copy of this signed authorization, which expires the earlier of ten (10) years from the date it is signed by me or other time period required under the laws of the state in which I reside.

☐ By checking this box, I agree to receive marketing information on offers, educational materials, and market research related to my medical condition, treatment and/or my prescription medication. I also agree to participate in any future customer relationship marketing program, if requested.

Ensure this form is filled out completely and sign your name in this section prior to submitting.

Patient Name: _____

Patient Signature: _____ **Date:** _____

Please see full Prescribing Information, including Medication Guide with **important warnings** at zydelig.com

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