SUPPORT path®
for **LIVDELZI®** (seladelpar)
10 mg Capsules

THIS PAGE TO BE COMPLETED BY **PATIENT** OR **PATIENT'S REPRESENTATIVE**

SPECIALTY PHARMACIES:

AcariaHealth	TEL: **1-833-236-9722**	FAX: **1-833-494-2747**
Orsini	TEL: **1-888-263-8004**	FAX: **1-877-846-0402**
PANTHERx Rare	TEL: **1-888-685-1482**	FAX: **1-877-914-0648**

PATIENT ENROLLMENT FORM

PHONE: **1-855-769-7284** FAX: **1-855-298-8700**
(MONDAY to FRIDAY, 9 AM–8 PM ET)

PATIENT CONFIDENTIALITY: Patient confidentiality is of primary importance to us. All patient information will remain confidential. Information may be provided to clinicians, social workers, or family members when required to complete the enrollment process and coordinate patient assistance, and to credit bureaus to determine program eligibility with your consent within this Enrollment Form.

After submitting this form, please expect a call from a dedicated Support Path Program Specialist within 2 business days. They will walk you through the next steps of the process and answer any questions.

CLEAR FORM

1. PATIENT SUPPORT OFFERINGS

PLEASE CHECK ALL THAT APPLY

☐ Patient Support Offerings *(includes: Benefits Investigation, Prior Authorization and Appeals Information, and Patient Assistance Program [PAP] Eligibility Screening)*

☐ Co-pay Coupon Program Eligibility Screening ☐ Interim Support Program

2. GILEAD MEDICATION PRESCRIBED REQUIRED

Product Name: **LIVDELZI®** (seladelpar)

3. PATIENT INFORMATION REQUIRED

First Name:	Last Name:	MI:	Preferred Name:
Address:	Apt/Unit #:	City:	
State:	ZIP Code:	Phone #: ( ) –	Preferred Language:
Email:	Date of Birth: / /	Gender: ☐ M ☐ F	SSN (Last 4 digits):	Resides in US/US Territories: ☐ Yes ☐ No
Alternate Contact Name:	Phone #: ( ) –	Relationship:	

CONTACT AUTHORIZATION

I authorize Support Path to provide me with information on my benefits and other communications that contain reference to the Support Path program or the Patient Assistance Program (PAP) dispensing pharmacy through the following (select all that apply):

☐ Email ☐ Phone call ☐ Text message ☐ Via my healthcare provider

☐ Yes ☐ No I authorize Support Path to leave a detailed message, including the name of my prescription, if I am unavailable when they call.

☐ Yes ☐ No I authorize Support Path to send me correspondence via US mail. This includes, but is not limited to, approval/denial letters for the PAP, reminder letters for re-enrollment periods, etc. If I select "No," or do not check either box, I understand that all communication will be via phone.

NOTE:

- If I do not select a contact preference, I understand that Support Path will provide program communications to me by phone and/or through my healthcare provider.
- By selecting "phone call" and/or "text message," I authorize Support Path to provide me information regarding my benefits and other communications that contain reference to the Support Path program of the PAP dispensing pharmacy via my contact authorization preference at the phone number I have provided. Note that text message and data rates may apply, and that you can opt out of such text messages at any time by replying "STOP."

4. INSURANCE INFORMATION REQUIRED

PLEASE INCLUDE A COPY OF THE FRONT AND BACK OF INSURANCE CARD(S)

☐ Patient is uninsured (ie, no health insurance through any public or private payer) **Complete "Additional Insurance Information" in Section 11**

☐ Patient is insured (Please fill out all of the applicable insurance information below — Include copy [front & back] of all insurance cards, including medical and prescription.)

PRIMARY INSURANCE

Primary Insurance:		Is this a Medicare Part D plan? ☐ Yes ☐ No	
Plan Name:		Insurance Phone #: ( ) –	
Subscriber Name:			
Policyholder Name:		Policyholder Relationship to Patient:	
Policy #:	Group #:	Rx Bin #:	Rx PCN #:

SECONDARY INSURANCE

☐ Check this box if patient has secondary insurance coverage and include a copy [front and back] of insurance cards, if available.

Secondary Insurance:		Is this a Medicare Part D plan? ☐ Yes ☐ No	
Plan Name:		Insurance Phone #: ( ) –	
Subscriber Name:			
Policyholder Name:		Policyholder Relationship to Patient:	
Policy #:	Group #:	Rx Bin #:	Rx PCN #:

SUPPORT PATH® LIVDELZI® (seladelpar) **PATIENT ENROLLMENT FORM**

PHONE: **1-855-769-7284** FAX: **1-855-298-8700**

PATIENT NAME: _____ **DATE OF BIRTH:** / /

5. PRESCRIBER INFORMATION REQUIRED

MUST BE COMPLETED BY A HEALTHCARE PROVIDER

Prescriber Name:	Specialty:	Facility Name:	
Address:	City:	State:	ZIP Code:
Office Contact:	Phone #: ( ) –	Fax #: ( ) –	
NPI #:	State License #:	Tax ID #:	

6. DIAGNOSIS/MEDICAL INFORMATION REQUIRED

MUST BE COMPLETED BY A HEALTHCARE PROVIDER

To ensure a timely response, be sure to include all details below and attach supporting documentation.

ICD-10 code: | Is patient ready to start therapy? ☐ Yes ☐ No

Diagnosis:

MEDICAL INFORMATION OPTIONAL

ALP range: Date of test: / / | Bilirubin score: Date of test: / /

7. PRESCRIPTION AND PHARMACY INFORMATION REQUIRED

MUST BE COMPLETED BY A HEALTHCARE PROVIDER

PLEASE FILL OUT THE BELOW PRESCRIPTION FORM WHICH WILL BE SENT TO THE APPROPRIATE DISPENSING PHARMACY ONCE YOUR PATIENT IS APPROVED.

Patient First Name: | Last Name: | Date of Birth: / /

Is this the patient's first treatment of **LIVDELZI®** (seladelpar)? ☐ Yes ☐ No

Has the prescription already been sent to the specialty pharmacy? ☐ Yes ☐ No
(If "No," Support Path will send this prescription to the specialty pharmacy for processing)

Known medication allergies: (☐NONE)

Current/previous PBC therapies:

Rx **NOTE:** Select both Specialty Pharmacy Rx and Interim Support Rx checkboxes if you would like your patient to be reviewed for eligibility in the event the patient is experiencing insurance delays or is uninsured (Terms and Conditions apply). Only one pharmacy may receive this prescription to dispense.

CHOOSE ONE

☐ **Specialty Pharmacy Rx**

☐ **Patient Assistance Program** (PAP)

Medication: **LIVDELZI Oral 10 mg capsules** | Directions: **Take 1 capsule PO per day** | Quantity: **30** | Refill: _____

Preferred Specialty Pharmacy: ☑ Orsini ☐ PANTHERx ☐ AcariaHealth ☐ Other: _____

☐ **Interim Support Rx**

Medication: **LIVDELZI Oral 10 mg capsules** | Directions: **Take 1 capsule PO per day** | Quantity: **30** | Refill: **1**

8. INTERIM SUPPORT PROGRAM ONLY APPLICABLE IF APPLYING FOR THE INTERIM SUPPORT PROGRAM

MUST BE COMPLETED BY A HEALTHCARE PROVIDER

☐ **By checking this box, my patient requires evaluation of the Interim Support Program based on their eligibility due to delay in coverage through their insurance provider.** The Interim Support Program offers temporary assistance to insured US residents aged 18 and above who are experiencing a delay in coverage for LIVDELZI therapy. Additional eligibility criteria apply. This program provides eligible patients with a 30-day supply of LIVDELZI free of charge while patients actively pursue coverage with their insurer. If coverage delays persist, a one-time refill is available. The Interim Support Program is not insurance, and participation does not guarantee successful insurance coverage. Products obtained through this program cannot be submitted for reimbursement to any third-party payer and should not be considered in the calculation for out-of-pocket costs under any health care program. Product may not be sold, traded, or distributed to anyone other than the intended patient. Participation in the Interim Support Program ends upon successful coverage or exhaustion of permitted fills, whichever comes first. Patients cannot re-enroll. Gilead reserves the right to change or terminate the program at any time without notice. Additional terms and conditions apply.

X **PRESCRIBER SIGNATURE** (REQUIRED): | **DATE:** / /

9. PRESCRIBER CERTIFICATION REQUIRED

MUST BE COMPLETED BY A HEALTHCARE PROVIDER

By signing below, I certify that I am personally prescribing and may furnish Gilead medication for the patient identified in Section 3. 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 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 Support Path program is complete and accurate to the best of my knowledge. If approved for the Patient Assistance Program (PAP), I certify that I have not received and shall not seek reimbursement for any Gilead medication dispensed 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 in Section 3 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, or dispense all or any portion thereof for the use of 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 in Section 3 is not prescribed, provided, furnished, or dispensed to that patient, and I will ensure such medication is returned to Gilead or its designated representative, by calling 1-855-769-7284 within 30 days. I certify that I will not sell, resell, offer for sale, trade, or barter medication provided to me under the PAP. I understand that if my patient's insurance or financial status changes, the patient may no longer be eligible for Interim Support and/or the PAP. If my patient is enrolled in the Interim Support Program, I certify that I will continue to assist my patient to pursue insurance coverage for his/her prescribed medication, as appropriate. I consent that Gilead may perform an audit related to: 1) the applicant identified in Section 3, 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 prescribed Gilead medication and the timely return of any medications received for, but not dispensed to, the patient identified in Section 3, 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 affiliates and its agents and contractors for the purposes of assessing the patient's insurance coverage and eligibility for participation in Support Path, 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 Medical Information in Section 10. 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 Support Path. I understand that Gilead may, if authorized by the patient, contact the patient directly to verify Support Path eligibility and updates to insurance coverage, as well as to confirm the receipt of Gilead medication through the PAP.

SPECIAL NOTE: New York prescribers, please submit prescription on an original NY State prescription blank. For all other states, if not faxed, prescription must be on state-specific form, if applicable for your state.

X **PRESCRIBER SIGNATURE** (REQUIRED): | **DATE:** / /

PATIENT NAME: _____ **DATE OF BIRTH:** ___/___/___

10. PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION REQUIRED

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 Support Path program (the "Program") and the Patient Assistance Program ("PAP"). Additional information about how Gilead may use my information can be found at https://www.gilead.com/privacy-statements.

Information to Be Disclosed: My personal information related to my enrollment or participation in the Program, which may include personally identifiable information and 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 ("HITECH") Act (collectively Personal Information or "PI"):

- General information about me, including my name, birth date, and contact information
- Information about my medical condition, including information about my liver disease-related status or treatment with this prescription medication and related medical condition
- Information about my health benefits or health insurance coverage
- Financial information (as necessary), such as my income
- All information provided on this enrollment form and otherwise provided by me to the Program or PAP

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, including my health insurance company, or programs that provide me with healthcare benefits

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

- My healthcare providers, including the pharmacy that fills my prescription medication
- My health plans, including my health insurance company
- 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 healthcare provider
- 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 and/or the PAP
- 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
- Deidentifying the information I provide, which means removing elements like my name and address so that I am no longer reasonably identifiable
- Meeting Gilead's legal requirements

Please continue onto next page >>>

PATIENT NAME: _____ **DATE OF BIRTH:** / /

10. PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION (CONTINUED) REQUIRED

Other Important Points:

- 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 and/or the PAP
- Once I sign this Patient Authorization and my PI is transmitted to Gilead and its partners, I understand that state and federal privacy laws may no longer protect or prohibit the redisclosure of the PI disclosed to Gilead and its partners by my healthcare provider or others
- I understand that I am entitled to a copy of this signed authorization and that the authorization expires on the earlier of two (2) years from the date it is signed by me or sooner if required under the laws of the state in which I live
- I understand that I may cancel this authorization at any time by notifying Gilead at 1-855-769-7284. 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

X **SIGNATURE OF PATIENT or AUTHORIZED PATIENT REPRESENTATIVE UNDER FEDERAL OR STATE LAW** (REQUIRED ONLY IF APPLYING FOR PAP):		**DATE:** / /
PATIENT REPRESENTATIVE'S NAME (IF SIGNING FOR THE PATIENT. PLEASE PRINT):	**PATIENT REPRESENTATIVE'S RELATIONSHIP TO PATIENT:**	**PHONE #:** ( ) –

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PATIENT NAME: _____ **DATE OF BIRTH:** ___/___/___

OPTIONAL

▼ ONLY REQUIRED IF APPLYING TO THE PATIENT ASSISTANCE PROGRAM (PAP) ▼

11. PATIENT FINANCIAL INFORMATION

REQUIRED ONLY IF APPLYING FOR THE PAP

Current annual household income: $ _____ (Documentation for all sources of income may be required [eg, tax return, W-2, last 2 pay stubs, etc.])

Number of people in household supported by current annual income: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ Other: _____

ADDITIONAL INSURANCE INFORMATION

Is the patient eligible for Medicaid? ☐ Yes ☐ No If No, state reason (if denied, include a copy of the denial letter):	Has the patient applied for Medicaid? ☐ Yes ☐ No If Yes, date of application: ___/___/___
Is the patient eligible for Medicare? ☐ Yes ☐ No If No, state reason (if denied, include a copy of the denial letter):	Has the patient applied for Medicare? ☐ Yes ☐ No If Yes, date of application: ___/___/___
Is the patient eligible for VA benefits? ☐ Yes ☐ No	If Yes, has the patient tried to obtain the medication through the VA? ☐ Yes ☐ No
Is the patient eligible for an insurance plan offered through a state insurance marketplace (also known as an exchange)? ☐ Yes ☐ No If No, state reason:	Has the patient applied for an insurance plan offered through a state insurance marketplace (also known as an exchange)? ☐ Yes ☐ No If Yes, date of application: ___/___/___

12. APPLICANT DECLARATIONS AND AUTHORIZATIONS

By signing below, 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 Support Path becomes aware of any false or inaccurate information or if this medication is no longer prescribed for me. I understand that I may only use the free product received through the Patient Assistance Program (PAP) for my own use and personal consumption, and that I will not offer the product for sale, resale, barter, or trade.

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. If I am a member of a Medicare Part D plan, I will not seek to have this medication, or any cost for items associated with it, counted as part of my out-of-pocket cost for prescription drugs. 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 the PAP and its administrator to forward my prescription to a dispensing pharmacy on my behalf. Support Path may require me to submit proof of identity and income documentation to verify my eligibility into the PAP (eg, identification card, tax return, W-2, last two pay stubs, etc). **I authorize Gilead, its affiliates, 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.**

REQUIRED X **SIGNATURE OF PATIENT or AUTHORIZED PATIENT REPRESENTATIVE UNDER FEDERAL OR STATE LAW:**	**DATE:** ___/___/___
PATIENT REPRESENTATIVE'S NAME (IF SIGNING FOR THE PATIENT. PLEASE PRINT)**:**	**PHONE #:** (___) ___–
PATIENT REPRESENTATIVE'S RELATIONSHIP TO PATIENT:	

GILEAD

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FAX COMPLETED FORM TO SUPPORT PATH AT 1-855-298-8700

PRINT FORM