HarborPath®

HarborPath Patient Assistance Program Application
(Rev April 2019)

Toll Free Phone 1-855-300-8916
Toll Free Fax 1-877-202-0127
Toll Free Refill Line 1-855-877-5953

Patient ID # _____

PROGRAM DESCRIPTION

The purpose of this enrollment tool is to collect information that numerous pharmaceutical companies and foundations providing donated products require for enrollment in the HarborPath Patient Assistance program. HarborPath provides medication no cost to eligible patients. To facilitate enrollment, this tool consolidates all of the necessary information in one place. **HarborPath will determine a patient's eligibility for assistance based on the individual program requirements.**

PATIENT GENERAL INFORMATION

Name First: _____ Middle: _____ Last: _____
Social Security Number: ___ – ___ – ____ Gender: ○ Male ○ Female
Mailing Address: _____ City: _____ State: -- County: _____ Zip: _____
Phone: ___ – ___ – ____ ☐ OK to call? Date of Birth M / D / Y
Number of people, including applicant, who contribute to or are dependent on household income: _____ Total gross annual income: _____
Check all that apply: ☐ IDU ☐ HIV/HCV Co-infected ☐ HCV Mono-Infected ☐ MSM ☐ Transgender ☐ LGBT ☐ None

ALLERGY & HEALTH INFORMATION

List any known drug allergies: _____
List of other current medications: _____
Diagnosis: _____

COVERAGE INFORMATION (CHECK ALL THAT APPLY)

AIDS Drug Assistance Program:	☐ Enrolled	☐ Denied	☐ Pending	☐ Not Applied	☐ Not Eligible	☐ Waitlisted
Medicaid:	☐ Enrolled	☐ Denied	☐ Pending	☐ Not Applied	☐ Not Eligible	
Medicare:	☐ Enrolled	☐ Denied	☐ Pending	☐ Not Applied	☐ Not Eligible	
Medicare Part D:	☐ Enrolled	☐ Denied	☐ Pending	☐ Not Applied	☐ Not Eligible	
Private Insurance:	☐ Enrolled	☐ Denied	☐ Pending	☐ Not Applied	☐ Not Eligible	
VA:	☐ Enrolled	☐ Denied	☐ Pending	☐ Not Applied	☐ Not Eligible	

PHYSICIAN/PRESCRIBER INFORMATION

Name First: _____ Middle: _____ Last: _____
Business/Facility Name: _____ Phone ___ – ___ – ____ Fax ___ – ___ – ____
Office Contact Name First: _____ Middle: _____ Last: _____
Mailing Address: _____ City: _____ State: -- Zip: _____
Professional Designation: _____ NPI Number: _____
Tax ID #: _____ DEA#: _____ State License #: _____

SHIPPING INFORMATION

Name First: _____ Middle: _____ Last: _____
Business/Facility Name: _____ Phone: ___ – ___ – ____ Fax: ___ – ___ – ____
Shipping Address: _____ City: _____ State: -- Zip: _____
Relationship to Applicant: _____

PATIENT AUTHORIZATION

By my signature, I authorize HarborPath Patient Assistance Program to do the following:

1. Use any information that I provide in any application for the purpose of enrolling in or to administer the HarborPath Patient Assistance Program;
2. Contact my doctor, healthcare provider, or pharmacist about my application for the HarborPath Patient Assistance Program, and disclose to them information contained in my application, in order to help me receive Program's products under the HarborPath Patient Assistance Program and ensure that guidelines are being met;
3. Request information from my insurer, doctor, healthcare provider, or pharmacist about the prescribed medications I receive or will receive under the HarborPath Patient Assistance Program and about my medical condition. This information will be used only to determine my eligibility for the HarborPath Patient Assistance Program and to administer the HarborPath Patient Assistance Program. By signing below, I also authorize my insurer, doctor, healthcare provider, or pharmacist to release information about my prescribed medications and medical condition that is requested by Programs or their agents used to run the HarborPath Patient Assistance Program;
4. Contact my insurer, other potential funding sources, including Ryan White programs, the Centers for Medicare and Medicaid Services, AIDS Drug Assistance Program (ADAP), social workers or patient advocacy organizations on my behalf in order to determine if I am eligible for health insurance coverage or other funds, and disclose to them information contained in my HarborPath Patient Assistance Program application or information about my prescribed medications and medical condition that has been provided by my physician, healthcare provider or pharmacist; and
5. Disclose any information obtained from the sources listed above to third-parties if required by law.
6. I give my consent to release any information to the Pharmaceutical Manufacturers or their designees for auditing purposes only for the Bulk Replacement Patient Assistance Medication Programs.

By my signature, I am signifying that I understand the following:

1. Once medical information about me has been disclosed in reliance upon this Authorization, the information may no longer be protected by federal privacy laws and may further disclosed, however, Programs agree to protect my information by using and disclosing it only for the purposes described above or as required by law.
2. HarborPath Patient Assistance Program will only ask for the information that is needed to process my application, to renew it, and to provide me with help throughout my participation in the HarborPath Patient Assistance Program, but will not have access to any information that does not relate to enrollment in a PAP administered by another Program.
3. This Authorization will remain in effect for as long as I participate in the Program and a period of 5 years after my participation if the Program ends, and that I am entitled to request a copy of this signed Authorization.
4. I have the right to revoke this authorization at any time by mailing a signed written statement of my revocation to HarborPath, Woodfield Corporate Center, 8000 Corporate Center Dr., Suite 200, Charlotte, NC 28226.
5. Such a revocation would end my eligibility to participate in the HarborPath Patient Assistance Program. Revoking this authorization will prohibit disclosures after the date written revocation is received, except to the extent that action has been taken in reliance on my authorization.

Finally, I understand I may refuse to sign this authorization and that if I refuse, my eligibility for health plan benefit and treatment by my doctor will not change, but I will not have access to the services available through this program. If I receive any free product from Programs, I certify that I will not seek reimbursement from any public or private prescription drug plan for the use of such product. I certify that the information in this application is complete and accurate to the best of my knowledge and agree to notify HarborPath or my provider of any change in my insurance eligibility, including the AIDS Drug Assistance Program (ADAP) or financial status within 30 days by mail: HarborPath, Woodfield Corporate Center, 8000 Corporate Center Dr., Suite 200, Charlotte, NC 28226, or by calling toll free at (855) 877-5953

Signature (Patient or Legal Representative)

M / D / Y
Date

PHYSICIAN/PRESCRIBER CERTIFICATION

By my signature, I certify:

1. To the best of my knowledge, the information on this patient is correct and complete and consistent with applicable privacy laws and regulations, and I understand that Program and/or their agents are relying on this representation.
2. I have no knowledge of any intent to sell, barter or give this product to any person other than the patient for whom it has been prescribed.
3. No reimbursement of the cost of product will be accepted by me from public or private sources, including patients, for any treatments where product will be provided free-of-charge by Program
4. The medication(s) covered by the HarborPath Patient Assistance Program are medically indicated for this patient and that I will be supervising the patient's treatment.
5. I agree to periodically verify continued use of Programs' medication and resubmit current prescriptions.
6. My State license is currently in good standing, I am not prohibited from participating in Federally-funded healthcare programs, nor am I on the List of Excluded Individuals/Entities maintained by the HHS Office of Inspector General.
7. I give my consent to release my information to the Pharmaceutical Manufacturers or their designees for auditing purposes only for the Bulk Replacement Patient Assistance Medications Programs.

I authorize the Program to forward this prescription to a dispensing pharmacy on behalf of myself and my patient, or to send the medication directly to the patient, or to send the medication to my office for dispensing to my patient.

Signature (Prescriber)

M / D / Y
Date

ABBVIE

See Legend Below

Kaletra® (lopinavir/ritonavir)
Norvir® (ritonavir)

JOHNSON & JOHNSON PATIENT ASSISTANCE FOUNDATION

See Legend Below

Edurant® (rilpivirine)
Intelence® (etravirine)
Prezcobix™ (darunavir, cobicistat)
Prezista® (darunavir)
Symtuza® (darunavir, cobicistat/emtrcitabine/tenofovir alafenamide)

MERCK

See Legend Below

Crixivan® (indinavir sulfate)
Delstrigo™ (doravirine, lamivudine, tenofovir disoproxil fumarate)
Dulera® (mometasone furoate/formoterol fumareate dihydrate)
Emend® (aprepitant)
Isentress® (raltegravir)
Janumet® (sitagliptin/metformin hydrochoride)
Janumet® XR (sitagliptin/metformin HCl extended-release)
Januvia® (sitagliptin)
Maxalt® (rizatriptan benzoate)
Maxalt® MLT (rizatrptan benzoate orally disintegrating)
Pifeltro™ (doravirine)
Proventil® (albuterol)
Trusopt® (dorzolamide hydrochloride) 2% ocumeter Zepatier™
(elbasvir and grazoprevir)
Zetia® (ezetimibe)

MYLAN

See Legend Below

Cimduo™ (lamivudine, tenofovir - disoproxil fumarate)
Symfi™ (efavirenz, lamivudine, tenofovir - disoproxil Fumarate)
Symfi Lo™ (efavirenz, lamivudine, tenofovir - disoproxil Fumarate)

VIIV HEALTHCARE

See Legend Below

Combivir® (lamivudine/zidovudine)
Dovato® (dolutegravir/ lamivudine)
Epivir® (lamivudine)
Epzicom® tablets (abacavir sulfate and lamivudine)
Juluca® (dolutegravir and rilpivirine)
Lexiva® (fosamprenavir calcium)
Retrovir® (zidovudine)
Selzentry® (maraviroc)
Tivicay® (dolutegravir)
Triumeq® (dolutegravir, abacavir and lamivudine)
Trizivir® (abacavir sulfate, lamivudine and zidovudine)
Viracept® (nelfinavir mesylate)
Ziagen® (abacavir sulfate)

ATTACHMENTS (REQUIREMENTS VARY BY PROGRAM):

1. Copy of recent paystubs or
2. Federal Income Tax return form signed and dated or
3. Social Security Check or awards letter
4. Original Prescription Form