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**In-Office Use Only**

**General Patient Information** (please print legibly)**:**

Name:_____ Address:_____Apt. #:_____

City:_____State: _____ Zip:_____ Phone:_____ DOB:_____

Allergies to Medications: _____

Email:_____

**Insurance Information:**

Carrier:_____ RX BIN:_____

RX Group:_____ PCN:_____

ID Number:_____ Relation Code: (cardholder/spouse/dependent)

**Information Required for Gilead Truvada® for PrEP Medication Assistance Program Activation:**

- Are you a current resident of the United States, Puerto Rico, or US Territories?: Y N
- Are your prescriptions paid for in part or in full under any federally funded program, including but not limited to Medicare or Medicaid, VA, DOD, or TRICARE?: Y N
- Are you in Medicare Part D coverage gap (donut hole)?: Y N

*If you begin receiving prescription benefits from such state, federal, or government-funded program at any time, you will no longer be eligible to use Gilead Advancing Access Co-Pay coupon card.

Patient Signature:_____ Date:_____

Name:_____ DOB:_____ Date:_____

Address: _____

℞

Refill_____Times

_____

Prescriber's Signature