CLEAR FORM

Letairis® Prescription and LEAP Patient Support Enrollment Form

Please complete all fields on this form to prevent any delays in shipment of Letairis to your patient and fax to 1-888-882-4035.

1 Patient Information (PLEASE PRINT)

First Name:	Middle Initial:	Last Name:		
Address:		City:	State:	ZIP:

Birthdate: / /	Gender: ☐ M ☐ F	Preferred Time to Contact: ☐ Day ☐ Evening	Home Phone: ( ) –	Mobile Phone: ( ) –	Email:
Alternate Contact Name:			Alternate Phone: ( ) –	Relationship:	

2 Patient Permission for Gilead to Provide Educational Information

I authorize Gilead Sciences, Inc., its affiliates, agents and contractors (collectively, "Gilead") to provide me with helpful tips about living with PAH, information about Gilead products and programs, and support for maintaining my prescribed treatment. I authorize my healthcare providers, pharmacies, health plans, or payers (my "healthcare organizations") to share personal and health information about me related to my Gilead PAH therapies ("my information") with Gilead (by signing Section 3 below) in order for Gilead to use it to communicate with me, including by e-mail, mail, or telephone (including voicemail and text messaging). Gilead may also use my information to learn how well Gilead programs are working. I understand that if I do not initial below, I will still be eligible for health plan benefits and treatment by my doctor will not change, but I will not receive the communications described above.

Please initial here to confirm your enrollment. _____

3 Patient Written Permission to Share Protected Health Information

I authorize my healthcare organizations to share my information with Gilead. I understand that once my information is shared with Gilead, my information may be protected by certain state privacy laws but not by federal health privacy laws, and may be redisclosed by Gilead. Gilead agrees to protect my information and to use and share it only for the reasons listed below. I understand that my pharmacy may receive compensation in connection with sharing my information with Gilead as allowed under this Authorization.

I authorize my healthcare organizations to share my information with Gilead, in order for Gilead to use and disclose my information for the following reasons: (1) to contact me or my healthcare organizations, or others I have identified, about my disease or treatment; (2) to confirm my health plan eligibility and benefits, identify other payers for my therapy, or determine whether I may be eligible for assistance programs; and (3) to communicate with me as described in Section 2 above, if selected.

This Authorization will expire 10 years from the date signed below unless a shorter period is required by the law of my state of residence. I may also cancel my permission at any time by writing a letter to Gilead and faxing to 1-888-882-4035 or by calling 1-866-664-5327. If I do not sign this form, I understand my eligibility for health plan benefits and treatment by my doctor will not change. I am allowed a copy of this signed authorization.

REQUIRED FOR ALL PATIENTS	Patient or Patient Representative: X	Date: / /

4 Specialty Pharmacy (LEAP WILL SEND PRESCRIPTION TO PATIENT'S IN-NETWORK PHARMACY)

Select a preferred Certified Pharmacy:

☐ Accredo ☐ CVS Caremark ☐ Humana Specialty Pharmacy
☐ AllianceRx Walgreens Prime ☐ Acaria Health Pharmacy ☐ OptumRx

5 Prescriber Information (PLEASE PRINT)

First Name:	Last Name:	State License #:		
Address:	City:	State:	ZIP:	

Phone: ( ) –	Fax: ( ) –	NPI #:
Office Contact (First and Last Name):	Email:	

6 Diagnosis

ICD-10 I27.0 Primary Pulmonary Hypertension

☐ Idiopathic PAH
☐ Heritable PAH

ICD-10 I27.21 Secondary Pulmonary Arterial Hypertension

☐ Connective tissue disease
☐ Congenital heart disease with repaired shunts
☐ Other (please specify): _____

7 Prescription

New York prescribers, please submit prescription on an original NY State prescription blank. For all other States, if not faxed or e-prescribed, prescription must be on State-specific blank if required by your State. Prescribers in all States must follow applicable State law. Prescribers and all female patients must be enrolled in the REMS program prior to initiating treatment.

LETAIRIS: ☐ 5 mg tablets (30 tablets) PO QD Refills:_____ Instructions:_____
LETAIRIS: ☐ 10 mg tablets (30 tablets) PO QD Refills:_____ Instructions:_____

Ship to: ☐ Patient Home (address listed above) ☐ Prescriber Office (address listed above) ☐ Other (please indicate below)

Name:	Address:			
City:	State:	ZIP:	Phone: ( ) –	

By providing my signature, I authorize LEAP to act on my behalf for the limited purposes of transmitting this prescription to the pharmacy designated by the patient's benefit plan.

REQUIRED FOR ALL PATIENTS (SIGN ONE)	Prescriber Signature (*Dispense as Written*): NO STAMP ALLOWED X	Date: / /
	Prescriber Signature (*Substitution Allowed*): NO STAMP ALLOWED X	Date: / /

8 Fax this form and all patient insurance information including pharmacy benefit cards (front and back) to 1-888-882-4035.

Please visit **www.letairis.com/professional/enrollpatient** or call **1-866-664-5327** for more information.
Please click here for patient Medication Guide and Prescribing Information, including **BOXED WARNING**.

GILEAD