Ranexa Connect™
Program Enrollment Form
For Ranexa® (ranolazine)

PHONE: 1-888-726-3925
FAX: 1-888-568-9228

Patient Name: ______________________ *Date of Birth:* ______________

1 REQUESTED SERVICE(S) (REQUIRED)

PLEASE USE THIS FORM TO REQUEST THE FOLLOWING SERVICES (CHECK ALL BOXES THAT APPLY):

- ☐ Benefits Investigation
- ☐ Prior Authorization and Appeals Support
- ☐ Patient Assistance Program (PAP) Eligibility Screening

2 PRESCRIBER INFORMATION (REQUIRED)

Prescriber Name: ______________________

Facility Name: ______________________

Address: ______________________

City: ____________ **State:** ________ **ZIP:** ________

Office Contact: ________ **Phone #:** ____________ **Fax #:** ____________

NPI #: ____________ **Tax ID #:** ____________

State License #: ______________________

3 DIAGNOSIS / MEDICAL INFORMATION (REQUIRED) MUST BE COMPLETED BY HEALTHCARE PROVIDER

Diagnosis: ☐ Chronic Angina ☐ Other: ______________

Patient Drug Allergies: ☐ No known allergies ☐ Other: ______________

Has This Patient Previously Received Ranexa? ☐ Yes ☐ No If Yes, please provide date range: ________
If Yes, how received: ☐ Samples ☐ Other: ________

Please Select Medications Tried / Failed for Angina: Please Be Specific.

☐ **Beta-blockers:** ☐ atenolol ☐ carvedilol ☐ labetalol ☐ metoprolol ☐ nadolol ☐ propranolol ☐ Other: ________
Date range of use: ______________
Therapeutic outcome for angina/other: ______________

☐ **Calcium Channel Blockers:** ☐ amlodipine ☐ felodipine ☐ diltiazem ☐ verapamil ☐ nicardipine ☐ Other: ________
Date range of use: ______________
Therapeutic outcome for angina/other: ______________

☐ **Nitrates:** ☐ isosorbide mononitrate ☐ isosorbide dinitrate ☐ nitroglycerin ☐ Other: ________
Date range of use: ______________
Therapeutic outcome for angina/other: ______________

Ranexa: ☐ 500 mg ☐ 1000 mg **Directions:** ☐ Twice daily ☐ Other: ________
Expected duration of therapy: ______________

4 PRESCRIBER CERTIFICATION AND STATEMENT OF MEDICAL NECESSITY (REQUIRED)

By signing this form, I certify that I am prescribing Gilead medication for the patient identified in Section 5. I certify that this prescription medication is medically indicated for the patient and that it will be used as directed. I certify that I will be supervising the patient's treatments and verify that the information provided is complete and accurate to the best of my knowledge. I agree that I shall not seek reimbursement for any Gilead medication dispensed to the patient through the Ranexa Connect™ Patient Assistance Program (PAP) or from any government program or third-party insurer.

I certify that I have received the appropriate permission from the patient and met any other applicable requirements imposed under the Health Insurance Portability and Accountability Act of 1996 and/or state law needed to release the above information to Gilead, and contractors designated by Gilead, for the purposes of verifying the patient's insurance coverage, seeking prior authorization if needed, on my patient's behalf, and providing information on appeals for denials of claims.

SIGN HERE

PRESCRIBER SIGNATURE (REQUIRED): ______________________ **DATE:** ____________

Gilead Sciences, Inc. reserves the right to modify or discontinue the Patient Assistance Program or terminate assistance at any time.
Third-party reimbursement is affected by a range of factors; therefore, Gilead Sciences, Inc. cannot guarantee any coverage or reimbursement.
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Last Updated: March 2018

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5 PATIENT INFORMATION (REQUIRED)

Patient Name:

Patient Language: ☐ English ☐ Spanish ☐ Other: __________

Address:

City: | **State:** | **ZIP:** | **Phone #:**

SS#: | **Date of Birth:** | **Gender:** ☐ M ☐ F | **Resides in US/US Territories:** ☐ Yes ☐ No

Alternate Contact Name: | **Relationship:** | **Phone #:**

I authorize Ranexa Connect to leave a message, including the prescription name if I am unavailable when they call. ☐ Yes ☐ No

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

☐ **Patient is insured** (Please complete all of the applicable insurance information below. Attach copy [front and back] of patient insurance card.)

☐ **Patient is uninsured** (No health insurance through any public or private payer). Complete **"Additional Insurance Information"** below.

Primary Insurance Name: | **Is This a Medicare Part D Plan?** ☐ Yes ☐ No

Plan Name: | **Insurance Phone #:**

Policy Holder Name: | **Policy ID #:** | **Group #:** | **Policy Holder Relationship to Patient:**

☐ **Check box if patient has secondary insurance coverage and fax insurance cards, if available.**

Additional Insurance Information:

Has the patient applied for Medicaid? ☐ Yes ☐ No

Has the patient applied for VA benefits? ☐ Yes ☐ No

Has the patient applied for an insurance plan offered through a state insurance marketplace (also known as an exchange)? ☐ Yes ☐ No

7 PATIENT FINANCIAL INFORMATION REQUIRED ONLY IF APPLYING FOR THE PATIENT ASSISTANCE PROGRAM

Current Annual Household Income: $ ____________________

Number in Household (circle): 1 2 3 4 5 6
Other: ____________________

Please include current documentation for all sources of income (eg, tax return, W2, last 2 pay stubs, 1099, SSI award letter, etc.).

APPLICANT DECLARATIONS AND AUTHORIZATIONS (REQUIRED ONLY IF APPLYING FOR THE PAP)

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 the program becomes aware of any fraud or if this medication is no longer prescribed for me. I understand that completing this application does not ensure that I will qualify for patient assistance. I certify that I will not seek reimbursement or credit for this prescription 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 prescription or any cost associated with it counted as part of my out-of-pocket cost for prescription drugs. I understand that the Ranexa 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 Ranexa PAP and its administrator to forward this prescription to a dispensing pharmacy on my behalf. **I authorize Gilead 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 Ranexa PAP.**

SIGN HERE **ONLY IF APPLYING FOR THE PATIENT ASSISTANCE PROGRAM**

PATIENT or PATIENT REPRESENTATIVE SIGNATURE: ______________________________ **DATE:** ____________

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8 PATIENT HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) AUTHORIZATION (REQUIRED)

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

I understand that in order for the Ranexa Connect™ program, sponsored by Gilead Sciences, Inc. (Gilead), and the Ranexa Patient Assistance Program (Ranexa PAP), also sponsored by Gilead, to provide me with assistance, they will need to obtain, review, use and disclose my personal health information (PHI), including information related to my medical condition and other medical, financial, and insurance information on my application form, and any prescription. I authorize my physician, pharmacy and health plan(s) to disclose my PHI to the Ranexa Connect program and/or the Ranexa PAP and their third-party administrator as necessary to complete the application process or to verify my application. I further authorize Gilead's third-party administrator responsible for the administration of both the Ranexa Connect program and the Ranexa PAP to use my PHI to provide services through the program(s), and to disclose my PHI to my health plan(s) and their contractors for the purpose of coordination of benefits, reimbursement support, and investigating insurance coverage. I also agree and consent to being contacted by Gilead or its third-party administrator by mail, telephone or e-mail about my participation in or experience with the program(s).

I understand that my PHI will be kept confidential and will not be further used or disclosed except to administer the program(s), or as required by law. I understand that information that I authorize to be disclosed hereunder may be re-disclosed and no longer protected by federal or state privacy laws. I agree that this Authorization is voluntary and that I may refuse to sign this Authorization. Refusal to sign will not affect my ability to obtain treatment but I will not be able to participate in the Ranexa Connect program and/or Ranexa PAP. I also understand that I can cancel this Authorization at any time by making a written request to my prescribing physician or by writing to Ranexa Connect program, PO Box 13185, La Jolla, CA 92039-3185; however, the cancellation will not apply to any information already used or disclosed pursuant to the Authorization. This Authorization will expire one (1) year after the date it is signed, below, or, if I receive Ranexa under the Ranexa PAP, one (1) year after the last date I receive Ranexa. I have read the Authorization or have had it explained to me. I understand that I may request a copy of this Authorization once it has been signed.

SIGN HERE

PATIENT or PATIENT REPRESENTATIVE SIGNATURE: ________________________________ **DATE:** ______________

FAX COMPLETED FORM TO RANEXA CONNECT AT 1-888-568-9228

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