

**INSURANCE BENEFIT VERIFICATION FORM  
 FOR PREZISTA™ (darunavir) 300 mg tablets  
 and INTELENCE™ (etravirine) 100 mg tablets**

Telephone: 1-866-836-0114  
 Fax: 1-866-836-0567

Mail to: TibotecTherapeuticsLine  
 P.O. Box 1016 San Bruno, CA 94066

Please print and mail or fax along with patient authorization.

**PATIENT INFORMATION**  
 Please print clearly.

\_\_\_\_\_  
 Patient Name

\_\_\_\_\_  
 Name of Guardian (if appropriate)

\_\_\_\_\_  
 Patient Address

\_\_\_\_\_  
 City State Zip

(\_\_\_\_) (\_\_\_\_)  
 Phone Number--Home Work

\_\_\_\_\_  
 Social Security Number Date of Birth

M\_\_\_\_ F\_\_\_\_

Can we contact the patient directly? Yes \_\_\_\_ No \_\_\_\_

**Please circle drug(s):** Prezista™ (darunavir) 300 mg tablets  
 Intence™ (etravirine) 100 mg tablets

**INSURANCE INFORMATION**  
 If possible, attach front & back of card/s

\_\_\_\_\_  
 Primary Insurance Co. Policy Number Group Number

(\_\_\_\_)  
 Phone Number Provider ID # For Insurance

\_\_\_\_\_  
 Subscriber's Name Date of Birth

\_\_\_\_\_  
 Subscriber's Relationship to Patient

\_\_\_\_\_  
 Secondary Insurance Co. Policy Number Group Number

(\_\_\_\_)  
 Phone Number Provider ID # For Insurance

\_\_\_\_\_  
 Subscriber's Name Date of Birth

\_\_\_\_\_  
 Subscriber's Relationship to Patient

**PHYSICIAN INFORMATION**

\_\_\_\_\_  
 Name of Facility

\_\_\_\_\_  
 Name of Physician

\_\_\_\_\_  
 Address

\_\_\_\_\_  
 City State Zip

(\_\_\_\_) (\_\_\_\_)  
 Phone Number Fax Number

(\_\_\_\_)  
 Office Contact Phone Number

\_\_\_\_\_  
 Provider Tax ID Number

\_\_\_\_\_  
 National Provider Identification Number

**PREZISTA™ (darunavir) 300 mg tablets and/or INTELENCE™ (etravirine) 100 mg tablets TREATMENT**

Is patient currently taking PREZISTA™ (darunavir) 300 mg tablets? \_\_\_\_

Is patient currently taking INTELENCE™ (etravirine) 100 mg tablets? \_\_\_\_

Treatment Diagnosis: \_\_\_\_\_

Additional Diagnoses (if applicable)  
 \_\_\_\_\_  
 \_\_\_\_\_

ICD-9 Code/s:  
 Primary: \_\_\_\_\_  
 Secondary: \_\_\_\_\_

Additional Information regarding treatment: (if applicable to benefits verification)  
 \_\_\_\_\_  
 \_\_\_\_\_

**Authorization to Share Health Information for Reimbursement  
or Patient Assistance Programs**

**Provider Instructions:** Patients must complete this form before they can participate in the Program.

I, \_\_\_\_\_, allow my doctor(s), any other health care providers, and my health plan or insurers to give medical information relating to my use or need for PREZISTA™ (darunavir) 300 mg tablets or INTELENCE™ (etravirine) 100 mg tablets to Lash Group. Lash Group runs the Reimbursement and Patient Assistance Programs (the "Programs") for Tibotec Therapeutics, a Division of Ortho Biotech Products, L.P.

This information can include spoken or written facts about my health and payment benefits I may have. It can include copies of records from my health care providers or health plans about my health or health care.

Lash Group and Tibotec Therapeutics will use and give out this information to see if I qualify for the Programs and to run the Programs. People who work for and with Lash Group and Tibotec Therapeutics may also see my information, but they may use it only to help me get assistance with the costs of my drugs. I understand that they will make every effort to keep my information private, but if it is accidentally given out, federal privacy laws will not protect it.

This Authorization will last until I am no longer participating in the Programs. If I change my mind before that time, I can tell my health care providers and my insurers in writing that I do not want them to share any more information with Lash Group or Tibotec Therapeutics, but it will not change any actions they took before I told them. I know that I have a right to see or copy the information my health care providers or insurers have given to Lash Group and Tibotec Therapeutics.

I KNOW THAT I MAY REFUSE TO SIGN THIS FORM. My choice about whether to sign this form will not change the way my health care providers or insurers treat me. If I refuse to sign this form, I know that this means I may no longer be able to receive assistance from the Programs.

Patient Sign Here: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

If the patient cannot sign, patient's personal representative must sign below:

Patient Name: \_\_\_\_\_

By: \_\_\_\_\_  
(Signature of person signing for patient)

Describe relationship to patient and authority to make medical decisions for patient:

\_\_\_\_\_

A copy of this form must be provided to the patient.