# ViiVConnect Savings Program Rebate

All applicable information is required to receive a Rebate Check. Not all patients are eligible for a Rebate. This Rebate Form registration will be processed by RxCrossroads by McKesson, its affiliates and service providers on behalf of ViiVConnect.

Instructions for Completing the Rebate Form:

1. PLEASE REVIEW FULL TERMS AND CONDITIONS OF YOUR VIIVCONNECT SAVINGS PROGRAM TO CONFIRM ELIGIBILITY. **Patients must be eligible to redeem the ViiVConnect Savings Program, consistent with the ViiVConnect Savings Program Terms and Conditions, to receive a Rebate Check.** If you have questions about the Rebate for the product for which you are seeking a Rebate Check, please call this toll-free number: 866-747-1170.
2. If the product was purchased from a retail or mail-order pharmacy, and the pharmacy did not accept the ViiVConnect Savings Program, complete this Rebate Form legibly and completely, including completing the applicable certifications below. You must be 18 years of age or older and a resident of the United States to request a Rebate.
3. Provide a copy of the following:
   - Front and Back of your Insurance Card
   - Your Prescription Medication Label
   - Your Prescription Medication Receipt
4. Once you have filled in the form, please certify below by selecting a response that the information you have provided is truthful and accurate.

How did you receive your medication? _____

Did your primary insurance pay a portion of the cost? ☐ Yes ☐ No

| **PATIENT INFORMATION (REQUIRED)** | |
|---|---|
| ViiVConnect Savings Program ID#*: | |
| First Name: | Last Name: |
| DOB: | |

*If you do not have a ViiVConnect Savings Program ID#, call ViiVConnect at 1-844-588-3288.

| **PATIENT CERTIFICATION (REQUIRED)**<br>**(You must be 18 years of age or older and a resident of the United States to request a Rebate)** | | | |
|---|---|---|---|
| Patient Address 1: | | | |
| Patient Address 2: | | | |
| City: | State: | ZIP: | |
| Pharmacy Name: | | Pharmacy Address 1: | |
| City: | State: | ZIP: | Pharmacy Address 2: |
| Medication Name & Strength: | | | |
| Prescription Number: | | Quantity Supplied: | |
| Days Supplied: | | Amount Paid by Patient: | |
| Date on Pharmacy Receipt: | | | |

| **PRIMARY INSURED CERTIFICATION (REQUIRED)**<br>**(The "Primary Insured" Certification must be completed by the primary insured individual, who may be the patient, if the patient is the primary insured)** | | | |
|---|---|---|---|
| Primary Insured Name: | | | |
| Primary Insured Address 1: | | | |
| Primary Insured Address 2: | | | |
| City: | State: | ZIP: | Phone: |
| Pharmacy Benefit Management Company Name (if applicable): | | | |
| Pharmacy Benefit Management Phone Number (if applicable): | | | |
| Primary Insured Health Insurance Policy Number: | | | |

I acknowledge that RxCrossroads by McKesson, its affiliates and service providers ("RXC") access to the information I have provided is necessary for data processing, eligibility verification, and follow-up related to this program. I authorize RXC to verify the information I have provided for compliance with this program.

By certifying below, I agree that RXC, the administrator of this program, has my authorization to use and verify the Primary Insured information provided. I understand my insurance company may be contacted by RXC in order to process the Rebate. I certify that my insurance company has not prohibited the redemption of manufacturer coupons for the product for which a Rebate is being sought through this Rebate Form.

☐ I certify that I have read and agree to the Terms and Conditions of my Rebate. I certify that I personally paid the required amount by my prescription insurer for the product for which I am seeking a Rebate. I certify that I have not sought and shall not seek a Rebate for the amount on the enclosed prescription receipt from any other party, including my insurer. I certify that I meet the eligibility requirements to participate in the ViiVConnect Savings Program. I certify that I am (and, if different, the patient also is) a resident of the United States.

* 1 Please attach a copy of the Front and Back of your Insurance Card

* 2 Please attach a copy of your Prescription Medication Label

* 3 Please attach a copy of your Prescription Medication Receipt

* Is the information that you provided above complete and accurate?

☐ Yes ☐ No