**Together with GSK Oncology Enrollment Form** 

GSK

Together with **GSK Oncology** 



Fax completed enrollment form to 1-800-645-9043 For assistance, please call 1-844-4GSK-ONC Monday-Friday (8 AM to 8 PM ET)

Visit us at www.TogetherwithGSKOncology.com

# Important instructions for completing pages 2 and 3 of the Together with GSK Oncology Enrollment Form.

# **Patient Information**

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Section 1: Select the services you are requesting.

Section 2: Complete the Patient Information.

**Section 4:** If you'd like to receive Together with GSK Oncology updates via telephone or text message, check the box to enroll.

Section 5: Read the HIPAA Patient Authorization on the last page, and then check the box, sign, and date in section 5.

Section 6: (optional): If you'd like to see if you're eligible for the Patient Assistance Program (PAP), check the box to enroll, and complete PAP Information to research eligibility.

Section 7: (optional): If you'd like to enroll in the optional Patient Support Program, read the content within section 7, then check the box, sign, and date.

# **Prescriber Information**

### Please provide a signed copy of this form to the patient.

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Section 3: Provide the Prescriber/Facility Information.

**Section 8:** Include legible copies (front and back) of the patient's medical and pharmacy insurance card(s). Include primary, secondary, Medicare/Medicaid (if eligible), and pharmacy benefit insurance information to ensure that ALL potential coverage options can be explored.

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Section 9 (not required for enrollment in Quick Start or Bridge programs): Select your preferred specialty pharmacy. If your preferred specialty pharmacy is not in GSK's limited distribution network or honored by the patient's insurance plan, the benefits investigation will inform you of the approved specialty pharmacy options available for your patient.

Section 10: Identify preferred shipping location if different than section 3.

**Section 11:** Diagnosis and appropriate ICD-10 code are required fields. For Quick Start or Bridge program prescriptions, please complete section 11b or 11c, respectively. For all other prescriptions, please complete section 11a.

Section 12: Read Prescriber Declaration, sign, and date. A healthcare professional's signature is required.

Next Steps:

Fax completed enrollment form to 1-800-645-9043. Together with GSK Oncology will confirm receipt with healthcare professionals by the next business day and conduct a summary benefits call within 1-2 business days regarding service options for patients. Patients will receive a call within 2 business days to be provided with coverage information for their prescribed treatment and co-pay assistance options if eligible.

| CSK<br>Together with<br>GSK Oncology   |   |  |  |  |  |
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| Check the services requested:       O Commercial Co-pay A         Benefits Investigation (Pharmacy and/or Medical Insurance Coverage)       O Prior Authorization and O Rior Authorization Authorization and O Rior Authorization Authorization and O Rior Authorization Authori Authorization Authorization Authorization Aut  | Appeals Support O Alternative Funding Sources Information   |  |  |  |  |
| 2 Patient Information  | 3 Prescriber/Facility Information   |  |  |  |  |
| Full Name:   | Prescriber Name:  |  |  |  |  |
| Sex: O Male O Female Date of Birth: MM_ DD_ YYYY   |   |  |  |  |  |
| Patient Address:   | NPI #: Tax ID #:  |  |  |  |  |
| City: ZIP:   | Site/Facility Name:   |  |  |  |  |
| Home Phone #: Cell Phone #:  |   |  |  |  |  |
| Email:   | City: State: ZIP:   |  |  |  |  |
| Patient Representative/Caregiver Name:   | Office Contact Name:  |  |  |  |  |
| Patient Representative/Caregiver Relationship to Patient:  |   |  |  |  |  |
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| OI have read and agree to the HIPAA Patient Authorization included   | Relationship to Patient:<br>I on page 4 <b>(required)</b>   |  |  |  |  |
| PATIENT OR PATIENT PATIENT OR PAT | PATIENT REPRESENTATIVE SIGNATURE HERE   |  |  |  |  |
| 6 Patient Assistance Program (PAP) for uninsured and elig  | jible Medicare patients   |  |  |  |  |
| Medicare Beneficiary Identifier (MBI):   | o receive free medication from GSK Oncology PAP. Upon request, GSK PAP will provide<br>consumer report. The program may request additional documents and information at<br>complete and true. Patients who participate or are enrolled in an Alternate Funding  |  |  |  |  |
| <ul> <li>Plan are not engible for GSK PAP. For additional questions about engibling, please contact</li> <li>Patient Support Program (optional)</li> </ul>   |   |  |  |  |  |
| <ul> <li>GSK believes your privacy is important. By providing your name, address, email as or with GSK permission to contact you for marketing, market research, or advertis channels (eg, mail, email, websites, online advertising, applications, and services) as other health-related information from GSK. GSK will not sell or transfer your nat additional information regarding how GSK handles your information, please see or negative side effects of prescription drugs to the FDA. Visit www.fda.gov/medwate</li> <li>Together with GSK Oncology support consent</li> <li>Patient signature:</li> <li>I have read and agree to the OPTIONAL Together with GSK Oncology Support consent. our privacy notice at https://privacy.gsk.com/en-us/.</li> </ul>  | sing purposes, or to invite you to interact with GSK in other ways across multiple<br>regarding the medical condition(s) in which you have expressed an interest, as well<br>me, address, or email address to any other party for their own marketing use. For<br>ur privacy notice at https://privacy.gsk.com/en-us/. You are encouraged to report<br>ch or call 1-800-FDA-1088. |  |  |  |  |
| Insurance Information (check the relevant box)   | Attach a copy of both sides of the patient's insurance card(s).   |  |  |  |  |
| Medicare     Omedicaid     Commercial/Private  | Medicare     O     Medicaid     Commercial/Private  |  |  |  |  |
| O TRICARE O Other O Uninsured  | ○ TRICARE ○ Other ○ Uninsured   |  |  |  |  |
| Primary Insurance Payer:   | Prescription Insurance Payer:   |  |  |  |  |
| Insurance Name:  | Insurance Name:   |  |  |  |  |
| Phone #: Policy ID #:  | Phone #: Policy ID #:   |  |  |  |  |
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| Policy Holder Name:  | Policy Holder Name:   |  |  |  |  |
| Policy Holder Name.  |   |  |  |  |  |
| Has a prior authorization (PA) been initiated?       Yes       No         Has a prior authorization (PA) been initiated?       Yes       No         If yes, PA status:       Approved       Denied       Pending   |   |  |  |  |  |

| GSK<br>Together with<br>GSK Oncology  |  |  |   |  |  |  |  |
|---|--|--|---|--|--|--|--|
| Patient Name:   |  |  |   | Date of Bir  | th:M / /YYYY   |  |  |
| <ul> <li>Preferred Specialty Pharmacy (sele<br/>Not required for enrollment in Quick Start or Bridge</li> <li>Preferred Specialty Pharmacy selection will be<br/>honored if permitted by patient's insurance p</li> <li>No preference</li> <li>Biologics by McK</li> <li>In-office</li> <li>Onco360 Oncological</li> <li>Pharmacy</li> </ul>  | Date of Birth: / |  |   |  |  |  |  |
| 11 Clinical Information   |  |  |   |  |  |  |  |
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| Prescription  |  |  |   |  | 1  |  |  |
| Medication  | Strength/Form         Quantity         Refills         Directions for Administration   |  |   |  |  |  |  |
| O 11a. OJJAARA: Standard Prescription   | <ul> <li>100 mg tablet</li> <li>150 mg tablet</li> <li>200 mg tablet</li> </ul>  |  |   |  | <ul> <li>Take 1 tablet orally once daily with or<br/>without food</li> </ul>   |  |  |
| • <b>11b. OJJAARA: Quick Start Program</b><br>For patients experiencing a delay in coverage<br>at first dispense  | <ul> <li>○ 100 mg</li> <li>○ 150 mg</li> <li>○ 200 mg</li> </ul>   | tablet   | 30  | 1  | <ul> <li>Take 1 tablet orally once daily with or<br/>without food</li> </ul>   |  |  |
| <b>11c. OJJAARA: Bridge Program</b><br>For patients experiencing coverage<br>interruptions while already on treatment0 100 mg tablet<br>0 150 mg tablet301O Take 1 tablet orally once daily with or<br>without food   |  |  |   |  |  |  |  |
| "Dispense As Written" / Brand Medically Necessary /       May Substitute / Product Selection Permitted /         "Do Not Substitute / No Substitution / DAW / May Not Substitute       Substitute / Product Selection Permitted /         Prescriber's Signature:       Signature:       Signature:         Date:       MM       /       DD       /         Special Note: If a New York prescriber, please use an original New York State prescription form. The prescriber is to comply with the prescriber's state-specific prescription requirements.       The prescriber's state-specific prescription requirements. |  |  |   |  |  |  |  |
| 12 REQUIRED: Prescriber Declaratio  | n  |  |   |  |  |  |  |
| I certify that the information provided above<br>that, for any insured patient seeking co-pay a<br>program, any applicable co-pay, coinsurance<br>treatment. I appoint Together with GSK Onco<br>permitted under state law. Special Note: Pres<br>states with official prescription form requirem<br>need to submit an electronic prescription to the   | assistance u<br>e, or other o<br>blogy, on my<br>scribers in a<br>nents, please  | Inder the C<br>ut-of-pocker<br>behalf, to<br>Il states mu<br>e submit ar | to-pay Progra<br>et cost for O<br>convey this p<br>ust follow app<br>n actual prese | am, in the al<br>JJAARA wo<br>prescription<br>plicable law | osence of financial support from such<br>uld be collected from the patient upon<br>to the dispensing pharmacy, to the extent |  |  |
| PRESCRIBER'S SIGNATURE  | SIGNATURE HERE Date: _MM / _DD / _YYYY   |  |   |  |  |  |  |
|   | No stamps  |  |   |  |  |  |  |
|   |  |  |   |  | Page 3 of 4  |  |  |

# **REQUIRED: HIPAA Patient Authorization**

By signing this form on page 2, **I agree** to allow my doctors, pharmacies, including my specialty pharmacy(ies), and health insurers (collectively "Healthcare Providers"), to use and disclose my health information to GSK and its agents, authorized representatives, and contractors (collectively "GSK") so that GSK can use and disclose my health information for purposes of providing Together with GSK Oncology services, which may include the following activities:

- 1. Communicating with my Healthcare Providers about my OJJAARA prescription and medical condition;
- 2. Investigating and resolving my insurance coverage, coding, or reimbursement inquiry, or reviewing my eligibility for GSK's patient assistance and co-pay assistance programs;
- 3. Contacting my insurer, other potential funding sources, and/or patient assistance programs on my behalf to determine if I am eligible for health insurance coverage or other funds;
- 4. Contacting me to offer (and, if I am interested, provide) optional educational services offered by healthcare professionals; and
- 5. Disclosing my information to third parties if required by law.

By signing this authorization, I acknowledge my understanding that:

- My Healthcare Providers will not and may not condition my treatment, payment for treatment, or eligibility for or enrollment in benefits on whether I sign this patient authorization.
- Certain Healthcare Providers, such as specialty pharmacies, may receive payment from GSK for disclosing my information to GSK as permitted by this authorization.
- Once information about me is released to GSK based on this authorization, federal privacy laws may no longer protect my information and may not prevent GSK from further disclosing my information. However, I understand that GSK has agreed to use or disclose information received only for the purposes described in this authorization or as required by law.
- This authorization will remain in effect for two (2) years after I sign it (unless a shorter period is required by state law) or for as long as I participate in the Together with GSK Oncology program, whichever is longer. I have the right to receive a copy of this signed form over the time it is valid.
- I have the right to revoke this authorization at any time by mailing a signed written statement of my revocation to **Together with GSK Oncology, P.O. Box 5490, Louisville, KY 40255**, but such a revocation would end my eligibility to participate in the Together with GSK Oncology program. Revoking this authorization will prohibit further disclosures by my Healthcare Providers based on this authorization after the date a written revocation is received, but will not apply to the extent that they have already taken action in reliance on this authorization. After this authorization is revoked, I understand that information provided to GSK prior to the revocation may be disclosed within GSK to maintain records of my participation.

The patient, or the patient's authorized representative, **MUST** sign this form (section 5) in order for the patient to receive Together with GSK Oncology services. If an authorized representative signs for the patient, please indicate relationship to the patient.

## Please provide a signed copy of this form to the patient.

Trademarks are owned by or licensed to the GSK group of companies.

