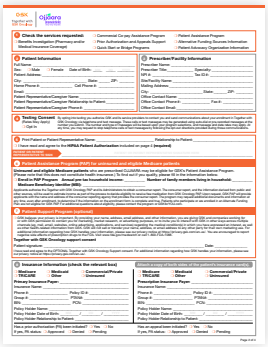
GSK
Together with GSK Oncology

Ojjaara (momelotinib)
200 mg • 150 mg • 100 mg tablets

Visit us at www.TogetherwithGSKOncology.com

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

Patient Information



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.

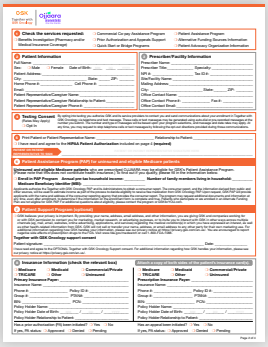
Section 5: Read the HIPAA Patient Authorization on the last page, and then check the box, sign, and date in section 5.

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.

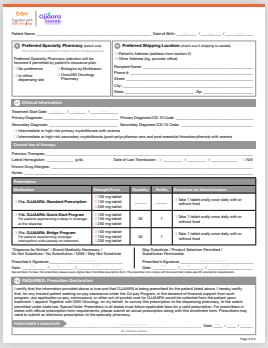
Prescriber Information

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



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.



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.

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1 Check the services requested:

- ❍ Benefits Investigation (Pharmacy and/or Medical Insurance Coverage)
- ❍ Commercial Co-pay Assistance Program
- ❍ Prior Authorization and Appeals Support
- ❍ Quick Start or Bridge Programs
- ❍ Patient Assistance Program
- ❍ Alternative Funding Sources Information
- ❍ Patient Advocacy Organization Information

2 Patient Information

Full Name: _____

Sex: ❍ Male ❍ Female Date of Birth: MM DD YYYY

Patient Address: _____

City: _____ State: _____ ZIP: _____

Home Phone #: _____ Cell Phone #: _____

Email: _____

Patient Representative/Caregiver Name: _____

Patient Representative/Caregiver Relationship to Patient: _____

Patient Representative/Caregiver Phone #: _____

3 Prescriber/Facility Information

Prescriber Name: _____

Prescriber Title: _____ Specialty: _____

NPI #: _____ Tax ID #: _____

Site/Facility Name: _____

Mailing Address: _____

City: _____ State: _____ ZIP: _____

Office Contact Name: _____

Office Contact Phone #: _____ Fax #: _____

Office Contact Email: _____

4 Texting Consent

(Rates May Apply)

❍ Opt In

By opting into texting you authorize GSK and its service providers to contact you and send communications about your enrollment in Together with GSK Oncology via telephone and text message. These calls or text messages may be generated using auto-dial or pre-recorded messages at the number you submit. The number and type of messages will be based upon your program selections, and message and data rates may apply. At any time, you may request to stop telephone calls or text messages by following the opt-out directions provided during those communications.

5

Print Patient or Patient Representative Name: _____ Relationship to Patient: _____

❍ I have read and agree to the **HIPAA Patient Authorization** included on page 4 **(required)**

PATIENT OR PATIENT REPRESENTATIVE TO SIGN

PATIENT OR PATIENT REPRESENTATIVE SIGNATURE HERE _____

6 Patient Assistance Program (PAP) for uninsured and eligible Medicare patients

Uninsured and eligible Medicare patients who are prescribed OJJAARA may be eligible for GSK's Patient Assistance Program. (Please note that this does not constitute health insurance.) To find out if you qualify, please fill in the information below.

❍ **Enroll in PAP Program** **Annual pre-tax household income:** _____ **Number of family members living in household:** _____

Medicare Beneficiary Identifier (MBI): _____

Applicants authorize the Together with GSK Oncology PAP and its Administrators to obtain a consumer report. The consumer report, and the information derived from public and other sources, will be used to estimate income as part of the process to decide eligibility to receive free medication from GSK Oncology PAP. Upon request, GSK PAP will provide applicants with the name and address of the consumer reporting agency that provides the consumer report. The program may request additional documents and information at any time, even after enrollment, to determine if the information on the enrollment form is complete and true. Patients who participate or are enrolled in an Alternate Funding Plan are not eligible for GSK PAP. For additional questions about eligibility, please contact the program or GSKforYOU.com.

7 Patient Support Program (optional)

❍ GSK believes your privacy is important. By providing your name, address, email address, and other information, you are giving GSK and companies working for or with GSK permission to contact you for marketing, market research, or advertising purposes, or to invite you to interact with GSK in other ways across multiple channels (eg, mail, email, websites, online advertising, applications, and services) regarding the medical condition(s) in which you have expressed an interest, as well as other health-related information from GSK. GSK will not sell or transfer your name, address, or email address to any other party for their own marketing use. For additional information regarding how GSK handles your information, please see our privacy notice at https://privacy.gsk.com/en-us/. You are encouraged to report negative side effects of prescription drugs to the FDA. Visit www.fda.gov/medwatch or call 1-800-FDA-1088.

Together with GSK Oncology support consent

Patient signature: _____ Date: _____

I have read and agree to the OPTIONAL Together with GSK Oncology Support consent. For additional information regarding how GSK handles your information, please see our privacy notice at https://privacy.gsk.com/en-us/.

8 Insurance Information (check the relevant box)

Attach a copy of both sides of the patient's insurance card(s).

❍ **Medicare** ❍ **Medicaid** ❍ **Commercial/Private**
❍ **TRICARE** ❍ **Other** ❍ **Uninsured**

Primary Insurance Payer: _____

Insurance Name: _____

Phone #: _____ Policy ID #: _____

Group #: _____ PTAN#: _____

BIN: _____ PCN: _____

Policy Holder Name: _____

Policy Holder Date of Birth: MM / DD / YYYY

Policy Holder Relationship to Patient: _____

Has a prior authorization (PA) been initiated? ❍ Yes ❍ No

If yes, PA status: ❍ Approved ❍ Denied ❍ Pending

❍ **Medicare** ❍ **Medicaid** ❍ **Commercial/Private**
❍ **TRICARE** ❍ **Other** ❍ **Uninsured**

Prescription Insurance Payer: _____

Insurance Name: _____

Phone #: _____ Policy ID #: _____

Group #: _____ PTAN#: _____

BIN: _____ PCN: _____

Policy Holder Name: _____

Policy Holder Date of Birth: MM / DD / YYYY

Policy Holder Relationship to Patient: _____

Has an appeal been initiated? ❍ Yes ❍ No

If yes, PA status: ❍ Approved ❍ Denied ❍ Pending

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Patient Name: _____ Date of Birth: MM / DD / YYYY

9 Preferred Specialty Pharmacy (select one)

Not required for enrollment in Quick Start or Bridge programs.

Preferred Specialty Pharmacy selection will be honored if permitted by patient's insurance plan.

- ❍ No preference
- ❍ In-office dispensing site
- ❍ Biologics by McKesson
- ❍ Onco360 Oncology Pharmacy

10 Preferred Shipping Location (check one if shipping is needed)

- ❍ Patient's Address (address from section 2)
- ❍ Other Address (eg, provider office)

Recipient Name: _____

Phone #: _____

Street: _____

City: _____

State: _____ Zip: _____

11 Clinical Information

Treatment Start Date: MM / DD / YYYY

Primary Diagnosis: _____ Primary Diagnosis ICD-10 Code: _____

Secondary Diagnosis: _____ Secondary Diagnosis ICD-10 Code: _____

- ❍ Intermediate or high-risk primary myelofibrosis with anemia
- ❍ Intermediate or high-risk secondary myelofibrosis (post-polycythemia vera and post-essential thrombocythemia) with anemia

Current line of therapy:

Previous Therapies: _____

Latest Hemoglobin: _____ g/dL Date of Last Transfusion: ❍ _____ / _____ / _____ ❍ N/A

Known Drug Allergies: _____

Notes: _____

Prescription

Medication	Strength/Form	Quantity	Refills	Directions for Administration
❍ **11a. OJJAARA: Standard Prescription**	❍ 100 mg tablet ❍ 150 mg tablet ❍ 200 mg tablet	_____	_____	❍ Take 1 tablet orally once daily with or without food
❍ **11b. OJJAARA: Quick Start Program** *For patients experiencing a delay in coverage at first dispense*	❍ 100 mg tablet ❍ 150 mg tablet ❍ 200 mg tablet	30	1	❍ Take 1 tablet orally once daily with or without food
❍ **11c. OJJAARA: Bridge Program** *For patients experiencing coverage interruptions while already on treatment*	❍ 100 mg tablet ❍ 150 mg tablet ❍ 200 mg tablet	30	1	❍ Take 1 tablet orally once daily with or without food

"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute

Prescriber's Signature: SIGNATURE HERE

Date: MM / DD / YYYY

May Substitute / Product Selection Permitted / Substitution Permissible

Prescriber's Signature: SIGNATURE HERE

Date: MM / DD / YYYY

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.

12 REQUIRED: Prescriber Declaration

I certify that the information provided above is true and that OJJAARA is being prescribed for the patient listed above. I hereby certify that, for any insured patient seeking co-pay assistance under the Co-pay Program, in the absence of financial support from such program, any applicable co-pay, coinsurance, or other out-of-pocket cost for OJJAARA would be collected from the patient upon treatment. I appoint Together with GSK Oncology, on my behalf, to convey this prescription to the dispensing pharmacy, to the extent permitted under state law. Special Note: Prescribers in all states must follow applicable laws for a valid prescription. For prescribers in states with official prescription form requirements, please submit an actual prescription along with this enrollment form. Prescribers may need to submit an electronic prescription to the specialty pharmacy.

PRESCRIBER'S SIGNATURE SIGNATURE HERE Date: MM / DD / YYYY

No stamps please.

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.