



Together with  
GSK Oncology



## 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.** To enroll in the optional Patient Support Program, read section 7 and check the box 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.**

### Prescriber Information

**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.

**1 Check the services requested:**

Benefits Investigation (Pharmacy and/or Medical Insurance Coverage)     Commercial Co-pay Assistance Program     Patient Assistance Program

Home Health Coverage Information     Prior Authorization and Appeals Support     Alternative Funding Sources Information

    Quick Start and Bridge Programs     Patient Advocacy Organization Information

**2 Patient Information**

First Name: \_\_\_\_\_ Last 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 #: \_\_\_\_\_ DEA #: \_\_\_\_\_ 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)

I have read and agree to the **Patient Support Program consent** included in section 7 (optional)

**PATIENT OR PATIENT REPRESENTATIVE TO SIGN**    **PATIENT OR PATIENT REPRESENTATIVE SIGNATURE HERE**

**PATIENT OR PATIENT REPRESENTATIVE TO SIGN**    **PATIENT OR PATIENT REPRESENTATIVE SIGNATURE HERE**

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

**Uninsured patients** who are prescribed ZEJULA 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:** \_\_\_\_\_

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. For additional questions about eligibility, please contact the program.

**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 statement 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](http://www.fda.gov/medwatch) or call 1-800-FDA-1088.

**8 Insurance Information (check the relevant box)**

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: \_\_\_\_\_

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

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: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: MM / DD / YYYY

<p><b>9 Preferred Specialty Pharmacy</b> (select one) <i>Not required for enrollment in Quick Start or Bridge programs.</i></p> <p>Preferred Specialty Pharmacy selection will be honored if permitted by patient's insurance plan.</p> <p><input type="radio"/> No preference      <input type="radio"/> Optum Specialty Pharmacy</p> <p><input type="radio"/> In-office dispensing site      <input type="radio"/> US Bioservices</p> <p><input type="radio"/> Biologics by McKesson</p> <p><input type="radio"/> CVS Specialty Pharmacy</p>	<p><b>10 Preferred Shipping Location</b> (check one if shipping is needed)</p> <p><input type="radio"/> Patient's Address (address from section 2)</p> <p><input type="radio"/> Other Address (eg, provider office)</p> <p>Recipient Name: _____</p> <p>Phone #: _____</p> <p>Street: _____</p> <p>City: _____</p> <p>State: _____ Zip: _____</p>
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**11 Clinical Information**

Treatment Start Date: MM / DD / YYYY

Primary Diagnosis: \_\_\_\_\_ Primary Diagnosis ICD-10 Code: \_\_\_\_\_

Secondary Diagnosis: \_\_\_\_\_ Secondary Diagnosis ICD-10 Code: \_\_\_\_\_

**Current line of therapy:**

1st line       2nd line       3rd line       4th line       4th line+

**BRCA Test:**       Positive       Negative       Results Pending       No Test

**HRD Test:**       Positive       Negative       Results Pending       No Test

Known Drug Allergies: \_\_\_\_\_

Notes: \_\_\_\_\_

Medication	Strength/Form	Quantity	Refills	Directions for Administration
<input type="radio"/> <b>11a. ZEJULA: Standard Prescription</b>	<input type="radio"/> 100 mg capsules	_____	_____	<input type="radio"/> Take ____ capsules by mouth, with or without food, at the same time each day (preferably in the evening)
<input type="radio"/> <b>11b. ZEJULA: Quick Start Program</b> <i>For patients experiencing a delay in coverage at first dispense</i>	<input type="radio"/> 100 mg capsules	15	4	<input type="radio"/> Take ____ capsules by mouth, with or without food, at the same time each day (preferably in the evening)
<input type="radio"/> <b>11c. ZEJULA: Bridge Program</b> <i>For patients experiencing coverage interruptions while already on treatment</i>	<input type="radio"/> 100 mg capsules	15	4	<input type="radio"/> Take ____ capsules by mouth, with or without food, at the same time each day (preferably in the evening)

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 ZEJULA 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 ZEJULA 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.

**HEALTHCARE PROFESSIONAL'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 ZEJULA 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 revoke this authorization at any time by mailing a signed written statement of my revocation to **Together with GSK Oncology, 101 Logistics Avenue, Jeffersonville, IN 47130**, 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 4) 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.*