



Together with GSK Oncology Enrollment for Patient Reimbursement Support Program for ZEJULA

Fax completed enrollment form to 1-800-645-9043

 Please see the instructions guide on page 4 for a quick reference on how to fill out this form and enroll your patient in the Patient Reimbursement Support Program for ZEJULA.

Check for services requested:

- Coverage Support (Benefits Investigation, Prior Authorization, and/or Appeals Support)
- Co-pay Assistance
- Patient Assistance Program
- Referral to Other Support Services (eg, patient advocacy organizations, peer to peer support, and non-co-pay support)

1 Prescriber/Facility Information

Prescriber's Name: _____

Prescriber's Title: _____ Specialty: _____

NPI #: _____ DEA #: _____

Tax ID #: _____

Site/Facility Name: _____

Mailing Address: _____

City: _____ State: _____ ZIP: _____

Office Contact's Name: _____

Office Contact's Phone #: _____ Fax #: _____

Office Contact's Email: _____

Preferred Method of Contact: Phone Email

2 Patient Information

Patient's Name: _____

Sex: Male Female Date of Birth: ____ / ____ / ____

Patient's Address: _____

City: _____ State: _____ ZIP: _____

Home Phone #: _____ Cell Phone #: _____

Email: _____

Best Time to Contact:
 AM (8 AM to 10 AM) Day (10 AM to 5 PM) PM (after 5 PM)

Alt. Contact's Name: _____

Alt. Contact's Relationship to Patient: _____

Alt. Contact's Phone #: _____

3 Clinical Information

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

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

BRCA Test: Positive Negative Results Pending No Test

Recurrent ovarian cancer in complete or partial response to platinum-based chemotherapy: Yes No

Treatment Target Start Date: ____ / ____ / ____

Known Drug Allergies: _____

Notes:

4 Insurance Information (check the relevant box)

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

Medicare Medicaid Commercial/Private Other Uninsured

Primary Insurance Payer: _____

Insurance Name: _____

Phone #: _____

Policy ID #: _____ Group #: _____

BIN: _____ PCN: _____

Policy Holder's Name: _____

Policy Holder's Date of Birth: ____ / ____ / ____

Policy Holder's Relationship to Patient: _____

Medicare Medicaid Commercial/Private Other Uninsured

Prescription Insurance Payer: _____

Insurance Name: _____

Phone #: _____

Policy ID #: _____ Group #: _____

BIN: _____ PCN: _____

Policy Holder's Name: _____

Policy Holder's Date of Birth: ____ / ____ / ____

Policy Holder's Relationship to Patient: _____

5 Preferred Specialty Pharmacy (select one) Preferred Specialty Pharmacy selection will be honored if permitted by patient's insurance plan.

No preference US Bioservices Diplomat Pharmacy, Inc. Biologics, Inc. In-office dispensing site



Call us at 1-844-283-7276,
Monday-Friday (8 AM to 8 PM ET)



Fax us the completed
enrollment form at
1-800-645-9043



Visit us at www.togetherwithgskoncology.com



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

- Patient's Address (address from Section 2)
- Other Address (eg, provider office, infusion center):
- Facility Name: _____ Phone #: _____
- Recipient Name: _____
- Street: _____
- City: _____ State: _____ ZIP: _____

7 Prescription Information/Prescriber Declaration

7 Prescription Information

Patient's Name: _____ Patient's Date of Birth: ____/____/____

Rx for ZEJULA® (niraparib) Quantity: _____ Refills: ____ Treatment Target Start Date: ____/____/____

Directions for Use: Take _____ (100-mg) capsules by mouth, with or without food, once daily, at the same time each day (preferably in the evening).

Other Directions:

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 the Patient Reimbursement Support Program for ZEJULA, 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.

With my signature, I authorize GlaxoSmithKline (GSK) and the specialty pharmacy to dispense ZEJULA directly to the patient.

Prescriber's Name (Please print): _____

Prescriber's Signature (No stamps please): _____ Date: ____/____/____

Please attach a separate prescription if this section does not comply with your state's prescription law. **Prescriptions from New York must be issued electronically.**

The prescribed quantity of ZEJULA will be shipped to the address indicated in Section 6 above.

8 Patient Financial Information (required for Patient Assistance Program)

Please note, eligibility for the PAP is based on the Federal Poverty Level and may change year to year.

Income will be verified using data from Experian Health. In cases where income cannot be verified, or there are discrepancies, additional proof of income may be required.

Annual Gross Household Income: \$ _____ # of Household Members (Including patient): _____

9 HIPAA Patient Authorization (patient signature required)

By my signature, I agree to the uses and disclosures of my health information described on the attached **HIPAA patient authorization**. The patient, or the patient's authorized representative, **MUST** sign this in order for the patient to receive services through the Patient Reimbursement Support Program for ZEJULA. If an authorized representative signs for the patient, please indicate relationship to the patient.

Patient Name or Caregiver Name (Please print): _____ Date: ____/____/____

Relationship to Patient: _____

Patient or Caregiver's Signature: _____



10 Optional Patient Services and Support

GlaxoSmithKline and its agents, authorized representatives, and contractors (collectively "GSK") offer helpful services and resources to support you on your treatment journey with ZEJULA.

GlaxoSmithKline and its agents, authorized representatives, and contractors (collectively "GSK") believe your privacy is important. By providing your name, address, phone number, email address, and other information, you are giving GlaxoSmithKline and its agents, authorized representatives, and contractors (collectively "GSK") permission to market or advertise to you 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. GlaxoSmithKline and its agents, authorized representatives, and contractors (collectively "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: <https://privacy.gsk.com/en-us/pharmaceuticals/default/>.

I have read and agree to receive optional patient services and support.

Patient Signature: _____ **Date:** ____ / ____ / ____

HIPAA Patient Authorization

By my signature, 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 GlaxoSmithKline and its agents, authorized representatives, and contractors (collectively "GSK") so that GSK can use and disclose my health information for purposes of providing services for the Patient Reimbursement Support Program for ZEJULA, which may include the following activities:

- Communicating with my Healthcare Providers about my ZEJULA prescription and medical condition;
- Investigating and resolving my insurance coverage, coding, or reimbursement inquiry, or reviewing my eligibility for GSK's patient assistance and co-pay assistance programs;
- 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;
- 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, 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 Patient Reimbursement Support Program for ZEJULA, whichever is longer.
- I have the right to revoke this authorization at any time by mailing a signed written statement of my revocation to PO Box 5490, Louisville, KY 40255, but that such a revocation would end my eligibility to participate in the Patient Reimbursement Support Program for ZEJULA. Revoking this authorization will prohibit further disclosures by my Healthcare Providers based on this authorization after the date 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.



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Instructions:



Complete the first 3 pages of this form.



Healthcare Professional to sign and date Section 7 on page 2.

Patient to sign and date Section 9 on page 2.



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ZEJULA Enrollment Form



Select services requested to specify the needs of your patient.

Sections 1 and 2: Prescriber and Patient contact information is required in this section. Be sure to include NPI and DEA numbers to help facilitate the Benefits Investigation.

Section 3: Clinical information requested is very important and often requested when verifying benefits. Diagnosis and appropriate ICD-10 code are required fields. Including clinic notes and/or supporting evidence of *BRCA* testing with this fax is optional.

Section 4: Be sure to fill out the patient's insurance information. In addition, a copy of both sides of the patient's insurance cards can be included at your discretion.

Section 5: 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 6: ZEJULA will be delivered to the patient's home unless otherwise requested in this section.

Section 7: This section can serve as the prescription for ZEJULA for commercial patients and requires prescriber signature.

Section 8: Be sure to fill out Patient Financial Information if enrollment in the patient assistance program is requested.

Section 9: HIPAA Patient Authorization: Patient signature on authorization form is required.

Section 10: Optional Patient Services and Support Consent for ZEJULA.



Together with GSK Oncology Program Offerings:

- Benefits Investigation
- Quick Start and Bridge Programs
- Referrals to Independent Co-pay Foundations
- Prior Authorization Facilitation and Appeals Support
- Commercial Co-pay Assistance Program
- Patient Assistance Program (PAP)
- Referrals to Patient Advocacy Organizations



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Visit us at www.togetherwithgskoncology.com

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