Together with GSK Oncology Enrollment Form for Quick Start and Bridge Programs

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)

Together with GSK Oncology

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Important Instructions:

Complete pages 2 and 3 of the Together with GSK Oncology Enrollment Form for Quick Start and Bridge Programs.

Patient to sign and date section 4 on page 2.
Healthcare Professional to sign and date section 9 on page 3.
Fax the completed and signed enrollment form, plus copies of your patient's medical and pharmacy insurance cards, to 1-800-645-9043.

Patient Information

Section 1: Select the service you are requesting.

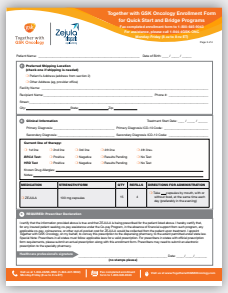
Section 2: Complete the Patient Information.

Section 4: Read HIPAA Patient Authorization on page 4, and check the box, sign, and date. Read section 5, and check the box for optional Patient Support Program.

Prescriber Information

Section 3: Provide the Prescriber/Facility Information.

Section 6: 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 7: Identify preferred shipping location if different from section 3.

Section 8: Clinical information is very important and often requested when verifying benefits. Diagnosis and appropriate ICD-10 code are required fields.

Section 9: Read Prescriber Declaration, sign, and date. A healthcare professional's signature is required.

Together with GSK Oncology Services:

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

1 Check for service requested:
❍ Quick Start Program ❍ Bridge Program

2 Patient Information Patient SSN: ___-___ - _____

First Name: _____ Last Name: _____

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

Patient 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 Name: _____

Alt. Contact Relationship to Patient: _____

Alt. Contact 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 Print Patient or Caregiver Name: _____ Relationship to Patient: _____

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

PATIENT TO SIGN PATIENT SIGNATURE HERE

❍ I have read and agree to the **Patient Support Program** consent included in section 5 **(optional)**

PATIENT TO SIGN PATIENT SIGNATURE HERE

5 Patient Support Program

GSK offers helpful services and resources to support you on your treatment journey. 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 or call 1-800-FDA-1088.

6 Insurance Information (check the relevant box)

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

Primary Insurance Payer: _____

Insurance Name: _____

Phone #: _____

Policy ID #: _____ Group #: _____

BIN: _____ PCN: _____

Policy Holder Name: _____

Policy Holder Date of Birth: _____ / _____ / _____

Policy Holder Relationship to Patient: _____

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

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

Prescription Insurance Payer: _____

Insurance Name: _____

Phone #: _____

Policy ID #: _____ Group #: _____

BIN: _____ PCN: _____

Policy Holder Name: _____

Policy Holder Date of Birth: _____ / _____ / _____

Policy Holder Relationship to Patient: _____

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

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

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

Facility Name: _____

Recipient Name: _____ Phone #: _____

Street: _____

City: _____ State: _____ Zip: _____

8 Clinical Information

Treatment Start Date: ____ / _____ / _____

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	QTY	REFILLS	DIRECTIONS FOR ADMINISTRATION
❍ ZEJULA	100-mg capsules	15	4	❍ Take ___capsules by mouth, with or without food, at the same time each day (preferably in the evening)

9 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 _____ Date: ____/____/_____

(no stamps please)

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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. 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, P.O. Box 220664, Charlotte NC 28222**, 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.