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

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

The Quick Start and Bridge Programs for ZEJULA offer free product to eligible insured patients experiencing a delay or gap in insurance coverage.

Check for services requested:

❍ Quick Start ❍ Bridge

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

Treatment Target Start Date: _____ / _____ / _____

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

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 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: _____

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Prescription Information/Prescriber Declaration

6 Non-commercial Prescription Information

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

Rx for ZEJULA® (niraparib) **Quantity:** 15 **Refills:** 4 **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 Quick Start and Bridge Programs 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 5 above.

7 HIPAA Patient Authorization (patient signature required)

By my signature, I agree to the uses and disclosures of my health information described on the **HIPAA patient authorization.** The patient, or the patient's authorized representative, MUST sign this in order for the patient to receive services through the Quick Start and Bridge Programs 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: _____

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 Quick Start and Bridge Programs 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 Quick Start and Bridge Programs 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 Quick Start and Bridge Programs 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.

Instructions:

- Complete this form.
- Healthcare Professional to sign and date Section 6.
- Patient to sign and date Section 7.
- Fax completed enrollment form to 1-800-645-9043.

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